Implementation of an Intentional Purposeful Hourly-Rounding Protocol in the Long-Term Acute Care Setting

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Abstract

Background: A quality improvement project in Southeastern Florida was conducted to decrease the fall rate in a long-term acute care facility. The hospital had an increase in fall rate over a six-month period as reported in 2019. An evidence-based intentional hourly rounding tool and fall knowledge questionnaire were developed to decrease the overall fall rate within the facility.

Aims: The purpose of the project was to evaluate the effectiveness of an intentional hourly rounding tool along with a fall knowledge questionnaire to decrease the fall rate over a 90-day period in the long-term acute care facility.

Methods: A review of evidence-based literature on quality improvement studies regarding intentional hourly rounding in the long-term acute care setting was used to tailor an educational outcome for bedside nurses. The use of a fall knowledge questionnaire from the Agency for Healthcare Research and Quality, was used to evaluate the level of knowledge related to falls by the nursing staff. A review of incidents reported through the facility PRISM reporting system was conducted for the 90-day period following the implementation of the intentional hourly rounding tool to determine the number of patient falls on a monthly basis. In measuring the fall rates, the number of falls and the number of patient days (occupied bed days) on a monthly basis was evaluated to obtain fall rates. In addition to the rounding tool, the fall knowledge questionnaire was evaluated for its effectiveness on fall rates.

Results: A comparison of the fall rate, pre and post, showed a statistical decrease in the fall rate beginning November 18th 2019- February 18, 2020. The comparison of the pre- and post-fall knowledge questionnaire showed improvement in the staff fall knowledge level, beginning

November 18th 2019 to February 18, 2020. Results also indicated that intentional hourly rounding was an aid to decrease falls and to avoid ineffective safety measures.

Conclusions: The evidence-based intentional hourly rounding tool designed for bedside nurses did not decrease the fall rates by 10% (17.77%-9.09% equal 8.68% decrease) of the pre-implementation score. The pre-implementation fall rates were reported at 17.77% three months prior to implementation and 9.09% post-implementation. While there were three injurious falls reported six months prior to implementation, there were no deaths or injurious falls reported three months pre-implementation. Therefore, a 15% decrease in deaths and injurious falls could not be sought for the three months post implementation comparison period. Due to the high mean score of 76% on the Fall knowledge questionnaire pre-implementation and a mean score of 98% post implementation a 50% increase in the staff competency related to patient falls was not sought. In addition, with the limited sample size of the project along with a (90-day) timespan, further investigation should be obtained.

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Chapter I

Falls in long-term care (LTC) can be a common event for older adults living in an acute care setting, resulting in a loss of independence, in injury, and even death (Shi, 2014; Singh & Okeke, 2016). Therefore, preventive measures of falls are a key concern for older patients and healthcare providers. Even in a year's time, there has been a report of 700,000 to 1,000,000 fall related incidents in the acute care settings within the United States (Ganz & Huang, 2013). Of course, this does not count the purposeful or unpurposeful cases which were not reported.

According to the U.S. Centers for Disease Control and Prevention (CDC), one in four Americans aged 65+ fall each year with more than 2.8 million injuries treated in emergency departments annually. Annual falls result in over 800,000 hospitalizations and more than 27,000 deaths, not to mention the financial toll for older adult falls, which is expected to increase as the population ages and may reach $67.7 billion by 2020 (CDC, 2015). With the occurrence of a fall, a healthcare organization does not get reimbursed for these never-events, which further adds to the financial burden placed on the organization (Ganz & Huang, 2013). It is crucial for healthcare professionals who are caring for the long-term care population to promote the best practice in management strategies for falls, thereby improving the overall safety and autonomy of these individuals. Purposeful and timely hourly rounding, according to current evidence-based practice, has been the best practice intervention in reducing falls in an inpatient setting. This type of intervention routinely meets the needs of the patient, decreases the incidence of falls in a unit, ensures the safety of the patient, and proactively addresses problems before they occur. Hourly rounding gained momentum with the Studer Group (2007) when the Alliance for Health Care Research (AHCR) conducted a study involving several hospitals nationwide for improving patient safety. The study addressed four areas that are correlated with the Hospital Consumer

Assessment of Healthcare (HCAHPS) and patients' perception of being satisfied with care. The research showed that rounding on patients, using keywords that focused on common patient needs, was considered purposeful and intentional. The keywords that addressed the patients were (pain, position, potty, possession, and patient safety- referred to as the five Ps) and demonstrated an increase in patient satisfaction scores by 12 mean points, decreased use of patient call lights by 37.8%, and improved patient safety from crises such as falls by 50% (Studer Group, 2007). The standard protocol in most organizations is to identify and locate patients at risk for falls to prevent an incident. It has become a challenging process within the inpatient settings due to the lack of staff communication and educational awareness toward intentional hourly rounding, and thus it remains a major healthcare concern.

In most long-term settings, the environment can add a hectic and time-consuming element due to the frequent call lights and disruptions in care, which detract from the nursing staff's ability to focus on a task that requires their undivided attention. Hourly rounding is considered a task that is nurse-led through a proactive strategy in anticipating what the patient might need and the use of evidence-based practice (Deitrick, Baker, Paxton, Flores, & Swavely 2012). The standard protocol in regard to hourly rounding in the literature is for the registered nurse to provide hourly-rounding on even hours between the hours of 06:00 hours to 22:00 hours, and the patient care tech to round on the odd hours (Deitrick et al., 2012) in reducing disruptions, frequent intentional hourly-rounding on patients can lessen the burden of distractions and improve patient satisfaction. There have been several studies conducted on hourly rounding indicating improved patient safety and quality of care, but few studied the outcome on the relationship between intentional hourly-rounding and staff education. In addition, to improve the patient experience and obtain optimal patient satisfaction scores, the needs of the patient must be

met, including attention to their overall comfort needs in order to see a significant decrease in patient falls. One study demonstrated that by decreasing the call light volume and increasing the nursing staff, there was a reduction in falls (Deitrick et al., 2012). However, few studies have addressed the barriers involved in analyzing the causes of patient falls, and the correlation of integrating a systematic rounding intervention into the everyday practice to achieve long-term outcomes. In addition, the use of collaborative interdisciplinary teams should be used in LTC to help reduce the likelihood of injurious falls (Wexler & D'Amico, 2015).

This project contributed to the currently available research on fall prevention strategies which are tailored to long-term acute care facilities. It identifies the areas that need improvement in the standard fall prevention protocol, thus applying the intervention of an intentional hourly rounding protocol coinciding with staff fall prevention education. At that point initiatives can be incorporated as adopted by other researchers' evidence, embracing the current hospital efforts to reduce the number of falls within the long-term acute care facility. Lastly, the project will address the safety of the patient and the measures that are needed for the specific unit to adopt a change and reduce falls.

