Summer 2020

Purposeful Hourly Rounding and Reduction of Patient Falls

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Date of Submission: July 9, 2020

Dedication

I dedicate this project to my husband, children, mother, and brother for their constant support and unconditional love. I love you all dearly.

I would like to pay special attention and dedicate this work to my late father, Bill Ray Scott, whose dreams for me have resulted in this achievement, and without his loving upbringing and nurturing, I would not have been where I am today and what I am today. It is true that if GOD ever existed, he would be in the form of a father because only a father can love and give without expecting anything in return. Had it not been for my father's unflinching insistence and support, my dreams of excelling in nursing would have remained mere dreams. I thank my father with all my heart, and I know he is; listening, watching over me, and sending me his blessings constantly.

Acknowledgment

I would like to take this opportunity to express my heartfelt gratitude to all those who helped me to make my doctoral work a success. First and foremost, I would like to thank the ALMIGHTY who has provided me the strength to do justice to my work and contribute my best to it so that it has turned out to be a successful milestone.

To my dear husband, John W. Bell Sr. who remains willing to engage with the struggle, and ensuing discomfort, of having a partner who refuses to accept the given role of the "Black woman" and is actively engaged in redefining and redesigning that role. A very special thank you for your practical and emotional support as I added the roles of wife and mother, to the competing demands of business, work, study and personal development.

I would also like to thank my children John Wesley Jr. and Jackson William for their patience and understanding whilst doing my assignments at home.

To my mother, Sandra E. Scott, who has been a source of encouragement and inspiration to me throughout my life, a very special thank you for providing and nurturing me through the months of writing all while allowing me to learn, grow and develop. Also thank you for the myriad of ways in which, throughout my life, you have actively supported me in my determination to find and realize my potential. To my brother, Bitrell Scott, you are an invaluable asset in my life, my best friend, my confidant, my guardian, and I am grateful to have you in my life. I deeply appreciate everything you have ever done for me.

Dr. Laura P. Walker has been the ideal faculty advisor. Her sage advice, insightful criticisms, and encouragement aided the writing of this paper in innumerable ways. I would also like to thank Dr. Leigh Ann Keith whose steadfast support of this project was greatly needed and deeply

appreciated. I offer special thanks to those who supported me in the mechanics of producing this capstone project.

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Abstract

Falls are a pervasive and persistent problem in all healthcare settings, with adverse clinical, social, and economic outcomes for patients, staff, and institutions involved. The systematic process of purposeful rounding is an intentional act conducted with a clear purpose for the patient's benefit. Prevention of inpatient falls remains a challenge for nurses. Despite fall prevention efforts by nurses, the rate of patient falls in the acute care setting is a major safety concern. A Doctor of Nursing Practice project was crafted and implemented to educate nursing staff on purposeful hourly rounding and apply the 4 P's (pain, positioning, possessions, and potty) to decrease patient fall rates on a medical-surgical unit. Staff education took place pre-implementation, and the staff was able to acknowledge an understanding of the material. The purposeful hourly rounding program was effective in decreasing the fall rate from an average of 2 to 0 falls per 1,000 patient days for two consecutive months. Results from this project support the use of the Studer Group's Hourly Rounding tool with evidence-based targeted interventions to decrease fall rates. This was a 99% improvement over the last reported year of falls. Ongoing monitoring of subsequent interventions implemented by the staff to prevent falls and frequent dissemination of unit-specific fall data is needed to ensure fidelity to the protocol. More information is needed on the context of falls to evaluate patient safety practice.

Keywords: falls, hospitalized, prevention, evidence-based practice, hourly rounding

Purposeful Hourly Rounding and Reduction of Falls

Introduction

Falls and fall prevention have become an essential theme across hospitals and other health care facilities, as well as across different countries. Regardless of geographic location, fall etiology is multifactorial, and its risk factors can be classified as intrinsic (patient-related) and extrinsic (environment and work-related) (Severo, Kuchenbecker, Vieira, Lucena & Almeida, 2018). According to the World Health Organization (WHO), falls are defined as "inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects" (p. 1). Given the magnitude of the economic costs associated with falls, it is not surprising that WHO urges health services to invest in prevention strategies: in many instances, the risks can be significantly reduced by implementing simple, low-cost changes in an individual's behavior and habits. Although falls are associated with serious morbidities, they are not an inevitable part of aging (WHO, 2017).

Fall and injury prevention continues to be a considerable challenge across the care continuum. Inpatient fall prevention is an area of concern for nursing. Traditional hospital-based incident reports deem all inpatient falls to be avoidable; therefore, falls are classified as adverse events (Morris & O'Riordan, 2017). Falls among inpatients are the most frequently reported safety incident in National Health Service (NHS) hospitals. Thirty to fifty percent of falls result in some physical injury and fractures occur in one to three percent. Falls are never harmless, with psychological sequelae leading to lost confidence, delays in functional recovery, and prolonged hospitalization. Consequences of falls can include fracture, unanticipated vascular and indwelling catheter, drain removal, fear of falling, change of emotional status, clinical worsening, and even death (Severo et al., 2018).

Hospital related falls incurs a high financial expenditure with a $43.8 billion projected cost by 2020. Nevertheless, falls are not true accidents and there is evidence, a coordinated multidisciplinary clinical team approach can reduce the incidence (Morris & O'Riordan, 2017).

Higher fall rates occur among older patients with neurology conditions in the rehabilitation setting (Ambutas, 2017). The American Geriatrics Society (2017) postulates clinical practice guidelines summarize evidence-based recommendation to avert incidence and decrease severity of falls. Some strongly recommended interventions are to investigate fall history using a multifactorial assessment; offer exercise incorporating balance, gait, and strength training; ensure interventions are conducted by the healthcare team; assess the environment for safety; and provide vitamin D supplementation. Although there is a range of national standards and guidelines linked to falls reduction and prevention, the implementation of complex multi-professional interventions remains challenging (Clasper, 2019).

Background

Falls are a significant cause of injuries, with over one-third of older adults experiencing at least one fall or more each year. Fall injuries are among the 20 most expensive medical conditions. Hence, there is a critical need for the development of cost-effective fall prevention policies to reduce the financial and health burdens associated with the consequences of a fall. Fear of falling is associated with adverse effects such as avoidance of activities of daily living, less physical activity, falling, depression, and lower quality of life (Rajagopalan, Litvan, & Jung, 2017). Existing systems mainly focus on detecting a fall with little emphasis on fall prediction and prevention. Hence, there is an urgent need for developing prevention tools minimizing this cost and improving the quality of life for patients who suffer from falls. Fall prevention policies

are of utmost importance to accomplish this task and can help reduce the financial, physical, and emotional consequences of falls (Rajagopalan, Litvan, & Jung, 2017).

In all regions of the world, death rates are highest among adults over the age of 60 years. Risk factors for falls; however, are not limited to, age, history of recent fall, mobility impairment, urinary incontinence or frequency, certain medications, postural hypotension, and cognitive impairment. Multiple nonclinical factors also contribute to acute inpatient falls, including inadequate staff orientation, supervision, staffing levels, or skill mix; lack of adherence to protocols; deficiencies in the physical environment; communication failures; and poor room design (e.g., trip hazards, suboptimal chair heights, inadequate lighting, etc.) (Westle, Berkert & Paulus, 2019).

The project site with characteristics of high patient to nurse staffing ratios, intense physical therapy, severe illnesses, and a high elderly population substantiates why the project is necessary. The Institute of Medicine (IOM) recognizes the centrality of the patient as a core component to achieve health quality. Patient Centered Care is regarded by the IOM as the way to establish a partnership among practitioners, patients, and their families to ensure their place in the decision-making process concerning the treatment and taking joint responsibility of the therapeutic process. At present, based on the current hospital strategy to detect fall risk, the patient is not a partner to any of the risk assessments or the program designed to prevent falls (Lipschuetz, 2017). This project will attempt to establish this area of education to involve the patient as a partner in an integrative method of fall prevention.

Problem Statement

A 'fall' is defined as "an unplanned descent to the floor with or without injury to the patient." (Shashank, 2017). The National Database of Nursing Quality Indicators (NDNQI) is the largest national database of U.S. data relating to the quality of nursing care. Falls in hospitals is one of the quality indices measured by the NDNQI organization since 2003 as a proportion of all falls per 1,000 hospitalization days (Lipschuetz & Toren, 2017). At present, hospitals focus on measuring the risk of fall rates based on specific and rigid risk assessment scales, which are mainly focused on the assessment of the patient's medical condition, mobility, mental status, toileting, history of falls, and medication therapy. Fall prevention programs are based on the above-mentioned vital factors, which focus on standard safety procedures associated with both patient's condition and hospital environment. (Lipschuetz & Toren, 2017). Falls are a focused clinical problem.

The common interventions to reduce hospital falls are based on the rationale that measuring the causes of falls and effectively assessing fall risk factors would help to identify the root causes of the problem accurately. Falls prevention programs in general hospitals are designed to handle both risk factors to falls, associated with the patient's clinical condition and the environmental hazards. These programs are applicable to all patients and consist of mainly nursing staff providing patient education and ensuring standard safety practices are in place such as nurse call bells, bedrails, non-slippery shoes, keeping the floor dry, and provision of vitamin D supplementation (Lipschuetz & Toren, 2017).

