Intentional Rounding as a Strategy to Decrease Patient Falls

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Introduction

- Falls are the leading cause of injuries and hospitalizations in the United States.
- Falls are directly related to the quality of nursing care in the hospital setting.
- Falls result in longer lengths of stay, effectively increasing patient morbidity and mortality in the acute care setting.

Purpose

Decrease the need for call light use by hourly rounding, thereby impacting patient fall rate.

Methods

- In 2015, a committee was formed to include Nursing staff, Nursing Management, and the Unit-Based Council.
- Baseline data was collected and reviewed for fiscal year quarter four 2015 (FY Q4'15).
- The team identified obstacles including: staff buy-in; availability of staffing; clearly defining the role of the hourly rounding staff; consistency of staff rounding; and patient perception of too many interruptions.
- A revised workflow was developed and implemented. Including but not limited to: taking a Certified Nursing Assistant out of patient assignment to serve solely as rounding staff; rounding on every patient at least once an hour; rounding conversations with patients targeting the areas of pain, bathroom help, position change, personal items not in reach, and equipment check.

Results

Baseline data for Quarter 4 of 2015

- Patient falls rate at 5.6%
- Patient calls at 42,000

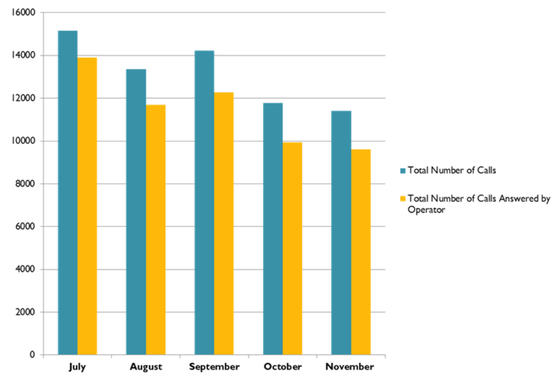
Post-implementation data for Quarter 1 of 2016

- Patient falls rate decreased to 1.46%
- Patient calls decreased to 37,000

Post-implementation data for Quarter 2 of 2016

- Patient falls rate decreased further to 0.46%
- Patient calls decreased further to 33,000

Unit	Q4 '15 Results	Q1 '16 Results	Q2 '16 Results
Falls Rates			
3 North	5.6%	1.46%	0.46%



Conclusions

- Positive impact on fall rate and the number of patient calls requesting assistance.
- Staff perception of CNA assigned as a rounder was positive.
- CNA completing hourly rounding additionally was able (depending on census and acuity) to assist with ambulating patients.
- The project was negatively impacted when there was a higher number of patients requiring 1:1 sitters.

Recommendations

- Further staff education is needed on the Morse Falls Scale.
- There are opportunities for the Unit Secretary to check the Morse Falls Scale fall prevention measures that are being utilized.
- Evaluate for a strategy that includes acuity.

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