Background and Significance

In the long-term acute care settings, a fall resulting in an injury is among the most common hospital-acquired conditions related to patient safety and resulting in, hopefully, at least a few effective prevention methods. The Joint Commission Center for Transforming Healthcare (2016) defines any patient of any age at risk of a fall when his or her physiological needs change related to the current medical condition. These falls can result in serious injuries that account for an additional average of 6.3 days in hospital stays and a cost of about $14,000 for such injuries (The Joint Commission Center, 2016). In preventing patient falls leading to serious injuries it is

necessary to identify risk factors associated with such a fall. In identifying these factors, an assessment of each patient can help identify whether the patient's current situation has a potential risk of causing a fall and formulating a preventive intervention for such patients at risk to prevent any recurrence of falls. Further analysis of the standards being kept in the units should also be obtained. For example, are there inadequate assessments of a patient, lack of leadership, inadequate staff orientation, lack of staffing, or lack of patient/staff supervision related to safety practices? One barrier that is apparent in the facilitation of a fall prevention practice is the lack of consistency in the standard of care, resulting in a failure to make the staff accountable when a fall does arise. If there is not a consistent routine that is put in place and strictly observed, barriers such as a lack of staff awareness, lack of staff education on fall prevention strategies, and an increase in patient falls may well occur, leading to a destructive situation. One way to help with this barrier is the use of data such as hospital records, medical error reports, and surveys to help guide the stakeholder in a more directional path (Blakley, Kroth, & Gregson, 2011) to promote change. Intentional-rounding is described as a process of proactively meeting the needs of the patient by a nurse making a conscious routine visit to patient rooms, by checking on specific items around the room, and inquiring about basic self-care of the patient on a regular, consistent basis (Blakley et al., 2011). Although these quantitative data help in promoting change, they are limited. That is, they may not be the driving factor to reduce falls and are insufficient in understanding the exact causes of falls. Therefore, planning an intentional hourly rounding protocol, along with an approach to educating staff on fall prevention, would add to the knowledge regarding the possibility of a fall.

Needs Assessment

Considering a long-term acute care facility located in Southeastern Florida, the fall rates within this facility had increased within a 6-month interval. The falls' prevention protocols which are currently in place have not been effective due to the lack of accountability and documentation from the staff. The current practice within the facility involves the use of hourly rounding including the four Ps (potty, pain, position, possession) on all admitted patients and establishing preventive measures for patients at risk based on the Morse Fall Risk Assessment Scale.

However, due to the lack of accountability and conscientious performance by nursing staff, the established protocol has not been effective. Therefore, the use of staff education and an intentional purposeful hourly rounding protocol have been identified to combat fall rates in the facility. Although there have been studies using evidence-based tools for fall risk stratification, the tools used in those studies are specific to the institution and the population being studied and it is nearly impossible to generalize these tools in practice as they were focused on a specific population and setting (Trepaniar & Hilsenbeck, 2014). The administration and nursing staff at the site selected for this project have agreed to take part in a falls' prevention program to determine relevant interventions needed for practice. The facility was assessed for a need during the Summer of 2019 by conducting an analysis on the current data reported on falls.

Problem Statement

In the proposed facility, the current problem involves the lack of accountability by nursing staff when conducting hourly rounding. The facility has not been able to devise a plan that will hold staff accountable in performing their hourly rounding duties. In turn, fall rates have increased, which led to injuries. Nursing staff personnel are not adequately conducting hourly

rounding on patients, leaving the patient at risk for injuries. According to the National Institute for Health and Clinical Excellence (NICE, 2004), positive results in the decrease of falls were effective when providing patients with information regarding fall-prevention education. This is partly due to the fact that residents in long-term care facilities are at a higher risk of experiencing a fall-related episode due to their long length of stay, decreased function, polypharmacology, and advanced age (Healey & Darowski, 2012). Given the increase in fall rates among the aging population, an intentional, purposeful hourly rounding protocol should be implemented to combat cost in fall-related injuries. The frontline nurses must maintain current knowledge of the intervention process that will be applied to ensure that optimal patient care is being carried out in promoting patient safety.

Project Aim or Purpose

The purpose of this DNP project is to evaluate the effectiveness of staff education on a fall prevention strategy by implementing an evidence-based intentional, purposeful hourly rounding protocol in a 48-bed, long-term, acute-care, non-profit facility located in Florida. The goal of the project is to deliver the best evidence-based practice guidelines through nursing education in examining the effect of evidence toward fall reduction.

Objectives. The goals of the project are:

- To evaluate current rounding practices, and their effects on fall prevention measures and decrease the fall rates by 10% of the pre-implementation score in the long-term acute care hospital by the end of the 3-month pilot project.
- To increase the educational competence within the nursing staff related to intentional purposeful hourly rounding by use of the Studer Group Research study by 50% of the pre-test

fall score and successfully abide within the intentional purposeful hourly rounding protocol safety checklist.

- To reduce deaths and injuries from unintentional falls in the long-term acute care setting by 15% of the pre-implementation scores by the end of the 3-month pilot project.

Clinical Question/PICOT

Will fall prevention education, along with an intentional purposeful hourly rounding protocol for staff, in a 48-bed, long-term, acute care hospital be effective in reducing the number of falls by 10% and injurious falls by 15% over a 3-month period?

Congruence with the Organizational Strategic Plan

For this project, the standards for the outcome of the organization were based on the Studer Group intentional-rounding intervention as well as consideration of the Joint Commission's National Patient Safety Goals related to reducing falls in the inpatient setting. The organizational strategic plan is based on promoting high-quality care, improving patient safety, decreasing adverse events related to falls, and maintaining the quality of care for all patients within the healthcare organization. Consequently, patient safety is one of the primary focuses for all healthcare organizations, and it is our belief that, with the participation of nursing staff through education, early identification of patients at risk for falls can be prevented (Mitchell, 2008).

Synthesis of Evidence

Search Process

A systematic review of literature was used to conduct an effective search on the topics of evidence-based fall prevention strategies directed toward long-term care facilities. Search keywords from 2006 to 2018 *included long term care falls, inpatient falls, fall prevention strategies in long term facilities, fall risk factors, fall risk scales, intentional rounding in long term facilities, rounding in the inpatient settings, and Morse Fall Scale*. Databases used for the search included Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane Collaboration and Medline. The searches produced more than 3,500 articles. There were 66 articles that met inclusion criteria for the project related to fall rates in the long-term settings, fall risk factors in the acute care setting (medication-related), intentional hourly-rounding as an intervention to reduce falls, and a different comparison of fall intervention strategies. Thus, 20 articles were selected in the specified inclusions for their substantial contribution to this study and included in the evidence table. Exclusion criteria were studies focusing only on any areas of clinical practice other than the acute long-term hospital setting. Several additional articles were used as sources specific to the acute care setting and fall rates but were not included as evidence based data and therefore not included in the evidence table.

High-Risk Medication Related to Falls

Patient falls are a common incident in the long-term care setting. One primary risk factor is the use of high-risk medications. Baranzini et al., (2009), Berry et al. (2011), Krauss et al., (2005), Oliver et al., (2004), Tinetti et al., (2014), as well as Woolcott et al. (2009), found various relationships between the use of multiple high-risk medications and fall incidence. In a

systematic review, Healey and Darowski (2012) reported that effective fall prevention strategies led to a 20-30% reduced risk of falls when combined with multifactorial assessment and an intervention plan. These studies demonstrate that close monitoring is warranted for patients using high-risk medications.

Patient Safety

Patient safety should be the primary goal of an institution. Jensen, Lundin-Olsson, Nybergy and Gustafson (2002); Cox et al., (2015), noted literature on risk factors related to falls, environmental modification, and exercise programs in creating fall preventions for patients in long-term facilities. In addition to these, ecological change such as intrinsic (postural hypotension, previous falls), extrinsic (dim lighting, obstacles and tripping hazards) and workforce factors were all related to falls within the acute care setting. The authors found that by implementing a fall prevention strategy, along with a higher number of staff employed, the number of falls decreased. Patient perspective related to a fall is vital in promoting future safety initiatives. Radecki, Reynolds and Kara (2018) conducted a semi structured interview including 12 patients at an academic healthcare center with an objective to understand the patients' perspective on their fall risk and help design a patient-centered strategy. Results revealed patients viewed themselves in three themes: (1) how they saw themselves, (2) how they saw the interventions; and (3) how they saw the healthcare team.