The DNP project will evaluate medical-surgical patients of an acute care facility to determine how purposeful hourly rounding (PHR) by staff members as compared to traditional every 4-hour rounding practices impact fall rates. The evidence already gathered by various studies conducted on hourly rounding practices all point to its impact on decreasing falls. Such studies have continued to validate the popularity of purposeful hourly rounding practices. The positive outcome of

decrease falls (dependent variable) relies on the use of purposeful hourly rounding practices (independent variable). In adult hospitalized medical-surgical patients, does an evidence-based fall prevention program including comprehensive assessment and individualized interventions based on patient-specific risks decrease fall rates in one month?

Purpose and intent—the forces making rounding effective—go beyond quickly eyeballing the patient and asking, "How are you doing?", followed by a hasty checkmark on a whiteboard or rounding sheet. Purposeful rounding with intent is a work process structuring the time staff spends with the patient by using an actual or mental checklist of procedures meant to promote optimal outcomes in a clean, comfortable, and safe environment.

Organizational Description of Project Site

Falls associated with serious injuries are among the top 10 reported sentinel events in The Joint Commission (TJC) sentinel event database. Because the stakes are so high, hospitals, nurses, and other healthcare professionals are challenged to ensure an effective fall prevention program is in place to prevent hospital falls. Patient falls not only increase the patient's length of stay and healthcare costs; however, it may also trigger lawsuits resulting in settlements of millions due to patient injury (Chu, 2017). As of 2008, the Centers for Medicare and Medicaid Services no longer reimburse any hospital-acquired conditions lengthening hospital stay. Now hospitals must absorb the extra medical costs of patient injuries sustained in falls, which are considered preventable or "never" events. This DNP project is appropriate for the acute care hospital site, where it will be implemented to decrease falls by utilizing a purposeful hourly rounding tool (Chu, 2017).

Review of Literature

A literature review was conducted using PubMed and Cochrane databases to determine what evidence-based practices would answer the PICO question in adult hospitalized medical-surgical patients, does an evidence-based fall prevention program including comprehensive assessment and individualized interventions based on patient-specific risks decrease the fall rate? Keywords such as *falls, hospitalized, prevention, evidence-based practice, and hourly rounding* were used to narrow the search.

Many studies are conducted regarding the impact of hourly rounding practices and all point toward its impact on reducing the number of patients falls. The Studer Group (2007), a hallmark study, published its findings demonstrating a 33% reduction in the number of patient falls when hourly rounding was implemented in its health care institutions. Olrich, Kalman, & Nigolian (2012), a landmark study, documented a 23% reduction in patient falls attributed to hourly rounding. Additionally, this study also presented evidence of a reduction in incidences of patient falls from 3.37 to 1.73 per 1000 patient days as a result of hourly rounding. There is increasing evidence to support fall prevention programs in hospitals. However, not all results have been positive, with several studies reporting no effect on falls after the implementation of a fall prevention program.

In a recent study, the Centers for Disease Control and Prevention (CDC, 2014) estimated the cost of injuries related to patient falls would peak at approximately $44 billion by 2020. Hospital-acquired injuries include falls by patients during their stay at the hospital, which in term translates to the burden of hospital-acquired injuries falling upon health care institutions. The result of these new CMS policies has contributed to an increase in the operational costs experienced by health care institutions. Ultimately, the institution must bear the burden of the

medical expenses and may also incur additional legal fees. The institution may also incur additional legal costs initiated by patients or families during legal proceedings if the loved one has experienced a fall (Fehlberg et al., 2017).

It was notable that many studies included in the synthesis illustrate the absence of theoretical development as they only reported outcomes of implementing PHR without providing any explanation of *how* or *why* they occurred. Similarly, many discussed the contexts influenced; however, failed to explain how these conditions interacted with mechanisms to produce specific outcomes. This highlights the minimal theoretical explanations of PHR that have been identified to date and the ambiguities surrounding its purpose. This poor understanding of how PHR works pose a significant challenge to learning, replication, and sustainability of the intervention, and supports the work of others in this field (Sims et al., 2018).

This review has shown how PHR may work by identifying the program resources the intervention offers and how these may be interpreted and acted upon by patients and staff. It has specified how each of these mechanisms may or may not be triggered by different contextual factors and lead to a range of desired outcomes (Sims et al., 2018).

Hourly Rounding

Hourly rounding as an evidence-based practice for improving health care delivery has continued to be implemented across many health care institutions. Hourly rounding is defined as a proactive and systematic nursing intervention designed to address and anticipate the requirements of patients through structured hourly rounding routines (Olrich, 2012). Purposeful hourly rounding is intended to check on patients between scheduled nursing tasks, such as conducting vital signs every four to eight hours. Purposeful rounding is designed to meet the

patient's predetermined needs, such as pain, positioning, possessions, and potty, as well as to provide patient-centered care. Another finding is, hourly rounding processes on inpatient units must be robust and complete with a purpose. Hourly rounding with a purpose means hospital staff are stating the purpose of the visit, "rounding," and asking the patient about the "4 Ps" (Pain, Potty, Position, and Possessions).

A descriptive study was conducted regarding patient perceptions of hospitalization, AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank you), and Hourly Rounding by using individual qualitative interviews. The setting was a 400-bed community hospital in the Midwestern United States. Similar to the Studer group study, the interview data were transcribed and opened coded, utilizing constant comparison to identify common themes such as the patient's experience of hospitalization. The study indicated a more formal process for hourly rounding might result in decreased falls (Allen, Rieck, & Salsbury, 2016).

In a systematic review of inpatient fall prevention programs, the Agency for Healthcare Research and Quality (AHRQ), highlight the challenges for collecting data on the education and training of clinical staff to determine the effectiveness of fall prevention. Many of the studies have conveyed training was completed; however, did not specify the amount of time and the effectiveness of the training. No single intervention in the implementation of quality improvement has shown to be the most effective (Miake-Lye, Hempel, Ganz, and Shekelle, 2013).

According to Sanyi (2018), evidence-based purposefully designed hourly rounding initiatives can be used to prevent falls in hospitals. Nursing staff can use these initiatives to address the urgent needs of patients, thus taking precautions to avoid falls. The utilization of the purposeful hourly rounding (PHR) strategy can enhance patient safety and foster satisfaction by

taking a proactive approach to the challenge of decreasing patient falls (Sanyi, 2018). The purposeful rounding is essential in the function of nurses as caregivers. However, some professionals view the intervention as an additional assignment. Effective leadership is required to facilitate the program by offering the necessary education, reducing staff workload, and improving the design of the acute care unit to facilitate the satisfaction of staff (Sanyi, 2018).

Health professionals can involve patients by regularly assessing their positions, the level of pain, and their closeness to possessions. When undertaking PHR, the nursing staff can introduce patients to the hospital environment to ensure factors such as risky bed positions are addressed (Sanyi, 2018). The professionals can ensure patients have access to footwear, hearing aids, and eyeglasses to avoid falls. The mobility aids such as the walkers and wheelchairs can be provided, and the lighting system adjusted to enhance patient safety. According to Sanyi (2018), the critical elements of hourly rounding encompasses the reduction of anxiety and solving the 4Ps such as pain, position, possession, and potty. The initiative prevents falls by evaluating the environment of the patient to identify and address safety concerns (Sanyi, 2018). Patients can be informed about the next visit by hospital staff to help them avoid movements that may result in falls and severe injuries. A review on 14 published studies concerning the application of hourly rounding as a fall's mitigation approach by Hicks (2015) found the program reduced falls and enhanced the experience of patients and motivated staff.

Independent research has recommended the utilization of PHR to mitigate the problem of falls. According to Brosey and March (2015), research studies have recommended the utilization of PHR to mitigate the problem of falls. Purposeful hourly rounding initiatives contributed to a reduction in the rate of falls from 7.02 to 3.18 for every 1000 days in the surgical unit.

The researchers used a structured hourly rounding strategy and observed the results in a 24-bed critical care unit. According to a study done by Ciccu-Moore et al. (2014), there was a 39% decline in the rate of falls because of the improvement in the 4Ps after implementing the hourly rounding initiative in a 29-bed acute care setting. Important aspects of preventing falls in a hospital includes: the use of an integrative care management system in which the design of the facility is taken into account, maximization of communication between healthcare professionals, and a systematic review of best practices (Gu, Balcaen, Ni, Ampe & Goffin, 2016).

The hourly rounding strategy has been proven to enhance patient safety by preventing falls in hospitals. As a result, quality care can be offered to patients because of the improved satisfaction of health professionals at their workplace. Nurses play a pivotal function in addressing the challenge of falls using evidence-based knowledge (Fabry, 2015). The purposeful hourly rounding is considered by health professionals to promptly meet the needs of patients as they arise to prevent the risk of injuries. Research evidence indicates the purposeful hourly rounding in hospitals can offer health professionals an opportunity to monitor patients, thus promoting safety proactively (Fabry, 2015). According to a survey undertaken by Meade et al. (2006), it was found falls reduced by 52% following the execution of the intentional hourly rounding that utilized the 4Ps. The study involved 14 healthcare institutions with 27 acute care units.

The acceptance rate of rounding intervention has gained momentum in the nursing profession. Fabry (2015) studied the responses of registered nurse professionals concerning the application of the hourly rounding approach. It was found 25% of nurses involved in the survey indicated familiarization with the strategy. Approximately 21.3% postulated that completing the hourly rounding document was evidence the initiative was being applied in the hospital unit to

decrease the rate of falls (Fabry, 2015). There is a positive reaction of the program application by registered nurses because of its benefits.

Tucker et al. (2012) stipulate the intentional hourly rounding program is a proper strategy for preventing patient falls and motivating staff. However, the action has its shortfalls, such as the disturbance of patients when sleeping. The implementation of the program requires adequate time, thus disrupting nursing duties. The perceived barriers to successful utilization of the hourly rounding strategy should be explored by nurses and other professionals to solve the problem of falls (Tucker et al., 2012). The initiative requires effective nursing leadership and culture of safety within the care settings where all employees are involved in its structuring and training to improve the commitment toward fall mitigation.

