Nursing Hourly Rounds

The Problem

Prevention of falls is an important component of our patient safety initiatives and is under our overall goal related to the Prevention of Harm. Farr 2 has consistently struggled to bring the fall rate to/below the national benchmark. Despite the implementation of our Fall Prevention Protocol on general units in 2007, the fall rate on Farr 2 remained high. In the first week of November 2008, Farr 2 experienced two patient falls with injury. Recent literature has established a positive correlation between hourly rounding by nursing staff and decreased fall rates. This model incorporates the LEAN principles related to efficiency in our work. The decision was made to implement hourly rounding on Farr 2 which began at the beginning of the second week of November 2008.

Aim/Goal

Through instituting hourly rounds, we aimed to decrease the patient fall rate on Farr 2 using evidence-based nursing practice. Accomplishment of this would contribute to the overall goal of Prevention of Harm.

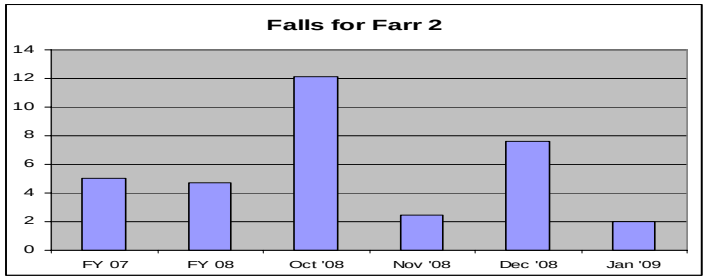
The Team

- Farr 2 Nursing Staff

The Interventions

- Education: Several staff meetings were held to review the adverse events, discuss the root cause analysis, and explain the hourly rounding process and standard.
- The hourly round identified the standard that each patient would be seen by a member of the Farr 2 nursing staff every hour.
- The hourly rounds includes a safety check for those patients identified as at risk to fall as well as a check on the 3P's of Patient Care (Personal needs, Pain and Position) and the 3R's of Patient care (Reach, Respond and Reassure).
- The hourly rounding is documented on a flow sheet.
- Follow up meetings were held during the next six weeks to receive staff feedback about the challenges or barriers to completing the hourly rounding.
- Audits were conducted 5x/week for six weeks in order to reinforce establishment of this standard.
- Audits are now performed weekly and further educational and compliance needs are addressed in real time.

The Results/Progress to Date



Lessons Learned

- The adverse events of two patient falls with injury provided opportunity to change practice and culture
- Staff were motivated to adopt new standards related to patient safety
- Leadership involvement was essential to successful adaptation in the practice on the unit
- Ongoing monitoring and reinforcement of the standard is required in order to sustain the gains

Next Steps/What Should Happen Next

- Hourly rounds were implemented as the standard on all general medical and surgical units in January of this year.
- Continued incorporation of staff feedback into strategies re to the adaptation of this practice on the units.
- Weekly audit activity will continue in order to address barriers to consistent implementation.
- Strategies will continue to be developed to support the accomplishment of hourly rounds despite unexpected changes in staffing patterns.
- Fall rate and patient satisfaction data will be followed to assess for improved outcomes in these two areas.

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