Most patients were aware that they were at risk for fall, but the awareness was limited to patients with physical limitations compared to those supposedly without physical limitations. Sonnad, Mascioli, Cunningham, and Goldsack (2014) & Oliver et al. (2006) agreed that patients did not believe they were at risk for fall due to their ability to ambulate, these studies showed that

individual and transient factors hindered a patient's safety. These similar studies imply a need for patient education related to patient safety in healthcare facilities.

Frontline Nursing Staff in Fall Prevention

It is essential to involve nursing staff in the implementation involving change. Black et al. 2011; Dykes et al. 2010; Goldsack, Bergey, Mascioli and Cunningham (2015); Pinkerton, 2005; Wagner et al. (2010) all identified the use of frontline nurses' involvement with the use of visual cues, communication, and teamwork, as a positive indicator for adverse events and fall reduction. In contrast, Fabry (2014), saw a decrease in falls when using a descriptive analysis survey on 67 registered nurses, and found that 25% felt a sense of ownership in the hourly rounding initiative, whereas 23% felt validated with the completion of a hard copy hourly rounding documentation tool. Contrary, Archer, 2010; Dacenko-Grawe and Holm, 2008; Dykes et al., 2010; Haines, Bennell, Osborne, and Hill (2004); Healey, 2004; Tzeng and Yin, 2008; Saravanakumar et al., 2014; Peterson and Berns, 2006; have shown a positive outcome in decreasing fall rates when patient, staff and family participate in fall education, along with a mindfulness of written information to help decrease falls with hourly rounding. For example, Peterson and Berns (2006) implemented a staff educational training for a falls' reduction intervention over four months, the authors provided in-person educational training to 80% of the staff, and within a year following the intervention, a 24% reduction in fall rates was observed. These studies show that involving frontline staff as well as patients with educational resources related to falls, it can lead to a reduction in falls in the healthcare setting.

Implementation Strategies

A fall prevention strategy is needed in the long-term care setting to reduce fall rates. DiBardino, Cohen, and Didwanla (2012); Goldsack et al., (2015) state there are a few implementation processes that have been developed to address the issue of healthcare related falls (hourly rounding, fall risk assessment, patient education, visual risk alert). However, many of the studies are lacking scientific evaluation. Rondinelli et al., (2012) conducted an action research design on eleven facilities in regard to their structure, their process, and outcome related to hourly rounding and found a decrease in fall rates when hourly rounding was done properly. The complexity of such a conclusion had led to debates about the effectiveness of quality improvements (QI) or whether improvement interventions would yield positive outcomes (Dixon-Woods et al., 2011). Hutchings, M., Ward, P., and Bloodworth, K. (2013), state that a proactive and intentional-rounding done in a 1-2-hour interval yield a positive result, improving patient satisfaction, reducing patient fall, increasing patient ratings to staff responsiveness and enhancing the nursing perception of their work. However, Danaf et al., (2017) conducted 3 case studies at 3 high performing hospitals to explore their implementation of a proactive nursing rounding and found that there were a 26% increase in nurse responsiveness and nurse communication with the use of a proactive rounding tool. In addition, there has been research conducted on intentional hourly rounding in the United States that has shown positive outcomes regarding patient satisfaction, falls, call bell use and decreasing pressure ulcer when staff involvement is utilized (Tea, Ellison, and Feghali, 2008; Meade, Kennedy and Kaplan, 2010; Olrich, Kalman and Nigolian, 2012; Phillips, Yarmo-Roberts, and Hunsaker, 2008; Miake-Lye. Hempel, Ganz, and Shekelle, 2013). However, the quality of studies yielding positive results has been criticized for being over-reported or misinterpreted (Snelling, 2013). Although the

successful implementation of an intended, purposeful hourly rounding protocol is needed, it hinges on the compliance and engagement of staff involvement. It appears that a structured approach can help simplify the change (Krepper et al., 2014; Ang, Mordiffi, and Wong, 2011). A need for an implementation strategy for such a project related to the effectiveness of purposeful hourly rounding is needed to add to evidence-based literature.

Intentional Purposeful Hourly Rounding

Intentional hourly rounding has been studied in evidence-based literature, but current research lacks evidence on the use of intentional, purposeful hourly rounding with staff education in decreasing fall rates in the healthcare settings. Standard fall intervention, strategies such as using 'Falling Stars' or 'Leaves' in the long-term care setting have been used as early as 1997 and have been shown to reduce falls by 19% (Ray, Taylor, & Meador, 1997). However, intentional purposeful hourly rounding allows staff to perform a purposeful task every hour (address patient needs, repositioning, potty, pain and assessing patient surroundings) to decrease the likelihood of patient fall and adverse events.

For example, in a formulated pilot study conducted by Braide (2013), the introduction of intentional hourly-rounding in Musgrove Park Hospital acute care units was used to improve the nursing care given to patients. The author used the PDSA cycles of improvement (Plan, Do, Study, Act) to help facilitate the implementation along with staff education prior to the application of IR. After one month of the pilot study, the fall rate dropped from 84% to 54% in the medical-surgical unit and a significant decrease in call lights and adverse events (Braide, 2013). Assessing patient risk factors, promoting patient safety, incorporating staff education, and initiating a purposeful hourly rounding protocol will further contribute to the current relevant research in improving patient outcomes.

Gap in Literature

There is an abundance of information on fall prevention strategies in the outpatient settings for geriatric patients, but the hospital in which this project will take place sees various patients in different age groups including geriatric patients so the potential for falls in this age group is warranted. The majority of the literature has documented the benefits of implementing hourly rounding, but little is written about identifying barriers related to falls in the acute care long-term facilities along with staff education. There is also limited literature to illustrate the significance of staff education combined with an intentional purposeful hourly-rounding protocol in the implementation of a fall's prevention and safety initiative in the long- term acute care facility. Therefore, the evidence synthesized will give readers an understanding of why an intentional hourly-rounding protocol along with staff education is warranted for the projected facility.

Conceptual Model and Theoretical Framework

Patient safety and comfort are important factors in the hospital settings. With this in mind, Kolcaba's theory of comfort (1991), and the Studer Group Model (2007), form the conceptual model and framework for this project. The theory of Kolcaba explains comfort as a basic need of all humans for the relief, ease, and transcendence. It concludes that if a specific comfort need of a patient is met, the patient will be more at ease with the plan of care. For example, a patient who receives pain medication for pain or water for thirst is receiving a measure of relief from pain and discomfort, thus providing him or her with a sense of comfort. One can apply this theory with the use of intentional-hourly rounding in providing comfort for patients' needs. If a nurse is conducting a structured timely hourly-rounding on his or her patients then the patient will feel ease, knowing that his or her needs will be met. The other part of the

theory is transcendence, that is, describing how a patient rises above his or her challenges. There are four contexts in which patient comfort can occur: physical, psychospiritual, environmental, and sociocultural (Kolcaba's theory of comfort, 1991). The Studer Group model (2007) and Kolcaba's theory of comfort (1991), uses specific nurse behaviors in the anticipation of the four Ps related to the comfort, care, and needs of the patient such as (pain, position, potty, and possession). With the Studer Group model (2007), rounding is performed on patients at a structured time. This is assumed to decrease the patient anxiety, knowing that he or she will see a nurse or nursing assistant on a continuous time schedule to address his or her comfort needs. This type of rounding enhances patient security while hopefully decreasing call light use, along with the nurse workload. The Studer model emphasizes the use of a proactive nursing tool with scripted cues, during timed schedules to address the common needs of patients, decreasing the risk of adverse events, decreasing impaired communication, and decreasing patient frustration. These frameworks complement each other to achieve patient outcomes and facilitate a structured environment that promotes safety and comfort.