The fall rate is expected to decline when interdisciplinary professionals are engaged within the healthcare setting to implement the initiative. Goldsack et al. (2015) notes the failure to involve the healthcare team is likely to be a barrier to successful utilization of the program to achieve the desired outcomes. The hourly rounding strategy should be standardized and implemented with a purpose of preventing falls. As a result, the expectations of patients and health professionals can be met. Research undertaken in a health setting in Ohio showed that standardization is a crucial step in the hourly rounding procedure to prevent falls (Reimer & Herbener, 2014). The different actions involved in the process can assist in decreasing the rate of call-light utilization by patients because of satisfied needs.

Melnyk and Fineout (2011) postulate the purposeful hourly rounding can provide desired outcomes when a multidisciplinary team is involved in the implementation process. The professionals are expected to evaluate the challenge of falls experienced in care settings to

implement the initiative of addressing the needs of patients effectively. Hourly rounding protocols are necessary to facilitate the effective implementation of the program (Melnyk & Fineout, 2011). Research evidence should be established by the interdisciplinary team to promote change in nursing practice aimed at introducing hourly rounding to minimize the number of falls.

Lowe and Hodgson (2012) assessed the effect of purposeful hourly rounding on one of the acute care units at Leeds Teaching Hospitals. The research was aimed at evaluating the safety of patients after implementing the fall prevention program. The hospital unit utilized during the study had 14 beds, and one registered nurse serving two patients who were 62 years old on average (Lowe & Hodgson, 2012). Trials on the effectiveness of the program were conducted using the framework focusing on the 4Ps. It was observed there were no patient falls because of the hourly rounding tools addressed to the 4Ps, thus meeting the expectations of patients (Lowe & Hodgson, 2012).

Ford (2010) researched the application of an hourly rounding initiative to enhance safety by decreasing the percentage of falls at the health unit. The study was undertaken in the 311-bed section of the University of Maryland Medical in Baltimore with an hourly rounding initiative implemented with emphasis on the 4Ps, and no falls were observed at the end of the investigation (Ford, 2010). Thus, the research indicates the intervention was successful in solving the problem to promote the safety of patients.

Olirich, Kalman, and Nigolian (2012) evaluated the effectiveness of purposeful hourly rounding in a 506-bed hospital in the U.S. The researchers used two acute care units and gathered data before and after implementing the fall prevention initiative. The sample population involved in the research comprised of patients that had been discharged during the year of study

(Olirich et al., 2012). The information related to the rate of falls was recorded six months before and after implementing the program. The fall rate in the hospital unit was reported to be 3.37 per 1000 inpatient days before utilizing the purposeful hourly rounding strategy (Olirich et al., 2012). However, the fall level reduced to 2.6 per 1000 inpatient days after implementing the initiative, which led to a 23% decline (Olirich et al., 2012). The fall level in the facility unit acting as a control to the experiment increased after the program was implemented.

A review undertaken on the effect of hourly rounding in enhancing safety among patients through a reduction in fall rates indicated positive outcomes. Kessler et al. (2012) conducted an assessment by studying a 30-bed acute care facility at Lehigh Valley Health Network. The facility staff utilized the initiative. The research focused on the creation of strategies and procedures that could facilitate the use of the program (Kessler et al., 2012). The workers appraised patients' needs during the hospitalization and after the discharge.

The study found most patients suggested the need to improve pain management and to ensure timely response to call bells. The health professionals evaluated the feedback from patients and employed the purposeful hourly rounding program (Kessler et al., 2012). The hospital employees attended regular meetings to discuss the progress made with the intervention, and continuous improvement plans were proposed and implemented (Kessler et al., 2012). The leadership of the hospital unit under investigation introduced the rounding logs for health professionals to sign during hourly rounding. The study established falls reduced from 5.46 to 2.19 per 1000 after six years of using the hourly rounding tool (Kessler et al., 2012).

A study undertaken by Brown (2016) concerning the effect of purposeful hourly rounding found it decreased the rate of falls by 25%. The initiative was implemented at a health facility in

Fargo, which had cardiac telemetry units. The hourly rounding used in the hospital emphasized on potty and proximity of the 4Ps. Different processes, such as training of hospital employees on the efficient use of the initiative, contributed to its success (Brown, 2016). The nurses were found to record the risk levels of falls for necessary actions to be taken to address the challenge. The result of the study within nine months indicated the decline in fall rates from 7 to 2.4 per 1000 inpatient days (Brown, 2016).

Proactive hourly rounding by nurses is observed to reduce anxiety and fear in patients. The process decreases the rate of call light utilization by patients. Studies undertaken by nursing professionals and patients noted pain relief and adequate help among the causes for the use of a call bell in hospitals (Mitchell, Lavenberg, Trotta, Umscheid, 2014). Purposeful hourly rounding plays a pivotal function in addressing the essential 4Ps, thus enabling healthcare staff to offer responsive and continued care.

The unveiling of purposeful hourly rounding to prevent falls poses significant challenges to nursing leaders. For example, the projected reimbursement levels in healthcare settings may be uncertain (Mitchell et al., 2014). Healthcare leaders are expected to be accountable for critical changes concerning time management by nurses and the level of staffing required to execute the program and the offering advantages that exceed costs. The professionals should provide a persuasive case for introducing the hourly rounding initiative to enable buy-in by stakeholders because of the associated costs (Mitchell et al., 2014). There is a need to undertake a systematic review of the intervention to determine its suitability.

Evidence should be created to provide insights on the proposed change in nursing practice to use hourly rounding effectively (Mitchell et al., 2014). Knowledge-based evidence is

crucial for decision-making on the execution of the program and allocating resources prudently to facilitate success (Mitchell et al., 2014). Therefore, hourly rounding can contribute to patient safety when necessary steps are undertaken by healthcare staff to organize resources to reduce falls in healthcare settings.

A systematic assessment of evidence on purposed hourly rounding by Mitchel at al. (2015) observed falls reduced significantly after its implementation. Most of the studies indicated an improved satisfaction of patients after implementing the initiative. The responsiveness of nurses was also enhanced as they could promptly address patient needs after activating the call light (Mitchel at al., 2015). The reviews suggest hourly rounding initiatives could promote effective responses from nurses in the health care units, thus solving the problem of falls.

The assessment of 16 published studies revealed the execution of the hourly rounding initiative minimized the use of call-lights by 23% to 70%, hence indicating improved patient satisfaction (Mitchell et al., 2014). Patient requests for positioning needs and toileting that have been significant causes of falls in hospitals declined. The urgent needs of patients to use the washrooms or change position declined because nurses performed proactively in frequent rounds and asked patients if they required assistance. The number of falls reduced from 24 to 80% leading to a significant improvement in the routine care offered to patients (Mitchell et al., 2014). Therefore, the reviews of the articles demonstrate there is sufficient evidence concerning the impact of conducting purposeful hourly rounds to prevent falls in hospitals.

The integration of training for the interdisciplinary team within the healthcare setting is necessary to use the purposeful rounding to reduce patient falls (Mojares, 2018). The involvement of staff in the program is likely to offer feedback concerning the rate of falls to

initiate proactive mechanisms for addressing the problem through PHR (Mojares, 2018). The leadership should adhere to the initiative to enhance the culture of mitigating falls to improve safety. According to Morgan et al. (2015), the intervention should be staff-led to facilitate its buy-in leading to success in reducing falls.

Summary

The critical evidence found in the literature identifies hourly rounding, conducted appropriately, accurately, and entirely, produces a significant reduction in patient falls and outcomes. Preventing falls in hospitalized patients is constant challenges the healthcare team faces daily. There are numerous studies on hourly rounding processes demonstrating the improvements with purposeful hourly rounding in fall reduction. Among the articles included in this review, there was considerable variability in the study protocols (i.e., the way the studies were carried out and how the results were measured). Interventions consistently aligned around the "four P's" of pain control, potty, positioning, and possessions. There were, however, variations in the frequency of rounding, and staff members completing the rounds (registered nurses vs. assistive personnel), which could be a significant consideration for nurse executives (Mitchell et al., 2014).

Theoretical Framework/Evidence-Based Practice Model

The growing use of healthcare services has led to growing competition among hospitals, and the social trend of professionalism and globalization has promoted hospitals' enlargement and specialization. Heightened expectations and needs from the public have naturally let healthcare organizations pursue a higher quality of healthcare services as well as continue to keep up with the ever-changing healthcare environment. Evaluating falls is a crucial element that might exert a significant effect on hospitals' profits and management (Shin & Park, 2018).

The current project adopted the Carolina Care Model (CCM) developed at the University of North Carolina Hospital, on the basis, of Swanson's model. The CCM was grounded in Swanson's middle-range theory explaining the nature of nursing care. Multidimensional nursing rounds in the CCM were implemented to measure the effect of purposeful nursing rounds. The Swanson theory of caring has five basic principles which are maintaining belief, knowing, being with, doing for, and enabling/empowering (Appendix A). Each caring process has sub-dimensions as the basis for nursing intervention and applies to the nursing process. It is assumed the focus of nursing is not on a person's disease alone and includes assisting patients in attaining, maintaining, or regaining an optimal level of well-being (Shin & Park, 2018).

