Rounding by the Hour: A Time to Focus on Fall Prevention

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Background

The majority of falls during hospitalization occur on medical / surgical units, primarily in patient rooms (70%) and in bathrooms (15%). While acute care patient falls account for the greatest number of non-fatal injuries in hospitals, most are predictable and preventable. Despite use of a valid fall risk assessment tool, implementation of preventive measures, and participation in state-wide arm band and patient signage campaign, fall rates in many acute care units at Denver Health ran above the national benchmarks during 2008. An extensive literature review revealed Hourly Rounding demonstrated numerous patient benefits as well as effective fall prevention as compared to other preventive measures.

Purpose

The purpose of this evidenced-based practice program is to decrease falls, decrease call light utilization and improve patient satisfaction on the acute care units.

Setting

Denver Health Medical Center
477 - bed urban public safety net hospital
Implemented on acute care units:

- In 2009: 9A, 8A, 7A, 6A, 3B, 4B, & Rehab
- In 2010: CCMF

Methods

- An extensive literature review was conducted – evidence supported Hourly Rounding as an effective fall prevention measure
- Initial rounding toolkit developed
  - The toolkit (including education and implementation strategies) were pilot-tested on the three acute care units with highest fall rates
- Based on feedback from staff, educators, and managers revisions were made to the program
- Implementation expanded to the remaining 5 units over monthly intervals, totaling 183 beds
- Baseline data collection included call light utilization, patient satisfaction scores, and fall rates

Oversight

In order to support the implementation of Hourly Rounding, Nursing Outcomes, Research, & Evidence-based Practice conducted staff tracers, patient interviews & held multiple meetings with managers, educators & staff. The following audits were conducted:

- 238 staff tracers
- 112 patient interviews

Toolkit

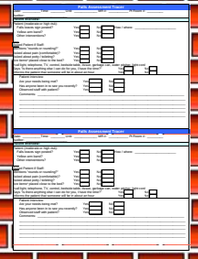
Room Sign

Pocket Reminders

Bedside Table Cards

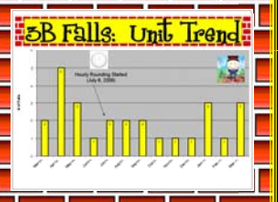
Documentation Log

Patient Tracer



Staff Tracer

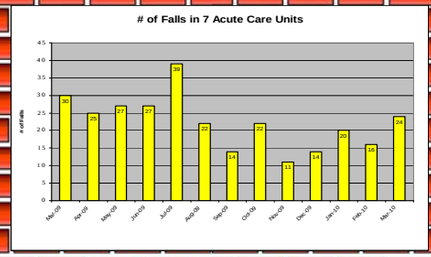
Sample Fall Board

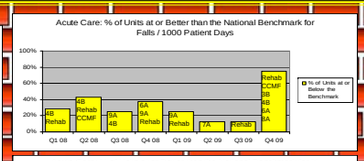


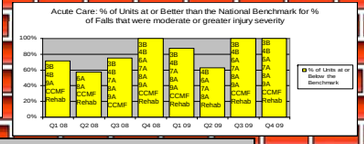
Outcomes

Quarter 4 2009:

- For the first time in 36 months, 6 acute care units were at or below the National Database of Nursing Quality Indicators (NDNQI) national benchmark mean
- Press Ganey patient satisfaction scores showed a marked improvement







Press Ganey

Overall Nursing Score by Unit	Qtr 1 2009	Qtr 2 2009	Qtr 3 2009	Qtr 4 2009
3B	91.1	88.6	85.8	82.9
4B	80.4	82.4	88.2	85.9
6A / Rehab	#N/A	88.8	84.5	93.5
7A	#N/A	89.1	71.9	91.2
8A	93.1	78.7	83.6	89.1
9A	84.1	86.6	84.9	86.9

>=Best Quartile Mean to Best Quartile < Mean

Implications for Practice

- Extensive oversight and coaching were required - some units needing more than others
- Call light utilization was eliminated due to confounding bed alarm data
- Unit fall prevention data information is reported to staff to keep them informed and to increase fall prevention awareness
- Extended fall prevention interventions:
  - Interdisciplinary Fall Prevention Committee:
    - First meeting, January 2010
    - Collaborative efforts to prevent falls
  - Fall debrief forms:
    - Created to be completed for each fall with staff participation
    - Improved communication among staff regarding the patient fall and how the fall could have been prevented
  - Evaluation of fall prevention technology (i.e. chair alarms)

In appreciation of unit leadership, nursing leadership and the staff who made this possible.