Relevance to the Clinical Question. After a careful examination of the selected population, both theories focus on providing individualized patient care to enhance comfort and maximize health care outcomes. But Studer's Group model advances the concept of comfort to include scheduled assessments of the patient in anticipation of comfort care needs through timely scheduled rounding. This event can be done by the use of an intentional-hourly rounding protocol along with staff education to help decrease the number of falls in the proposed medical surgical unit. The use of such a protocol will add to the limited research regarding fall prevention strategies along with staff education in decreasing falls in the medical-surgical unit.

Chapter II: Methodology

Project Design

A pre- and post-intervention design quality improvement pilot study within a 48-bed, long-term acute care facility with three levels of care: med-surgical, progressive care, and intensive care located in Florida.

Setting. As located in the state of Florida, BCAH is a 48-bed long-term acute care facility with three levels of care: med-surgical, progressive care, and intensive care. The facility was selected due to the increasing number of falls within a six-month time frame and the need for a quality improvement safety initiative in the reduction of fall rates in the identified clinical areas. The standard practice and policies of the facility regarding rounding will be discussed. The patient to nurse ratio on the units is usually 1:4 or 1:5, but is dependent on census levels and staffing. Currently, the registered nurses are not mandated to document their hourly rounding using the electronic health record, but the certified nursing assistants (CNA) do record any task that is done for the patient in the electronic health record and therefore, staff accountability is a significant issue for the organization.

A patient is identified at risk for falls during admission with the use of the Morse Fall Risk Assessment Scale (MFS). The facility uses Cerner as its primary electronic health record system to document nursing assessments, activities of daily living (ADL), and fall screening. In return, if the patient is at risk for fall dictated by the MFS, the patient receives a yellow pair of non-skid socks and a yellow wrist band. The patient's bed is placed in the lowest setting, there is availability of a bed alarm and there is a falling leaf sign outside the patient door. All 48 beds are

located in private rooms, with beds locked in a stationary position though they can go up and down by preference of the patient.

Population/Sample

All 35 employed nursing staff members at the long-term acute care facility were encouraged to participate in the project. The population sample included 12 certified nursing assistants and 23 registered nurses. There were no exclusions criteria, as this project reflected a quality improvement project on an already established hourly rounding protocol for patient safety and therefore staff participation is encouraged.

Tools and Instruments

To evaluate the need for the project, the use of a falls' knowledge test consisting of 13 multiple choice questions was given to the staff. This comprehensive assessment tool was recommended by the Agency for Healthcare Research and Quality, to help improve staff knowledge on falls in the acute care setting. It was used to analyze a pre- and post-staff-knowledge on the causes of falls as a comprehensive assessment tool. Permission to use the tool was not needed, as the tool was indicated for educational use on the website. (Accessed at https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2e.html) (see Appendix A) Research has shown communication and knowledge between all disciplines was found to be lacking in most facilities' fall prevention programs (Phillips et al., 2008; Anderson et al., 2012; Wagner, Damianakis, Mafrici, & Robinson-Holt, 2010). In addition, the already established use of the Morse Fall Risk Scale (MFS) will measure each patient at risk for falls and will allow the staff to contribute the required protocol for these higher-risk patients. This event would include the use of a yellow pair of non-skid socks, a yellow wristband, lowering the

patient bed to the lowest setting, the use of a bed alarm and a falling leaf sign outside the patient door. Finally, a rounding sheet similar to the Studer Group Research (2007) would be used by the investigator and approved by the Director of Nursing and Nurse Manager for implementation. This rounding sheet was part of the Strategic Quality Initiatives division of the Missouri Hospital Association that periodically releases tips and tools on their website to assist hospitals in achieving safe patient outcomes. This rounding tool sheet was one of the tools released by the division to help other hospitals and permission to utilize this tool was granted (see Appendix C)(https://web.mhanet.com/Issue_Brief_Triple_Aim_Rounding_0515.pdf) and (see Appendix B).

Project Plan

Interventions and Implementation Process

- The National Center for Patient Safety (2004), states that when a fall occurs it is essential for staff to investigate trends leading to the fall. Therefore, before the implementation, data reflecting fall increase within a three months' time-frame was evaluated.
- The implementation of the project began soon after IRB approval. Staff education began shortly after project approval by the IRB and chair team.
- A voluntary staff meeting, directed by the Director of Nursing (DON) and nurse manager was held on two calendar days to ensure that all staff has an opportunity to attend.
- A sign-in sheet was posted prior to entry to the educational training to establish participation and attendance.

- A pre-test developed by the Agency for Healthcare Research and Quality Improvement consisting of 13 multiple choice questions to assess the knowledge and efficacy of an educational intervention related to falls was given to all nursing team members for completion (see Appendix A,).
- The data collected was summarized in its entirety, and no identifiers were present on the pre-test.
- The nursing staff were educated on the proposed intentional purposeful hourly rounding protocol and risk related to falls.
- The new intentional, purposeful hourly rounding protocol included a daily rounding sheet that was placed in each patient's room near the communication board. With the approval of the management team, all nursing staff (registered nurses, certified nursing assistants, and secretary) assigned to patients per the assignment sheet was responsible for completing their purposeful rounding on every assigned patient, during their shift.
- The rounding sheet consisted of dates and times to initial by the nursing staff to ensure accountability and completion of hourly rounding by nursing staff.
- Staff were reminded to conduct their intentional purposeful hourly rounding during huddle before the start of the shift daily.
- Patients were informed of the use of intentional purposeful hourly rounding to ensure patient involvement in the plan of care.
- The new protocol will continue to be reinforced during staff meetings in addition to daily reinforcements.

- The assigned staff (Charge Nurse) will educate all future new employees on the use of the intentional purposeful hourly rounding sheet in the long-term acute care facility.
- To measure effectiveness of the project, a reevaluation of the falls data, along with a posttest identical to the pretest, was conducted three months after completion of the project.
- Audits were conducted weekly (by management) to assess the intentional purposeful rounding process and assessing for log documentation in patients' rooms.

Data Analysis

Descriptive data, with trends, were used to evaluate the outcomes. Grove et al. (2013) identify how descriptive designs illustrate a picture of the situation as it happens and thus help identify current problems within the practice. The data on the hourly rounding log sheets in regard to staff sign-offs was evaluated by the investigator and the project team leaders. Data of any documented intervention during intentional hourly rounding audited on a weekly basis by the project leader (Nurse Manager) for effectiveness and accountability. The investigator (Student) applied the data to a descriptive chart with trends of fall rate pre and post-implementation. The finding was reviewed by the project team members to evaluate the effectiveness of the intentional purposeful hourly rounding log sheets on fall rates.

Ethical Issues

IRB approval/ethical issues: Staff names were not identified to ensure the protection of the participants. The protection of patients' rights, privacy, welfare, and confidentiality was maintained. The project was part of a mandatory staff training to improve patient safety and

therefore consent was encouraged. IRB application was submitted and approved by the chair of the committee.

Chapter III: Organizational Assessment & Cost-Effective Analysis

Organizational Assessment

Readiness for change

The organization has assessed the staff readiness for change and agrees that providing a safe environment for the patients overrules any form of barriers. Staff members are accustomed to the constant changes made in the healthcare organization in promoting patient safety, and therefore, the readiness for change should not be an issue but somewhat expected. In addition, with reassurance from management and project team members, the nursing staff was excited for the transition to happen.

Barriers/Facilitators

Staff involvement would possibly form a barrier but this is expected in any change initiative, with support from management and project team leaders, such a barrier was minimal. Staff was provided with educational tools to help promote the implementation of the intentional purposeful rounding protocol and thus help facilitate changes. Patient involvement did not play a role as the rounding is done by nursing staff. Patients were encouraged to be aware of intentional purposeful hourly rounding taking place. Lastly, the input from staff contributed to facilitating the implementation, as they are the frontline assessor in the project.