As a middle-range theory inductively derived from nursing research, the CCM is based on concepts such as nursing provision, professional relationship, values of professional nursing, rewards, and leadership. The framework was selected because it is consistent with the mission, vision, and values of the healthcare system's need to prevent falls (Shin & Park, 2018). The goal of nursing is to promote the peace of subjects. In this case, therapeutic techniques to communicate with patients to prevent falls are fundamental. Swanson, in turn, discussed how care could be promoted and maintained in clinical settings and proposed a variety of circumstances where the interaction would happen between nurses and patients (Shin & Park, 2018).

Swanson's structure of caring provides a coherent explanation of the links between caring processes and patient well-being. At a deeper level, the sub-dimensions of each process suggest actionable interventions making the theory-practice connection intelligible and useful to clinicians. The caring theory postulates nurses demonstrating care as essential to patient well-being as caring for them through clinical activities such as preventing infection and administering medications.

Spending time to actively listen to patients' descriptions of problems and expressions of feelings and concerns convey nursing presence and availability. Taking action to address concerns enables patients to feel a greater sense of control of the environment (Shin & Park, 2018).

Iowa Change Model

The Iowa Change Model was first published in 2001 and was revised in 2015. The model utilizes a problem-solving approach based on the scientific process and is recognized as a useful change model by many multidisciplinary healthcare teams. The Iowa Change Model offers a framework for understanding the evidence-based practice (EBP) process, and for designing an EBP change in the clinical setting. This model includes a multi-step change process with feedback loops (Hanrahan, 2015). The Iowa Change Model is particularly effective as a framework for the implementation of hourly rounding, as it includes several feedback loops, which reflect analysis, evaluation, and modification of processes and outcomes. These modifications are essential to individualizing practice in a clinical setting and ensuring evidence-based practice (EBP) is patient-centered (Hanrahan, 2015).

To facilitate change in practice, The Iowa Evidenced-Based Practice Model (IEBPM) was used for the project (Appendix B). Permission was obtained to utilize the model for this project (Appendix C). The model provided a framework for clarity of the scientific practice process and offered a step-by-step process guide using an algorithm to assist through the application of care. According to the Iowa Change Model, a pilot study should first be undertaken before a change in practice is made. A pilot study involves multiple steps, including the selection of outcomes to be achieved, the collection of baseline data, the design of EBP

guidelines, implementation of the pilot study, evaluation of process and outcomes, and the modification of practice guidelines (Steelman, 2015).

The first step in the Iowa Change model is the identification of the problem or selection of the topic. (Melnyk & Fineout-Overholt, 2011). The Iowa Change Model begins with identifying practice questions or clinical "triggers" that come from questioning current clinical practices. The problem-focused trigger in this project is the alarming incidence of patient falls. The examination of hourly rounding protocols on inpatient fall reduction should be a tremendous change priority in most organizations, where reimbursement is based on patient safety metrics (Ryan, 2015).

Once the need for hourly rounding protocols is identified a clinical and administrative team should be assembled to review the problem, or topic, and begin developing and implementing a solution (Melnyk & Fineout-Overhol, 2011). This team can be multidisciplinary and should include Nurse Leaders, Advance Practice Nurses (APNs), and other stakeholders. The implementation of hourly rounding protocols requires buy-in from those it impacts, for this project that would include nursing assistants, licensed professional nurses, registered nurses, and advanced practice nurses. Studies show hourly rounding is most effective when all levels of nursing personnel participate in the practice. This step also involves the review and analysis of existing research evidence to identify a base for the practice change. When sufficient evidence is collected, a practice change can be initiated (Ryan, 2015).

Creating, or identifying, an Hourly Rounding Toolkit can assist the healthcare organization implement hourly rounding protocols, as well as improve quality and safety in patient care. This toolkit could be useful in anticipating and meeting patient needs and promoting

patient safety. Toolkits may include; promotion flyers describing the concept of hourly rounding to staff and patients. This creates awareness of the program. Patient Welcome Cards (Appendix D) introduce the concept of hourly rounding to patients and have been linked to higher patient satisfaction scores.

A pilot study is an essential component of the change process, as it identifies potential barriers to change that can be overcome prior to instituting a facility-wide rollout (Melnyk, 2015). A pilot study can be conducted over a short time period (usually over a minimum period of 6 months), in random units. The outcome to be achieved from the implementation of an hourly rounding protocol is a statistically significant reduction in patient fall rates. Baseline data can be collected from the units participating in the pilot study, prior to the implementation date. Data collected can include fall rates for each unit over a set period prior to the beginning of the pilot study. Hourly rounding protocols and practice guidelines need to be provided to the nursing staff, to outline how purposeful hourly rounding will be implemented.

Goals, Objectives and Expected Outcomes

Hourly rounding, as the name implies, is the practice of nurses and unlicensed assistive personnel making scheduled visits to the rooms of hospitalized patients and performing specific nursing interventions every hour. The goal is to improve fall rates by the nursing staff addressing patients' needs in a proactive manner. The primary outcome measure is to correlate the effects of hourly rounding to patient falls with the expected result of a decrease in fall rates within 30 days. Utilizing a patient-centered approach to fall prevention, by involving both patients and caregivers to reduce falls, may significantly improve quality of life and clinical outcomes. The project objectives are as follows:

- Investigating variables impacting staff resistance to this concept of rounding.
- Change the unit culture to consistently meet patient needs proactively.
- The project site will establish purposeful rounding as a process on the medical-surgical unit by March 1, 2020.
- The medical-surgical unit at the project's site will show a 50% decrease in falls in one month.

Project Design

The project's design is a structured patient rounding program using evidence-based practice to reduce falls. Data for this study will be collected by conducting a retrospective data review to determine the incidence of falls one month before and after the implementation of a purposeful hourly rounding program by using a quantitative method. The evidence-based practice improvement (EBPI) model developed by Lewin and colleagues will be used as the method of using evidence-based practice (EBP) to improve patient care. The EBPI model combines the best of EBP and performance improvement paradigms. The EBPI model will give direction to project methods for implementing the evidence-based practice change.

Stage 1 - Unfreezing: This is the first stage of transition and one of the most critical stages in the entire process of change management. It involves improving the readiness as well as the willingness of people to change by fostering a realization for moving from the existing comfort zone to a transformed situation. It involves making people aware of the need for change and improving their motivation for accepting the new ways of working for better results. During this stage, effective communication plays a vital role in getting the desired support and involvement of the people in the change process.

Stage 2 - Change: This stage can also be regarded as the stage of transition or the stage of an actual implementation of change. It involves the acceptance of new ways of doing things. This is the stage in which the people are unfrozen, and the exact change is implemented. During this stage, careful planning, effective communication, and encouraging the involvement of individuals for endorsing the change is necessary. It is believed that this stage of transition is not that easy due to the uncertainties, or people are fearful of the consequences of adopting a change process.

Stage 3 - Freeze (Refreezing): During this stage, the people move from the stage of transition (change) to a much more stable state, which we can regard as the state of equilibrium. The stage of Refreezing is the ultimate stage in which people accept or internalize the new ways of working or change, accept it as a part of their life, and establish new relationships. For strengthening and reinforcing the new behavior or changes in the way of working, the employees should be rewarded, recognized, and provided positive reinforcements, supporting policies or structures can help in reinforcing the transformed ways of working.

Project Site and Population

This study will be conducted at a 122-bed acute care facility in Alabama, with over 350 professionals. The facility is a non-profit, community, rural-based hospital. The organization strives every day to bring advanced care to the community. The hospital believes in serving the community outside the hospital walls, as evidenced by the commitment to health education, and contribution to organizations. There is only one medical-surgical unit in the hospital staffed with registered nurses, certified nurse assistants, monitor technicians, and managers. The average daily census of the unit is 24 patients with an average length of stay of 3.2 days. The project's

site offers a full range of services to meet the diverse needs of patients, including a patient-first approach to home health and hospice care, surgical services, orthopedics, rehabilitation, and psychiatric care. There are anticipated challenges that may introduce variability and play a role in the interpretation of results. The hospital experiences a frequent change in administrative leadership, occasional low patient census, and limited financial and human resources.

Setting facilitators and barriers. Potential barriers to implementation of this quality improvement project may include a lack of supplies and funding. Organizational resistance to change may be a barrier. Finally, a lack of support from the leadership team may limit implementation efforts. To address these barriers proactively, the leadership team must play active roles throughout the implementation of the project. The use of the (EBPI) model will help address some of the potential barriers by providing a reliable support system and clearly defining the roles and responsibilities of key stakeholders throughout the organization ("Catching Quality Before It Falls," 2019).

Strategies to overcome potential barriers. Successful falls prevention program implementation in acute hospital units are likely to require a multifaceted, planned approach that includes: regular practical face-to-face education and training for nurses to modify skills and established beliefs; provision of equipment; audit, reminders and feedback; leadership and champions; and the provision of falls data (Ayton et al., 2017). The best way to reduce the risk of not having enough resources to complete the project is by making sure the resource management plan is as thorough as possible. To start, list the necessary resources, and schedule them to meet your deadline. That means all the people, equipment, and materials that are necessary to complete the project. To assist with a lack of support from leadership, organize a staff meeting to

explain the need for a fall prevention program that includes education for the staff related to evidence-based practice and how it is used in similar practice settings. Discuss the value of implementing the practice method in the facility. Explain that instituting evidence-based practice methods will require a cultural shift on the unit and involvement from everyone (Jennifer, 2017).

