



“CATCH ME BEFORE I FALL”: THE EFFECTIVENESS OF HOURLY ROUNDING IN REDUCING PATIENT FALLS

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INTRODUCTION

- Patients arrive at healthcare facilities seeking care and treatment, and of course are never planning to be injured during their stay. However, according to the Agency for Healthcare Research and Quality, somewhere between 700,00 and 1,000,000 adults get injured from falls at healthcare facilities every year in the United States. (2018). As of 2008, costs related to falls and injury are not covered under Medicare, making hospitals responsible for all costs involved (Centers for Medicare and Medicaid Services, 2016). Due to various physical and environmental circumstances, a patient may be at risk for falling, and it is the responsibility of clinical staff to anticipate, prevent, and protect against falls happening to patients while under their care. How can clinicians prevent unnecessary, accidental falls in the clinical setting? This research analyzes the effectiveness of implementing hourly rounding to reducing the fall incidences occurring in clinical settings.

RESEARCH QUESTION

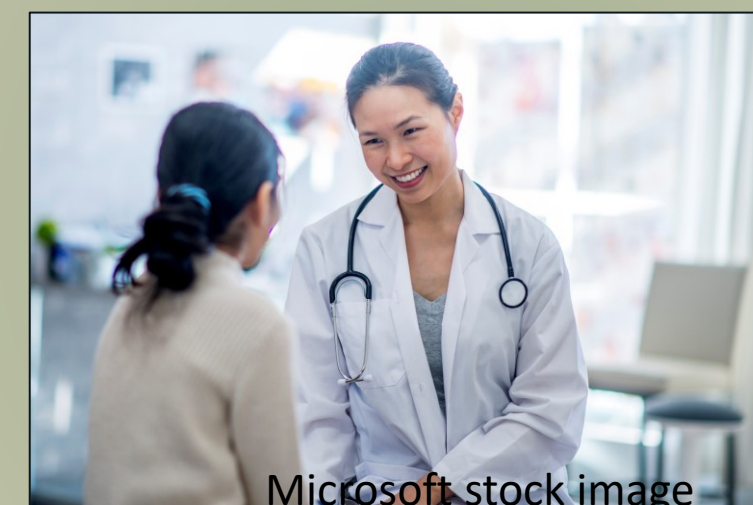
- Within clinical adult inpatient units, does the use of hourly rounding reduce fall rates compared to not having hourly rounding on those inpatient units?

PURPOSE

- The purpose of this systematic review is to look at research related to hourly rounding and ascertain if implementing hourly rounding in clinical settings leads to a reduction of in-patient falls, compared to in-patient units that did not have hourly rounding occurring.

CONCEPTUAL FRAMEWORK

- The Theory of Self-Care Deficit, created by Dorothea Orem, provides a conceptual framework for this particulate research study. According to Orme’s theory, it is the caregiver’s responsibility to assess the patient’s needs related to their activities-of-daily-living (Nursing-Theory, 2016). The caregivers on acute inpatient units need to ascertain where and when patients may need extra support with eating, toileting, or ambulating. Hourly rounding on all patient on the unit helps to ascertain patient’s needs on a consistent basis. The goal is to reduce patients at risk for falls from trying to get up on their own because they may perceive staff is unavailable or “too busy” to help them.

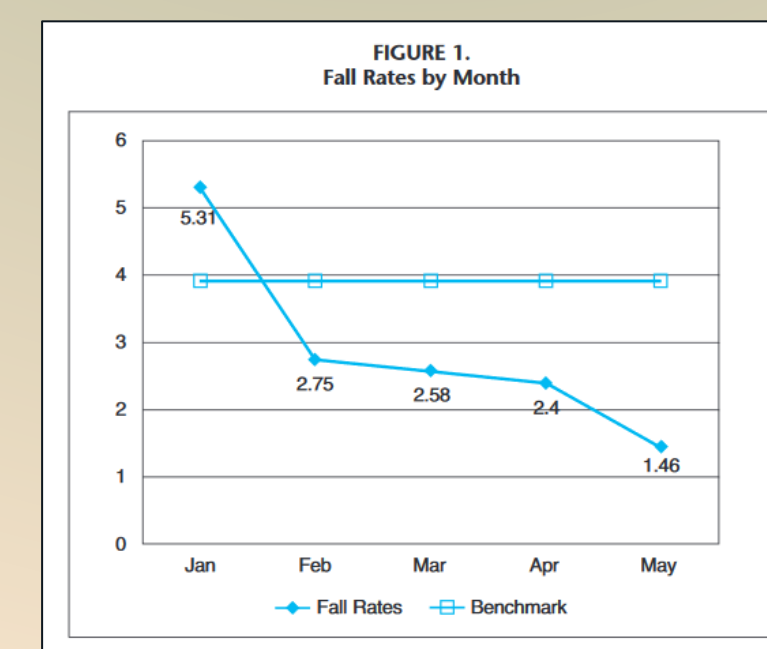


METHODS

A systematic review was conducted with looking at various research studies in order to ascertain if the implementation of hourly rounding reduces the occurrence of patient falls. Inclusion criteria for this study was that it the article had to be published within the last five years. The study had to have been performed in a clinical setting. The studies had to be conducted on adult patients (age 18-100). Exclusions were pediatric patients, or patients in clinical institutions within prisons or behavioral health units.

RESULTS

- Walsh, Li-Jung, et. al: Studied the fall rate over a time frame of 2001-2014. Interventions implemented during that time included fall committees, flagging high-risk patients, and instituting hourly rounding, among other interventions. The results found the crude fall rate from July 2003 declined from 3.07 to 2.22 per 1,000 patient days and injury declined from 0.77 to 0.65 in the same amount of time (2018).
- Nuckols, Needleman, et. al: Their study was done at two hospitals using a decision-analytical model. They looked not only at fall decline over a period of time, but also estimated a savings in cost. Their results were that falls declined at 1 hospital but not at the other. Their costs analysis projected a 67.9%-72.2% probability of net savings from RN’s not having to deal with fall-related tasks (2017).
- Grillo, Firth, & Hatchel: Audited falls related to adult patients on a hospital unit. Using a CQI Model. They looked at a 31-day period with hourly rounding and fall protocols implemented compared to 31 days before that time frame without the interventions. The results did not show a significant difference (see figure 1). However they did discover that call-light responsiveness increased, and fall-risk protocols were used more often by nursing staff (2019).



NURSING IMPLICATIONS

- Nurses are constantly held responsible for the safety and well-being of patients under their care. Accidental, preventable falls happen too often on many in-patient units. The implementation of purposeful hourly rounding, as evidenced by this research, is an intervention that could lead to cost savings for facilities by reducing costs related to post-fall care. Nurses also can educate patients on the risks of falls and create a plan with the patient to work together to ensure trust that visits will happen consistently, and help will always be there whenever they use the call-light.

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