Risk and/or unintended consequences

There is no known perceived risk for the development of the project.

Interprofessional Collaboration

Interprofessional collaboration with this project would include staff and management team. The use of other disciplines should not be needed. However, regarding this fall prevention protocol, all staff present on the shift are responsible for promoting patient safety. The staff are responsible to conduct intentional rounds on their assigned patient. Management is to perform weekly audits to make sure rounding logs are being signed off by the charge nurses, validating the fact that nursing staff are conducting intentional purposeful rounding and adhering to patient safety guidelines.

Budget

In the projected facility, nursing staff are mandated to several hours a year to allow for continuing education and therefore, there were no associated cost by the facility to educate staff on the new safety initiatives. Since the facility manager collected all statistical data, all printing of materials was held at the facility. Thus, there is an unrelated cost associated with materials. Results were reviewed independently by the investigator and the project team, and therefore, there is no associated cost with hiring outside resources.

Chapter IV: Outcomes

Analysis of Implementation Process

The focus of the project was to use an evidence-based intentional hourly rounding tool (see Appendix B) to help decrease the rate of falls and injurious falls in the long-term acute care setting. The focus, as well, should improve the overall educational knowledge of the staff related to falls with the use of a pre/post Fall Knowledge Questionnaire (see Appendix A). The project sought to evaluate the effect of an evidence-based hourly rounding tool along with a fall knowledge questionnaire regarding the impact of falls within the long-term acute care. Prior to implementation, staff were not conducting intentional hourly rounding effectively and therefore a rise in patient falls occurred. There was also no protocol in place within the facility to hold staff accountable for hourly rounding. With this project, a protocol was established to determine its effectiveness on fall rates.

Grove et al. (2013), stated that quantitative descriptive designs have the ability to illustrate a picture of the problem at hand as well as identifying problems within an organization. The author decided to use a quality improvement project to determine the relationship between the intentional hourly rounding tool, along with the fall knowledge questionnaire on fall rates. A voluntary staff meeting, led by the Director of Nursing (DON) and nurse manager was held on two calendar days (November 11th and 12th) to ensure that all staff had an opportunity to attend. A sign-in sheet was posted at the entrance of the educational training to establish participation and attendance. Twenty-eight out of thirty-six staff members agreed to participate in the project. A consent form was read and passed out to all participants, and all participants signed and understood the requirements given. A pre-test had been developed by the Agency for Healthcare Research and Quality Improvement consisting of 13 multiple choice questions to assess the staff

knowledge regarding falls was administered. Twenty-eight staff members took the fall questionnaire with a mean score of 76%. On November 18, 2019, the project went live. All participants were made aware prior to start of shift of the new protocol at hand. The intentional hourly rounding sheets were placed in each patient room near the communication board, consisting of dates and times to initial by the nursing staff, overall 91% (82 days with full compliance/ 90-day length of project) of the time the nursing staff utilized the rounding tool. Every morning at 5:00 a.m. a new rounding sheet was given to staff by the charge nurse to place in patient rooms. Daily reminders during shift huddle were performed to promote compliance. Random observations were conducted by management to observe staff use of the four Ps within the patient care plan. To promote consistency of the project, new staff were educated on the new protocol by the charges nurses but were not a part of the project. Lastly, weekly audits were conducted for staff accountability of the hourly rounding tool in each of the assigned patient rooms.

Analysis of Project Outcome Data

In the three months before implementation, the fall rate was reported at a 31.09% per 1000 patient days or the months of (June-October 2019). Due to the prior increased numbers of falls within the facility, the project sought to improve the fall rate within a 3-month period. The fall rate was obtained by taking the number of patient falls divided by the number of patient days for the given months and then multiplied by 1000 (# of patient days) which results in the number of falls per 1000 patient days or the "fall rate." The number of reported falls obtained is given to the facility by the number of PRISM "incidents" reported. For this project I evaluated the fall rate three months pre-intervention and compared the results three months post-intervention. In measuring fall rates, the number of falls and the number of patient days on the unit over a given

period of time, such as 1 month or 3 months were assessed. Fall rates are calculated monthly based on information from incident reports and daily census. Three months prior to implementation, the fall rates were calculated at a 17.77%, with thirteen reported falls, and three injurious falls. Three-month post-implementation the fall rate dropped to 9.09% with eight reported falls, and no deaths or injurious falls reported (see figure 1&2).

The decrease in patient falls can be attributed to the persistence in management to conduct intentional hourly rounding as well as staff participation. But, the inability to decrease fall rates by 10% could be contributed to the staff inability to adhere to patient safety measures rather than the intentional hourly rounding sheet. The staff falls knowledge questionnaire improved from a pre-intervention mean score of 76 % to a post-intervention mean score of 98%. An increase of 50% in staff mean score of the pre-fall knowledge questionnaire was not met due to a high mean score pre-implementation. The comparison of fall rates three months pre and post implementation of the intentional hourly rounding project is shown.