Implementation Plan and Procedures

The project implementation will begin with the orientation of the charge nurses to the project and its purpose. Each member of the team, including the nurse managers, will be provided an orientation and training on the project's protocol. The orientation curriculum will consist of the following topics (see Appendix E for a detailed script): overall purpose/goal of the project, measurement of project, training, rounding program explained in detail, and how fall rates will be analyzed. The staff will be provided with a questionnaire at the end of the training session to determine the level of understanding and comprehension of the material given. The questionnaire (Appendix F) will list five questions for staff to answer. After the implementation of the project for thirty days, fall rates will be reviewed on the unit and compared to the average fall rates previously. The National Database of Nursing Quality Indicators (NDNQI) Data Website has a link in the bottom right corner titled "ANA is the NQF measure steward." The site has definitions of falls and patient days, so fall rates may be calculated and used as a tool to evaluate the DNP project.

The purposeful hourly rounding protocol is integrated with each patient's fall prevention interventions and care activities. There are no changes made to patients' daily routines and activities; however, nursing staff is expected to check on patients and complete protocol items. As a team lead for the project, this DNP student is responsible for educating staff on the hourly

rounding protocol and providing educational materials. The DNP Project Manager will also give the participants protocol guidelines and tools for documentation weekly. Nursing assistants are responsible for checking on the patient and performing the protocol as well. Nurses are to check for completion of documentation at the end of every shift and place the documentation from each shift in binders for future review by the implementation team.

The scheduled rounding protocol allows nursing staff to proactively implement universal fall precautions while meeting the needs of patients. Upon entering the patient's room, the staff informs the patient about the routine scheduled rounding. The staff will then assess the 4 Ps, as well as confirm fall interventions are in place based on that patient's fall risk assessments. A documentation log (Appendix G) is used each time rounding is performed for compliance and reliability of data. The staff will ensure the patient is safe before leaving the room and remind the patient staff will return in an hour for the next round; however, the patient is instructed to use the call light for assistance at any time. After implementing the above steps, data will be collected for any falls during the implementation period and analyzed.

Measurement Instruments

Creating or identifying an hourly rounding toolkit can assist the healthcare organization in implementing hourly rounding protocols, as well as improve quality and safety in patient care. The tool will be posted in all patient's rooms in the hospital unit for staff to document each hour. To measure the outcomes of this DNP project, fall rates will be reviewed pre-implementation, active implementation, and post-implementation of purposeful hourly rounding. To regularly measure fall rates requires setting up a routine workflow (a scheduled set of activities and tasks performed by designated people) for data collection. The primary investigator will calculate fall rates from incident report totals.

Data Collection Procedures

A medical-surgical unit, with documented high fall rates, is chosen to determine the effectiveness of purposeful hourly rounding. Purposeful hourly rounding education will be conducted and implemented in December 2019. To evaluate the efficacy of hourly rounding, the student plans to compare fall rates for October 2018 – October 2019 to fall rates for December 2019 – February 2020. Data is supplied from the Risk Management team.

In measuring fall rates, the DNP project manager plans to count the number of *falls* and the number of *occupied bed days* on the medical-surgical unit over one month. To count falls properly, staff in the hospital or hospital unit need to agree on what counts as a "fall." Defining a fall is especially a problem in "borderline" cases, such as when a patient feels her knees giving out while walking with a hospital staff member and the staff member eases the patient onto the floor. The DNP project will expect staff to generate a report for every fall that occurs. The incident report will need to contain, at a minimum the type of incident being a fall, patient in whom the fall occurred, date the fall occurred, unit the patient was assigned to at the time of fall, location of fall, detailed report about the circumstances of the fall, and level of injury if any. ("How do you measure fall rates and fall prevention practices? Agency for Healthcare Research & Quality", 2019). Providing staff education prior to implementation will create awareness on the importance and significance of a fall prevention program that focuses on changing the behaviors of direct care. The IOWA care model step of design and piloting the practice change will be used to prepare clinicians and materials. This will enforce that staff understand how and when to effectively complete an incident report.

The best measure of falls is one that can be compared over time within a hospital unit to see if care is improving. Therefore, the DNP project will calculate falls as a rate, specifically, the rate of falls per 1,000 occupied bed days. The hospital information system will provide the DNP project manager with the average daily census on the unit of interest for the time period over which fall rates are to be calculated. The hospital site has access to a computerized system for a daily census ("How do you measure fall rates and fall prevention practices? | Agency for Healthcare Research & Quality", 2019).

Data Analysis

The data for the DNP project will be analyzed by graphing a run chart to examine trends visually. The data will be disseminated to key stakeholders and unit staff. The data analysis strategy based on the research design requires a descriptive examination of pre-and post-changes in the fall rate. Specifically, the data collected will compare changes in study metrics as a result of hourly rounding training sessions. Descriptive analysis is used to examine and analyze the data pre-and post-implementation of the educational sessions provided for the project. The staff will also be provided with a questionnaire at the end of the training session to determine the level of understanding and comprehension of the material given. The questionnaire (Appendix F) will list five questions for staff to answer.

The following section describes the data collected for the patient fall events. It also provides an overview of the statistical methods used to analyze the data obtained from the hospital. For the first month time period for this study (January 1, 2020 through January 31, 2020), the hospital provided an initial incident/event report for every fall event that occurred during this period. The information provided by the hospital for this data collection period was

from the Midas reporting system for each patient fall. Due to compliance, the information of each individual fall, such as time of day, patient's date of birth, and medical records number was not disclosed to the primary investigator. In addition to the individual fall information obtained for this period, the hospital-wide monthly patient fall rate was provided to this student from January 2019 through February 2020.

Fall Data Collected for the First Data Collection Period (January 2019 - December 2019)

A target monthly fall value was established for the hospital-wide performance. Thus, the monthly measured fall rate could be readily compared to the target fall rate determined by the hospital. Following the collection and analysis of the first set of patient falls data and following discussion of the data with the site preceptor and project chair, a presentation was prepared and made to members of the hospital staff. This presentation on November 19, 2019 provided a synopsis of the data assessment performed, together with several suggestions that were developed based on the data collected and analyzed. Following this presentation, another discussion about possible changes in the existing patient fall data collection process was held with a few nursing staff supervisors in November 2019 to consider the implementation of suggestions made by the DNP project manager, and hospital staff members for application of the second data collection period. Pre-implementation data showed

Changes in Fall Data Collected for Second Data Collection period (December 1, 2019 – December 31, 2019)

From December 1, 2019 until the end of the second data collection period December 31, 2019, a new method of rounding by the nursing staff was being prepared and implemented in the medical-surgical unit of the hospital. This new rounding procedure was designed to ensure each

patient on the unit knew that every hour during the shift, either a nurse or a nurse's aide would check each patient and room. This check would assess the patient's pain level, offer toileting assistance, ensure necessary items (such as telephones and water cups) were within reach for the patient, check fall alarms, and inspect the room for safety and clear pathways. This revised rounding procedure is provided in more detail in (Appendix H).

The change in the rounding procedure was based on a study performed by the Studer Group (2007). The implementation of this new rounding process was viewed by the staff as a significant hospital cultural change. It was recognized for the process to make a significant impact on improving patient care; however, both the nursing staff and administration would have to agree to a "buy-in" to the effort of changing the existing culture. Specialized training was provided to the nursing staff before the implementation of this procedure to ensure the requirements associated with the hourly rounding procedure were understood. This training was followed by a questionnaire to determine the understanding and need for re-education. The potential impact of this change in nursing rounding, although not able to be adequately addressed by this paper due to the project's strict focus on fall improvement, will be discussed in the conclusion section.

Discussion of Data Collected The initial monthly patient data fall rate for January 2019 through December 2019 varies from a low of zero to a maximum of four (patient falls per 1000 patient-days). The average value is 1.67 and the standard deviation is 1.1547. Seven of the monthly values are more significant than the hospital goal of one or fewer patient falls per month. Visual observation of the monthly patient fall data indicates over the time period presented, there does not appear to be any strong trend in the data. To provide perspective as to

the raw number of patient falls that occurred over the period Figure 1, presents the monthly total number of patients falls over the period of one year. The average number of monthly falls was 1.67, the median was 2, the standard deviation was 1.1547, the minimum value was 0 and the maximum value was four. Basically, the figure shows a large month-to-month similarity of the number of patient falls. The total number of falls between January 2019 through December 2019 were 20.

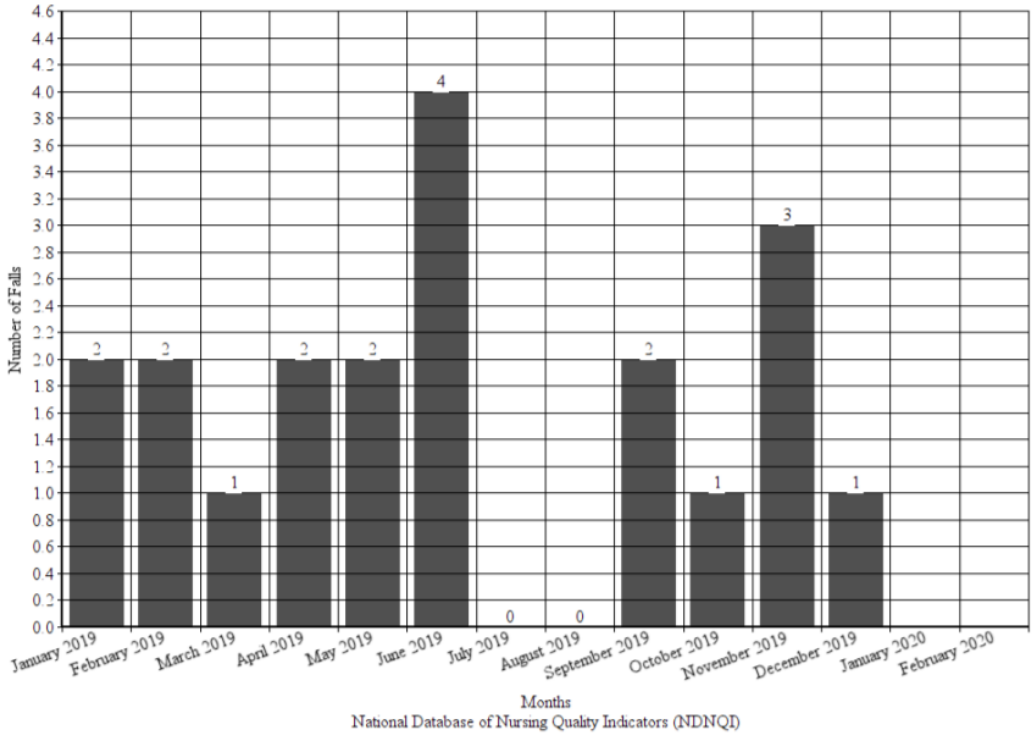

Figure 1.0 Fall Chart

Results

The results of the fall prevention program initiative suggested that a standardized program that includes nursing staff organization and purposeful hourly rounding can reduce the