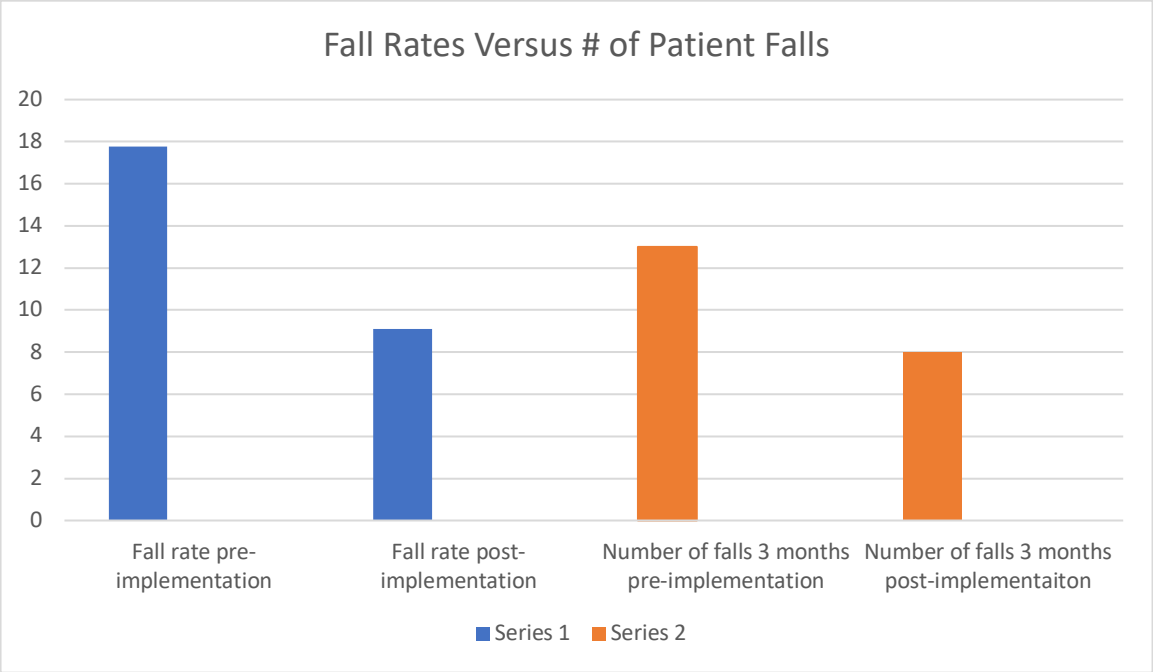

Figure 1. Fall Rates versus # of patient falls

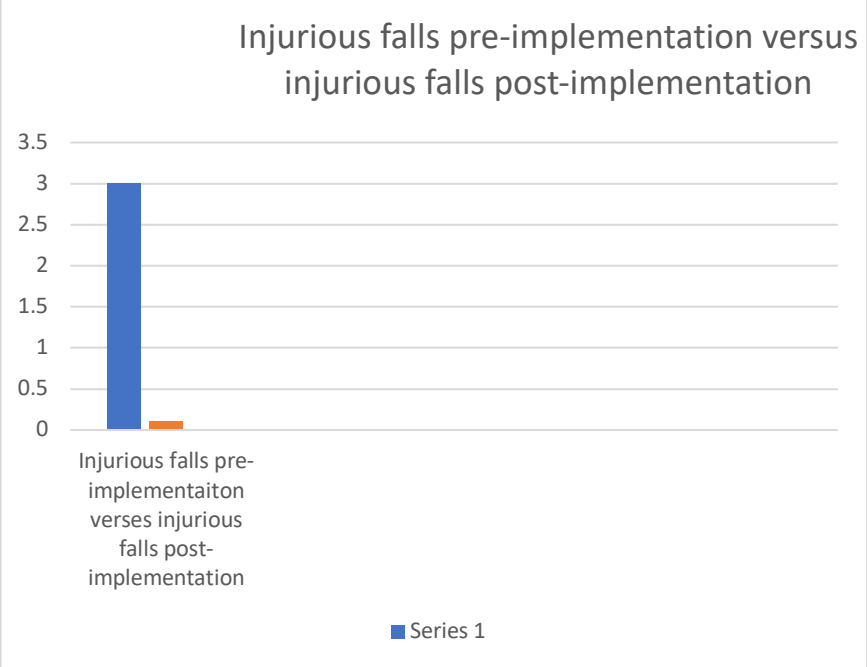

Figure 2. Injurious falls pre-implementation versus injurious falls post implementation

Chapter V: Discussion

Findings

Bedside nurses who provide intentional hourly rounding and initiate proper safety measures can reduce the number of falls from occurring. Although the use of the intentional hourly rounding tool was occurring, patient falls continued to increase due to several factors such as staff forgetting to put bed alarm on and improper use of restraint. For example, staff would conduct rounding on the patient, provide patient care, and forget to put the bed alarm on. Another incident, a patient had restraints on, and due to the improper placement of the restraint, the patient fell. Mostly, all falls that occurred were due to inadequate safety measures rather than the ineffective use of the intentional hourly rounding tool. The major success of the project was the ability to decrease patient falls by more than 30% as well as acquiring inquiring no injurious falls. The project also sought to improve the institutional knowledge for staff related to falls by 50%, but due to a pre-implementation high mean score of 76%, and a post-implementation score of 98%, a 24% was achieved. The difficulties of the project were the inability to keep the team consistent with regular, intentional hourly rounding and making sure all safety measures were in place. During data collection of the intentional hourly rounding forms, a large number of hourly rounding forms were incomplete on several days. The pattern showed that one shift documented more than the other. This may have occurred due to one shift being busier than the other, usually day shift. In the first and second month, a more consistent rounding pattern was seen, and most staff on both shifts had initials during their rounding. In the third month, the consistency decreased, and the day shift had the least compliance versus night shift. It was clear at that point that staff needed regular re-enforcement on safety measures along with hourly rounding education to prevent falls. The incomplete rounding forms made it difficult to evaluate evidence-

based data and project implementation. The unit also experienced new staff which contributed to a gap of knowledge in the new implementation process. Overall, the project interventions were a success in decreasing patient falls but not fall rates. We were able to identify that intentional purposeful hourly rounding was not the cause of patient falls, but rather the lack of implementing safety measures during intentional hourly rounding by nursing staff. Intentional hourly rounding has helped improved the hospitals HCAPS score with by 20 points in all major areas. It has also shown a positive indicator in reducing fall rates, when all safety measures are done correctly.

Limitations or Deviations from Project Plan

There were a few limitations to the quality improvement project. These limitations included the length of the plan (restricted to 90-days), the small population sample of just 220 patients admitted within the 90-day timeframe, the use of only one facility, and a small nursing staff of 28. Staff documentation was a barrier due to the infrequent initial of the team. The strength of the project consisted of a strong leadership facilitating the project and committed to decreasing falls. Another was the commitment of the charge nurses to lead in the education of the new protocol. A positive to the plan was the ability to initiate a protocol to address intentional hourly rounding within the facility, as before implementation, no protocol existed. For future projects using a hard copy rounding sheet, I would consider deleting initials but instead documenting the task in the patient chart in real-time. It will allow for specific tasks documented on time.

Implications & Impact to Practice

a. Practice

The nursing staff is responsible for the well-being and safety of the patients. The need for regular staff education in regards to patient safety, along with intentional hourly rounding education is

warranted to improve patient outcomes and reduce falls. Without such interventions, patients are at risk for falls, and therefore staff education was needed to minimize such occurrences. Also, an implementation of an hourly rounding intervention that has in-depth training for nursing staff on how to properly initial tasks, and documentation would be an effective strategy to decrease falls. It would also be of benefit to incorporate nurse leaders on routinely rounding on patients to make sure that hourly rounding is being done. This type of strategy can help with holding staff accountable for their intentional hourly rounding. The use of an intentional hourly rounding sheet has a positive outcome in the acute care setting because it can improve patient safety as well as decrease the number of falls.

b. **Future Research**

The success of this project, as well as the barriers encountered can add to evidence-base literature to improve other inpatients' implementation processes related to patient falls. Healthcare organizations should first conduct an in-depth review of their rounding practice and tailor such practice to one that addresses educational components that may be lacking as well as holding staff accountable for rounding. This project focused on an evidence-based process that successfully decreased patient deaths and injurious falls by more than 30% in the long-term acute care setting in a 90-day timeframe.

c. **Nursing**

The nursing team planned and conducted intentional hourly rounding using the Studer Group (2007) model. There was an observational change in behavior in staff during hourly rounding. Staff seems more aware of patient needs and overall calmness. There were fewer call bells and

patients seem to be more comfortable. Staff knowledge in falls increased and this may have been because management provided frequent re-enforcement & reminders of hourly rounding benefits.

d. Health Policies

It is of importance that all long-term acute care facilities establish an action plan to help prevent patient falls. Intentional hourly rounding has been a proven evidence-based tool to help decrease falls in inpatient settings, but few policies focus on staff education in conjunction with an hourly rounding tool. It would be of a facility's best interest to identify nursing staff's weak areas related to fall knowledge and tailor a plan that will increase such knowledge as well as improve patient falls. Post-implementation of this project, fall analysis identified that there is a need for staff awareness related to patient safety. Management should explore a policy that can guide nursing staff with conducting proper safety checks for patients at risk for falls. The policy should be clear to address the hourly rounding safety checks. This is because all but one fall occurred due to a lack of proper safety measures in place. The use of a unit-based safety team, nurse leadership rounds, and on-going fall education would provide an effective solution to patient falls. This can be done with a checklist that staff can reference during their shift or any measures that can facilitate safety awareness. The intentional hourly rounding tool & fall knowledge questionnaire contributed to fewer patient falls, injuries and an improvement in staff fall knowledge. All which are major healthcare concerns, but were addressed using such intervention. The tool also allowed management to identify a break in the process contributing to patient falls.

Chapter VI: Conclusion

Value of the Project

During the project, there was a decrease in patient fall post-implementation. Although the fall rate did not decrease by 10%, there were fewer patient falls from the previous three months pre-implementation. This concludes that fewer patients experienced a fall during the project and no injuries. The project helped the unit identify a break-in process, related to improper safety checks and allowing the unit to form a plan to address staff awareness to safety checks. Although the staff was conducting intentional hourly rounding, they were not actively addressing all the 4Ps leading to multiple patient falls. The nursing staff frequently forgot to assess the patient safety measures before leaving the patient room and thus contributing to patient falls. This finding adds value to literature as it shows that although intentional hourly rounding can help decrease inpatient falls if not done properly and actively then patient falls will continue.