number of falls within a facility. Pre implementation falls varied from one to three falls monthly. Post education and implementation to purposeful hourly rounding showed a significant decrease on a small medical surgical unit to zero. The average of pre-implementation falls is 1.67 for the year of 2019. Post-implementation, there were zero falls for January and February 2020. The implementation period of 30 days shows a 100% decrease of change from the average of 20 falls for 2019 rates.

Cost-Benefit Analysis

To comply with this directive, a training on purposeful hourly rounding was implemented in conjunction with the current unit meetings already established as a routine and did not result in any additional cost. Additionally, training for the program was implemented during charge nurse meetings already scheduled on the units. The host organization of this project is estimated to have at risk $0 dollars through this program, compared to $0 expense of the rounding program; the benefit is clear to support its initiation. The DNP will incur a cost of $400 which includes; printing cost for training material and printing of the hourly rounding tool.

Timeline

The project implementation is anticipated to be over three months, to allow time for staff training and preparation, implementation and data collection, and evaluation of the effectiveness of hourly rounding and decreasing patient falls. The three months include, pre-implementation, implementation, and post implementation. Pre- Implementation in relation to this project includes; training the staff on an effective hourly rounding program, the questionnaire to determine a thorough understanding by the staff and increasing the importance of the program to management staff. An effective implementation phase with the purposeful hourly rounding

program includes monitoring fall weekly totals while staff incorporate the newly introduced tool when entering patient's rooms. During the post- implementation phase the hospital will be evaluated on continuation of the project and success of decreased falls. The DNP student will then evaluate the effectiveness of the project without frequent monitoring and presence.

Step 1: Selection of a topic/ Pre- Implementation

In selecting a topic for evidence-based practice, several factors need to be considered. These include the priority and magnitude of the problem, its application to all areas of practice, its contribution to improving care, the availability of data and evidence in the problem area, the multidisciplinary nature of the problem, and the commitment of staff. During this phase, the current practice was examined, and aspects needing improvement were identified. Specifics on what needs to be changed were decided upon as the fall rate, and the process of how to effectively meet this change were decided.

Step 2: Forming a team/ Pre- Implementation

The team is responsible for the development, implementation, and evaluation (LoBiondoWood and Haber, 2006). The composition of the team should be directed by the chosen topic and include all interested stakeholders. The process of changing a specific area of practice will be assisted by specialist staff team members, who can provide input and support and discuss the practicality of guideline implementation (Frost et al., 2003; Gagan and Hewitt-Taylor, 2004). Specific areas of responsibility and paths of communication for nursing staff and administration were determined. Staff roles were considered based on the features of the organization and the individual unit involved in fall prevention. Staff roles were clearly defined so that the staff will understand if and how their roles will change. The unit champion was assigned as the charge

nurse of the medical-surgical floor, and this individual was instructed to provide results, report on program progress, and provide updates in staff meetings. During this phase is also when the education occurred for the nursing staff. Staff was provided training on three separate days to accommodate schedules. The staff was given a lecture on falls, the current rates of the hospital, what the facility's goal was, and the plan to address this issue.

Step 3: Evidence retrieval/ Pre- Implementation

From the team formation and topic selection, a brainstorming session should be held to identify available sources and critical terms to guide the search for evidence. As the DNP project manager that will implement the fall prevention program, the skills and strengths of the current staff were reviewed with the chief nursing officer (CNO) to account for allocating responsibilities. During the pre-implementation phase, a thorough literature review was completed to retrieve evidence of practice. The topic was refined to narrow the search results for a literature review during this stage. A search was conducted with the following words: falls, hospitalized, prevention, evidence-based practice, hourly rounding. After the execution of the literature search, a critical assessment and analysis were completed. The DNP project manager then ensured the information summary included the title, author, publication year, and source type. A strong argument was given, highlighting the existing studies from a new and different perspective (Taylor, 2016).

Step 4: Grading the evidence/ Pre-Implementation

To grade the evidence, the team will address quality areas of the individual research and the strength of the body of evidence overall. This step included a transparent process of reviewing and assessing the quality of evidence available in the studies. Practice recommendations were synthesized graded as to the scope and quality of the evidence that supports the proposal.

Step 5: Developing an Evidence-Based Practice (EBP) standard

After a critique of the literature, team members come together to set practice recommendations. The type and strength of evidence used in practice need to be transparent (LoBiondo-Wood and Haber, 2006) and based on the consistency of replicated studies. There is moderate-strength evidence that hourly rounding programs improve inpatient falls.

Step 6: Implementing EBP

For implementation to occur, aspects such as written policy, procedures, and guidelines that are evidence-based need to be considered (LoBiondo-Wood and Haber, 2006). The hospital, along with the chief nursing officer and chief executive officer is considering in the future to provide a written policy for staff to follow with hourly rounding. This change will follow the guidelines of this DNP project; purposeful hourly rounding.

Step 7: Evaluation

Evaluation is essential to seeing the value and contribution of the evidence into practice. A baseline of the data before implementation would benefit, as it would show how the evidence has contributed to patient care. Continued monitoring of the project in February 2020 showed benefits. There were zero falls for February.

Ethical Considerations/ Protection of Human Subjects

The Jacksonville State University Institutional Review Board (IRB) approval will be obtained before initiating the DNP project. As this project will not involve a comparison group and will not generate new knowledge, it is not considered research. All participants were protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which,

among other guarantees, protects the privacy of patients' health information (Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, 2013). All information collected as part of evaluating the impact of this project was aggregated data from the project participants and did not include any potential patient identifiers. All electronic files containing identifiable information were password-protected to prevent access by unauthorized users, and only the project coordinators had access to the passwords. Permission for project implementation had been obtained from several layers of leadership within the host organization, including the chief nursing officer of the hospital, and chief executive officer of the organization (Appendix I).

The purpose of the hourly rounding project is to reduce falls and ensure patients perceive they are getting the highest quality of care possible and to identify and rectify the obstacles to that perception. The injuries and complications, as a result of falling, can have devastating long-term effects on independence and quality of life. Falls often lead to pain and limited physical ability, thereby reducing the activities and functional abilities of fallers (Peeters, Jones, Byles, & Dobson, 2015). The principle of beneficence, defined as the act of "doing good" as opposed to "doing harm," is the guiding principle for this project (Johnson, 2003). The proposed hourly rounding project will help to identify any concerns the patients and families have about the care rendered thus far and provide an opportunity for the nursing staff to take action for correction to ensure the organization delivers high-quality care and therefore "do good."

Evaluation of Project Effectiveness

Continuing to monitor fall rates and fall prevention care processes is critical for the sustainability of a fall prevention program. Measurement is necessary for improvement, particularly as a check to ensure the program is not veering off track. Analysis is also needed to show the ongoing success of the program to leadership. Leaders will be more willing to invest in

a program that has credible evidence of success. Progress made during each phase of deployment and system change was celebrated through a recognition program. Thus, the workgroup's achievements were an integral part of the medical center's staff recognition program. Another critical intervention, medication reviews, was initiated to heighten the awareness of side effects that may increase fall risk and are now done routinely for patients with frequent falls.

Lastly, an essential intervention was implemented to address communication gaps in the information collected about a fall and reporting the fall occurrence among disciplines. Since these falls related information are an integral part of the fall prevention program, a unit-based fall data and communication tracking sheet (Appendix J) was developed to monitor fall specific data and is available to all providers directly responsible for the care of the patients. This new process is considered an administrative intervention to fill gaps in the fall prevention program, and thus can be tracked for impact on the fall prevention program.

As a result of this sheet, anyone on the unit can visually see a patient who fell, and where the staff are in the communication process about the fall occurrence and revising the plan of care to prevent a repeat fall. Also, staff can easily view a resident who experienced multiple falls and track when all elements of the post-fall care plan were completed. This type of information complements a control chart, because this sheet provides information about the single fall, whereas a control chart uses averaged data about monthly fall rates.

Conclusion

Addressing this clinical project includes a pragmatic approach to gathering data, selection of an outcome that is both meaningful to patients and the healthcare system, and an intervention that included a generalizable study population and allowed for flexible implementation. In conclusion, it is recommended that reducing falls will continue to be an ongoing process that

requires a consistent effort and focus. Falls can be prevented, and the severity of fall-related injuries can be minimized. When updating new hospital fall prevention policy, factors essential for revision included up-to-date teamwork collaboration between staff (i.e. RN and nursing assistants) for fall prevention and nurse-patient communication. More study time may be needed to determine if a similar program evaluated over a longer period can help reduce patient falls (Rednak, 2015).