DNP Essentials

The Essentials of the Doctor of Nursing practice was utilized for this quality improvement project. Essential #1, understanding the scientific underpinnings for nursing practice as it reflects the complexity of nursing practice (The Essentials of Doctoral Education for Advanced Nursing Practice, 2006). The project was developed by examining a decrease in falls with the use of intentional hourly rounding. With the discovery of evidence-based literature, the ability to decrease patient falls would improve patient well-being and maintain optimal function. Essential #2 Organizational and systems leadership for Quality Improvement and Systems Thinking as I evaluated the current delivery system on intentional hourly rounding on

the units. The current protocol was evaluated by identifying patient outcomes related to scientific findings. Staff was held accountable for patient safety as they completed the intentional hourly rounding rounds. The use of advanced communication allowed for staff education related to falls and the overall improvement of patient safety initiatives. Essential # 6 Interprofessional Collaboration for Improving Patient and Population Health Outcomes allowed me to the ability to facilitate effective communication with project team leaders as well as staff members. The ability to employ effective communication and leadership allowed me to assume leadership of the team throughout the project. Essential #7 Clinical Prevention and Population Health for Improving the Nation's Health was vital to the project as it allowed me to design, implement, analyze and evaluate the intentional hourly rounding tool related to patient falls. Essential #8 Advanced Nursing Practice allowed me to develop a partnership with the staff and my project team leaders to facilitate the best outcome for the patients. This essential guided me through the ability to guide, mentor, educate and support staff to achieve excellence in nursing practice (The Essentials of Doctoral Education for Advanced Nursing Practice, 2006).

Plan for Dissemination

The data collection has been presented to the Quality Improvement Manager as well as the nursing staff at the facility. The final presentation is scheduled to be presented to the Bradley University committee in April 2020. The current intentional hourly rounding tool is being evaluated by management with plans for continued education on falls, safety measures and early identification of patients at risk for falls. The quality improvement project information will be submitted to the Corporate office of BayCare Healthcare for use in other facilities.

Attainment of Personal and Professional Goals

This project evaluated staff education through a fall knowledge questionnaire and the use of an intentional hourly rounding tool as a way to measure patient fall rates, and injurious falls. I was able to conclude that providing continued staff education related to patient falls and safety measures nursing staff will have the tools needed to reduce the incidence of falls within the long-term acute care facility. The need for further investigation is needed to determine if the intentional hourly tool along with staff education alone is needed to decrease fall rates and injurious falls in the inpatient setting. By implementing this quality improvement project at my facility I was able to identify a need for evaluating a break-in process with the intentional hourly rounding tool and allowed my co-workers to evaluate their patient rounding skills while completing the requirements for my Doctor of Nursing Practice.

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APPENDIX A

PRE AND POST FALL QUESTIONNAIRE TEST INSTRUCTIONS: PLEASE DO NOT PLACE YOUR NAME OR IDENTIFYING INFORMATION ON THIS DOCUMENT

Each question may have more than one option as the correct answer.

Please circle the letters that correspond to the correct answers.

1. **Which of the following statements is *correct*?**
    a. Falls have multifactorial etiology, so fall prevention programs should comprise multifaceted interventions.
    b. Regular review of medication can help to prevent patient falls.
    c. The risk of falling will be lessened when a patient's toileting needs are met.
    d. The use of antipsychotic medications is associated with an increased risk of falls in older adults.
2. **A multifaceted intervention program should include:**
    a. Individually-tailored fall prevention strategies.
    b. Education to patient/family and health care workers.
    c. Environmental safety.
    d. Safe patient handling.
3. **Risk factors for falls in the acute hospital include all of the following *except*:**
    a. Dizziness/vertigo.
    b. Previous fall history.
    c. Antibiotic usage.
    d. Impaired mobility from stroke disease.
4. **Which of the following statements is *true*?**
    a. The cause of a fall is often an interaction between patient's risk, the environment, and patient risk behavior.
    b. Increase in hazardous environments increases the risk of falls.
    c. The use of a patient identifier (e.g., identification bracelet) helps to highlight to staff those patients at risk for falls.
    d. A fall risk assessment should include review of history of falls, mobility problems, medications, mental status, continence, and other patient risks.

5. **Patients with impaired mobility should be:**
    a. Confined to bed.
    b. Encouraged to mobilize with assistance.
    c. Assisted with transfers.
    d. Referred for exercise program or prescription of walking aids as appropriate.
6. **The management of the acutely confused patient should include all of the following *except*:**
    a. Moving patients away from the nursing station.
    b. Involving family members to sit with the patient.
    c. Orienting patients to the hospital environment.
    d. Reinforcing activity limits to patients and their families.
7. **Which of the following statements is *false*?**
    a. Fall prevention efforts are solely the nurses' responsibility.
    b. A patient who is taking four or more oral medications is at risk for falling.
    c. A patient who is taking psychotropic medication is at higher risk for falling.
    d. Testing or treatment for osteoporosis should be considered in patients who are at high risk for falls and fractures.
8. **In hospital settings, intervention programs should include:**
    a. Staff education on fall precautions.
    b. Provision and maintenance of mobility aids.
    c. Post fall analysis and problem-solving strategy.
    d. Bed alarms for all patients, regardless of risk.
9. **When assessing patients, which of the following statements is *false*?**
    a. All patients should be assessed for fall risk factors at admission, at a change in status, after a fall, and at regular intervals.
    b. Medication review should be included in the assessment.
    c. All patients should have their activities of daily living and mobility assessed.
    d. Environmental assessment is not important in the hospital as it is all standardized.

10. **Risk factors for falls include:**
    a. Parkinson's disease.
    b. Incontinence.
    c. Previous history of falls.
    d. Delirium.
11. **Exercise programs for ambulatory older adults should:**
    a. Be very aggressive.
    b. Be unsupervised.
    c. Be ongoing.
    d. Include individualized strength and balance training.
12. **Which of the following statements on education in fall prevention is *false*?**
    a. Education programs should target primarily health care providers, patients, and caregivers.
    b. Education programs for staff should include the importance of fall prevention, risk factors for falls, strategies to reduce falls, and transfer techniques.
    c. Instruction on safe mobility, with emphasis on high-risk patients, should be provided to both patients and families.
    d. Education should only be given at the start of the fall prevention program.
13. **Which of the following is recommended to improve patient safety?**
    a. Locking wheeled furniture when it is stationary.
    b. Having nonslip flooring.
    c. Placing frequently used items (including call bell, telephone, and remote control) within reach of the patient.
    d. Rounding hourly to address patient needs.

Fall Knowledge Test. Content last reviewed January 2013. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2e.html

APPENDIX B
APPROVAL FOR ROUNDING SHEET

Hello Eva Mathurin,

I'm writing to provide express written permission to publish Figure 3 from the May 2015 Quality Brief (https://web.mhanet.com/Issue_Brief_Triple_Aim_Rounding_0515.pdf) in your dissertation. However, I'd also like to make note of the original source for the rounding log, which is Page 17 of this publication by the Studer group https://www.mc.vanderbilt.edu/root/pdfs/nursing/hourly_rounding_supplement-studer_group.pdf, as referenced in the MHA publication. Please cite and/or reach out to Studer as appropriate.

Good luck, and let me know if you need anything further.