As the literature describes, falls are a leading cause of death in people 65 years of age or older, greater than 10 percent of fatal falls for the elderly occur in hospitals and high health care system cost yearly (IHI, 2014; CDC, 2013). Routinely RNs and nursing assistant's receive specific updates to policy and procedure related to fall prevention revisions. Moreover, these changes are typically based on the latest evidence-based research and align with the mission of the hospital. It is anticipated an updated falls committee, stricter staff accountability for policy review, and improved patient rounding may be necessary based on best practice methods to help decrease falls, as described by Colón-Emeric, Schenck, Gorospe, McArdle et al. (2006). The next phase of this project initiative is the consideration of how the program should or should not be rolled across the organization. It is presumed the outcomes generated by this project will garner interest in extending this program to other units. With that in mind, subsequent revisions to the project should seek to identify knowledge and problem triggers associated with patient falls. Beyond seeking to improve the interventions, the consideration of a broad expansion of the program will need to leverage the results of the current project to establish additional urgency and priority with increasing the organization's utilization of the purposeful hourly rounding tool.

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APPENDIX A:

Kristen Swanson's Theory of Caring

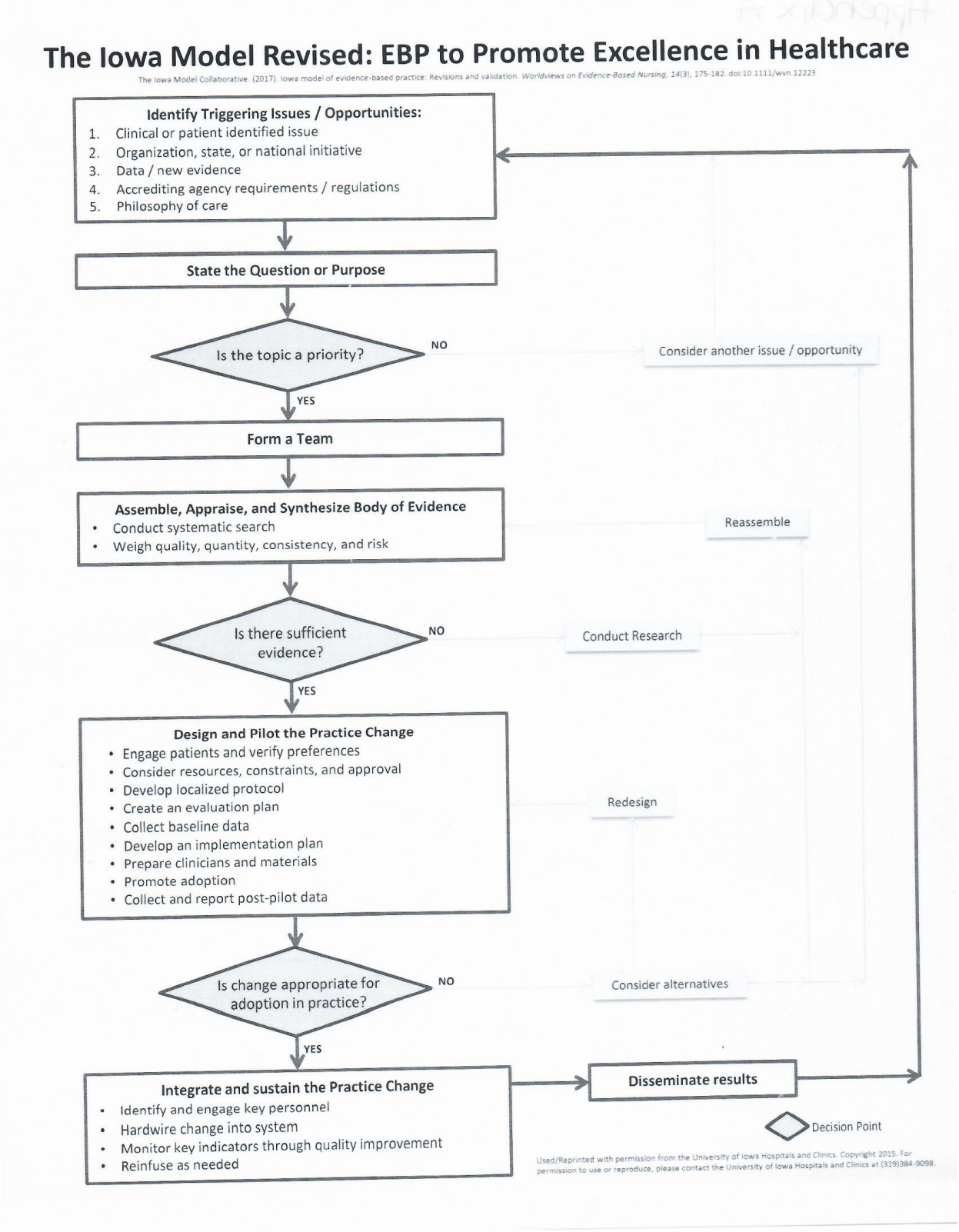
Swanson Theory of Caring:

- Defines caring as nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility.
- Supports the claim that caring is a central nursing phenomenon but not necessarily unique to the nursing practice.

5 Processes of this theory:

- Knowing: striving to understand an event as it has meaning in the life of the other; avoiding assumptions.
  - -Centering on the one cared for
  - -Assessing throughly
  - -Seeking cues
  - -Engaging the self or both
- Being with: being emotionally present to the other
  - - Being there
  - - Conveying ability
  - - Sharing feelings
  - - Not burdening
- Doing for: doing for the other as he or she would do for self if it were at all possible
  - - Comforting
  - - Anticipating
  - - Performing skillfully
  - - Protecting
  - - Preserving dignity
- Enabling: Facilitating the others passage through life transitions and unfamiliar events
  - - Informing/explaining
  - - Supporting/allowing
  - - Focusing
  - - Generating alternatives
  - - Validating/giving feedback
- Maintaining belief: sustaining faith in the others capacity to get through an event or transition and face a future with meaning
  - - Believing in
  - - Maintaining a hope filled attitude
  - - Offering realistic optimism

APPENDIX B:


The Iowa Model Revised: EBP to Promote Excellence in Healthcare
The Iowa Model Collaborative. (2017). Iowa model of evidence-based practice: Revisions and validation. Worldviews on Evidence-Based Nursing, 14(3), 175-182. doi:10.1111/wvn.12223
Identify Triggering Issues / Opportunities:
1. Clinical or patient identified issue
2. Organization, state, or national initiative
3. Data / new evidence
4. Accrediting agency requirements / regulations
5. Philosophy of care
State the Question or Purpose
Is the topic a priority?
NO
Consider another issue / opportunity
YES
Form a Team
Assemble, Appraise, and Synthesize Body of Evidence
• Conduct systematic search
• Weigh quality, quantity, consistency, and risk
Reassemble
Is there sufficient evidence?
NO
Conduct Research
YES
Design and Pilot the Practice Change
• Engage patients and verify preferences
• Consider resources, constraints, and approval
• Develop localized protocol
• Create an evaluation plan
• Collect baseline data
• Develop an implementation plan
• Prepare clinicians and materials
• Promote adoption
• Collect and report post-pilot data
Redesign
Is change appropriate for adoption in practice?
NO
Consider alternatives
YES
Integrate and sustain the Practice Change
• Identify and engage key personnel
• Hardwire change into system
• Monitor key indicators through quality improvement
• Reinfuse as needed
Disseminate results
Decision Point
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APPENDIX C:

Permission to Use The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care

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Mon 9/2/2019 7:40 PM
To: Iesha Bell <iscott@stu.jsu.edu>

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APPENDIX D:

Purposeful Hourly Rounding, A Quality Improvement Program
Patient Welcome/Admission Card

We are currently focusing on hourly rounding as a component of improving the patient experience. Hourly rounding is a structured means of promoting patient-centered communication in a healthcare setting between staff, patients, and their loved ones to ensure the best outcomes.

Hourly rounding is the process in which every hour, a staff member (either a nurse or nursing assistant) enters a patient's room to assess the person's needs. Generally, rounding occurs every hour during the day shift and every two hours on the night shift. A nurse and nursing assistant often rotate on the even and odd hours. As the staff make their hourly rounds, they focus their assessment on four key concepts — pain, position, potty, and placement of environmental items. Staff members use a checklist to ensure everyone asks the same questions. Staff place a checkmark next to the patient name at each rounding time.