Thank you,

Kendra Hanauer

Vice President of Corporate Communications

Missouri Hospital Association

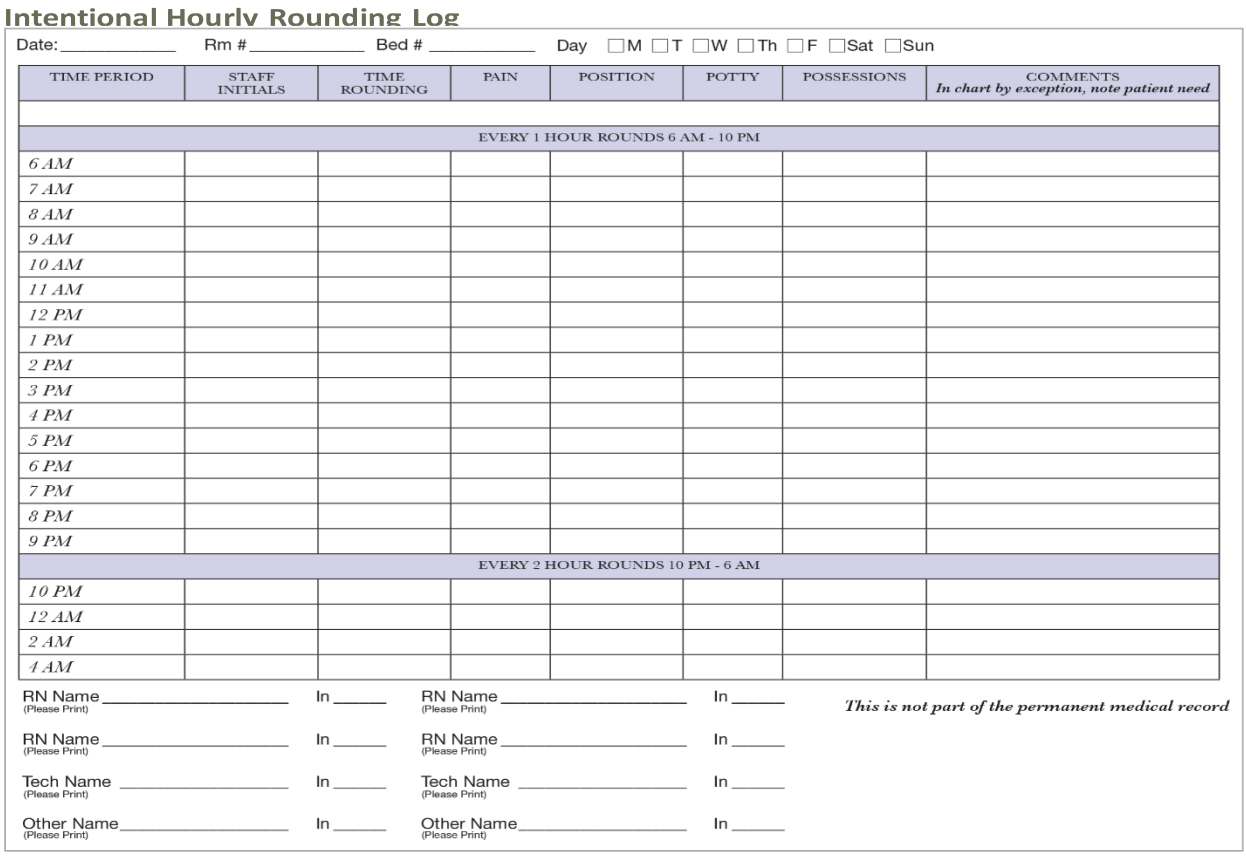
573/893-3700, ext. 1310

MISSOURI HOSPITALS

A sign of good health.

APPENDIX C

Intentional Purposeful Hourly Rounding Sheet



Intentional Hourly Rounding Log

Date: _____ Rm # _____ Bed # _____ Day ☐M ☐T ☐W ☐Th ☐F ☐Sat ☐Sun

TIME PERIOD	STAFF INITIALS	TIME ROUNDING	PAIN	POSITION	POTTY	POSSESSIONS	COMMENTS *In chart by exception, note patient need*
EVERY 1 HOUR ROUNDS 6 AM - 10 PM							
6 AM							
7 AM							
8 AM							
9 AM							
10 AM							
11 AM							
12 PM							
1 PM							
2 PM							
3 PM							
4 PM							
5 PM							
6 PM							
7 PM							
8 PM							
9 PM							
EVERY 2 HOUR ROUNDS 10 PM - 6 AM							
10 PM							
12 AM							
2 AM							
4 AM							

RN Name (Please Print) _____ In _____ RN Name (Please Print) _____ In _____

This is not part of the permanent medical record

RN Name (Please Print) _____ In _____ RN Name (Please Print) _____ In _____

Tech Name (Please Print) _____ In _____ Tech Name (Please Print) _____ In _____

Other Name (Please Print) _____ In _____ Other Name (Please Print) _____ In _____

Source: Studer Group Hourly Rounding Supplement, Best Practice — Sacred Heart

APPENDIX D

CONSENT FOR NURSING STAFF

Intentional Purposeful Hourly Rounding

Consent to Participate in Quality Improvement Project

November 2019

Purpose of the Project:

You are invited to participate in a quality improvement project. That is being done by Evisencia Mathurin, a Bradley University Doctorate student. The purpose of this research is examining whether intentional purposeful hourly rounding can help reduce the fall rates in the long-term acute care setting over a 3-month period. You are being asked to participate because the management team has identified a need to improve patient safety due to an increase in falls within the last six months.

Your participation will involve taking a brief 5-minute questionnaire related to falls in the inpatient setting to help identify competency levels related to falls. Your involvement in the project is voluntary. If you choose not to participate in this project or answer any of the questions, there will be no consequences to your continued employment. There will be no names or identifiers with the questionnaire associated with your response. There is no known risk with this project, but some individuals may experience some discomfort or loss of privacy when answering these questions. Your participation in the project and the data collected will remain anonymous, as there will be no link between your name and the record.

The findings from this project will provide information on whether intentional purposeful hourly rounding has helped with a decrease in fall rates. If published, results will be presented in summary form only. If you have any questions, concerns, or complaints, about the research please feel free to call Dr. Peggy Flannigan, the project leader in charge. She can be reached at 309-677-2540. By providing your signature you are agreeing that you have read and understood the information presented and have decided to participate. Your participation also means that all of your questions have been answered to the best of your knowledge and satisfaction. If you think of any additional questions, you may contact the project leader(s).

If you have any questions regarding your rights as a research participant, or about what you should do in case of any harm coming to you, contact the following:

Committee on the Use of Human Subjects in Research (CUHSR)

Bradley University

1501 W Bradley Avenue

Peoria, IL 61625

(309) 677-3877

By providing your signature, you are agreeing to participate in the above research.

_____	_____	_____
Name of Adult Participant	Signature of Adult Participant	Date

_____	_____	_____
Name of Research Team Member	Signature of Research Team Member	Date

APPENDIX E
PRE-INTERVENTION FALL DATA

Metr+A1:O40ic 2019	2019 Target	2018 END	Jan	Feb	Mar	1st Qtr	YTD	April	Jun	2nd Qtr	YTD	Jul	Aug	Sep	3rd Qtr	YTD	Oct	Nov	Dec	4th Qtr	Year End
QUALITY OUTCOMES (pt days)		10,121	959	796	836	2591	2591	764	721	2413	5004	772	840	679	2291	7295	788	716	664	2168	9463
Fall Rate	2.10	2.27	4.17	2.51	2.39	3.09	3.09	2.62	5.55	3.32	3.20	7.77	2.38	10.31	6.55	4.25	5.08	4.19	0.00	3.23	4.02
Total Falls	21	23	4	2	2	8	8	2	4	8	16	6	2	7	15	31	4	3	0	7	38
Falls with proper safety measures in place	NA	NA	3	0	0	3	3	2	1	4	1	3	0	4	7	14	2	2	0	4	18