APPENDIX E:

Item A

IMPLEMENTATION TIMEFRAME:	IMPLEMENTATION STEPS:
Several months prior to implementation	**Round on staff, send and manage thank you notes, implement key words** ➢ These are foundational tactics to the successful implementation of hourly rounding o When the staff feels valued and has the tools and equipment to do their job, they are more likely to be open to working on new behaviors o The success of hourly rounding is enhanced when all team members are participating **Discuss the benefits of hourly rounding** ➢ **Designed to promote high quality patient care** o Increases patient satisfaction by average of 12 raw points ➢ **Provides health care that is safe** o Reduces falls up to 50% o Reduces pressure ulcers up to 16% ➢ **Increases efficiency for staff** o Anticipates reasons why the call lights ring o Reduces call lights up to 38% o Saves nurses from 150 – 300 hours per month

Item B:

IMPLEMENTATION TIMEFRAME:	IMPLEMENTATION STEPS:
Two weeks prior to implementation	➢ **Get a team together to discuss the pilot** o Use this group to make decisions, plan and monitor processes ➢ **Discuss hourly rounding in staff meetings**

	o Share the results of the Studer Group research in the September 09, 2006 AJN Article o Solicit input from staff in the planning and implementation stages to encourage empowerment and a sense of pride in the process ➢ **Conduct Training** o Select nursing units with strong leaders who have good communication skills for your pilot units o Make training mandatory o Train nurses, techs and unit secretaries o Train day and night shift ➢ **Give staff a Competency Checklist and Hourly Rounding Pocket Cards** o Competency checklist specific behaviors necessary to master hourly rounding o Pocket cards are quick reminders of the "P" behaviors o Have staff perform a self assessment o Staff then practice for one week prior to leader evaluating the staff's competency during hourly rounding ➢ **Distribute Hourly Rounding Welcome Cards** o The nurse admitting the patient uses the card to explain hourly rounding to the patient and describe what the patient can expect from the staff o Staff signs their name on the welcome card "contracting" with the patient to round hourly and address prescribed behaviors ➢ **Distribute Hourly Rounding Pillow Cards**

	o Use cards when patients are out of the room for tests o Card states "Sorry I Missed You! We perform hourly rounding to ensure that you receive Very Good Care. Let us know if you need anything when you return. I will be back in about an hour." o Staff indicates time of round, signs their name and leaves the card and a mint [sugar free or regular] on the patient's pillow
One week after implementation date	➢ **Leaders complete Competency Checklists** o Give staff an opportunity to complete a self assessment o Staff successfully completing check-offs receive a special retractable badge holder o Badge holder is a quick visual indicator at shift change of who has been trained on hourly rounding o Manager should not delegate this important function

Item C:

IMPLEMENTATION TIMEFRAME:	IMPLEMENTATION STEPS:
Implementation Date	Implementation begins

Item D:

IMPLEMENTATION TIMEFRAME:	IMPLEMENTATION STEPS:
Ongoing	Leaders round with purpose ➢ **Round daily to determine if patients are receiving "Very Good Care" and monitor to see if staff is prompting for the 3P behaviors.** o If logs are complete but call lights are not reduced, staff are likely "checking on patients" or rounding hourly and asking, "how is everything?" Patients will commonly

	respond "fine". The patient will then use the call light because the behaviors (3P's) were not addressed. ➢ **Ensure that rounds occur on night shift and weekends** ➢ **Leader questions during rounding** o Our goal is to round on patients every hour; did you receive our hourly rounding welcome card? ➢ o How are we doing with rounding? Are we offering assistance in positioning, pain and taking you to the bathroom? How about on night shift and on weekends? ➢ **Post rounding questions in the staff lounge communicating that this is an open book test. Staff will go the extra mile when they know what is expected.**
Ongoing	➢ Sign the rounding logs when making leader rounds to demonstrate to the staff that you are reviewing their logs and communicate the importance of the staff signing the logs. ➢ Place the hourly rounding logs inside the rooms vs. on the outside of the room door allowing families to visualize the staff signing the log. Use of key words when signing will provide an opportunity to engage the family, enhance trust and promote care and concern. Hardwiring ➢ **Have unit secretary send out pages or reminders immediately if call lights begin to increase** ➢ **Review call light logs daily to spot trends.**

	➢ **Indicate room number and nurse's name on call light logs so training can be focused on the appropriate staff nurse.** ➢ **Develop a float packet with tools including a pocket card** ➢ **Include hourly rounding in nursing and tech unit coordinator orientation** ➢ **Incorporate hourly rounding competency goals into job evaluations** ➢ **Develop a plan up front to address shift change, breaks and confused patients** o Decide who will change out logs every 24 hours o Adjust staff to cover call lights during shift change o Have staff round before going to lunch and when returning letting patients know that they will be at lunch and that someone will be back in about an hour o Automatically get confused patients up to the bathroom. Often, they will tell you they do not need to use the bathroom and then will immediately use the call light for the same request.
Ongoing	Reward and recognize success ➢ **Share results with the staff. The more the positive results are shared with the staff, the quicker understanding will come and behaviors will be reinforced.** ➢ **Review call light logs and reward and recognize both the nurse and the unit secretary with the least call lights recorded.**

	➢ **E-round or send out a broadcast note weekly to associates addressing one of the following topics to keep the positive impact of hourly rounding top of mind** o Comments you are hearing from the patients o Positive staff comments and feedback o Call light percentage reduced o Hourly rounding stars of the week and why o Patient's perception of care – patient satisfaction results ➢ **Read positive patient's letters to the staff which will encourage them by reminding them why they went into health care**

Item E:

IMPLEMENTATION TIMEFRAME:	IMPLEMENTATION STEPS
Weekly	Hourly Rounding Meeting o Initially schedule meeting weekly o Change to bi-weekly when patient's perception of care is indicating consistent practices ➢ The meeting should be led by CNO or Director (someone the leaders report to) to foster accountability and support cross learning. ➢ Include units currently doing hourly rounding and those planning to come up in the future. ➢ Agenda o What is going well? Share wins, letters, stories, staff feedback o What are barriers identified? Problem solve solutions o What are the tough questions?

	○ Review the % of competency check sheets completed ○ Review the call light logs and daily rounding logs for the past 24-hour period ○ Review patient satisfaction results by unit for the week ○ Leaders trade logs and give each other feedback based on what they are seeing ○ Leaders discuss actions for improving results ○ Next steps are discussed and agreed upon

Appendix F:

Hourly Rounding Training/ Education Questionnaire and Competency

Circle True or False

1. Hourly rounding is a systematic, proactive, evidence-based nursing practice of regularly checking on patients' needs in an hourly basis using the 4 Ps with the promise to return in 1 hour.

   TRUE or FALSE

2. The concept of Purposeful Rounding is introduced to the patient and family members upon admission in order to set expectations for the hospital stay.

   TRUE or FALSE

Answer in your own words

3. Define what Hourly Rounding is at your hospital – who can/will be rounding? How will we track this program to make sure it's happening? How will this be rolled out? How will people be held accountable?

4. List the 4 P's of purposeful hourly rounding

5. Why should hourly rounding, as a fall prevention strategy, be a high priority for hospitals today?

   A. The inpatient population is aging and most of the elderly are at risk for falls due to advanced age.
   B. Nursing shortages mandate the need to utilize ancillary nursing personnel to perform nursing duties.
   C. Reimbursements are based on patient safety metrics.

APPENDIX G:

Daily Hourly Rounding® Log – Sample

Note: All patients in this unit are visited hourly by the nursing staff between 6:00 a.m. and 10 p.m., and every two hours between 10 p.m. and 6:00 a.m.. Please place your initials in the corresponding time box after round has been complete. Round is only complete if all 8 Key Behaviors have been done.

DATE: _____ Room Number: _____ DAY OF WEEK: Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐

TIME PERIOD	STAFF INITIALS	ROOM EMPTY ✓	PATIENT SLEEPING ✓	COMMENTS
6:00am				
7:00am				
8:00am				
9:00am				
10:00am				
11:00am				
12:00pm				
1:00pm				
2:00pm				
3:00pm				
4:00pm				
5:00pm				
6:00pm				
7:00pm				
8:00pm				
9:00pm				
Every two hours between 10 p.m. and 6:00 a.m.				
10:00pm				
12:00am				
2:00am				
4:00am				

RN Name (printed)_____ Initials: ___
RN Name (printed)_____ Initials: ___
CA Name (printed)_____ Initials: ___
OTHER Name (printed)_____ Initials: ___

RN Name (printed)_____ Initials: ___
RN Name (printed)_____ Initials: ___
CA Name (printed)_____ Initials: ___
OTHER Name (printed)_____ Initials: ___

Note: This is not part of the permanent medical record.

StuderGroup

APPENDIX H:

Attachment #2

MARYLAND Patient Safety CENTER

MPSC 2010 Annual Conference Solution Submission

Name:_____ Badge #:_____ Unit:_____

Hourly Rounding Competency Skills Checklist

Directions: Use this tool as a competency checklist to document the demonstration of hourly rounding competencies and behaviors. There are two parts to this competency – the learner's self evaluation and the manager/supervisor/or designee's evaluation of the learner which must both be signed-off to complete this competency. All information reviewed/skills assessed are based on the 2006 StuderGroup, Patient Care Strategies: Achieving Nursing & Patient Care Excellence (Hourly Rounding). Successful completion of this competency will be documented in NetLearning, 0.5 ECH.

Competence Statements	Successfully Demonstrated Self Evaluation (learner's initials)	Successfully Demonstrated (initialed by evaluator)
Introductions ▪ Knocks on patient's door prior to entering, asks permission ▪ Uses good eye contact ▪ Explains the purpose of hourly rounding (initial visit) ▪ Uses key words "excellent" care ▪ Describes rounding schedule (7am-10pm q 1 hour; midnight-6am q 2 hours)		
Update White Boards ▪ Places name on white board ▪ Updates information as per unit practice.		
Addresses 4P's Pain . . . Position . . . Potty . . . Possessions. Asks: ▪ "How is your pain?" ▪ "Are you comfortable?" ▪ "Do you need to go to the bathroom?" ▪ "Is everything you need within your reach?" (move items as needed table, call bell, phone, tissues, water)		
Performs and Explains Scheduled Tasks, Treatments, Care and Medication Use ▪ Completes MD ordered treatments, procedures ▪ Completes nursing care as needed ▪ Administers scheduled medications		
Closing ▪ Explains to patient, "We will be rounding again in about an hour." ▪ Asks "Is there anything else that I can do for you? I have the time." ▪ Documents rounding on the rounding log in the patient's room		

APPENDIX J:

MONTHLY TRACKING

CHART FOR MONTH OF ____________ YEAR ____________

SUBJECT:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTALS