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The Effect of Purposeful Hourly Rounding on the Incidence of Patient Falls

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The Effect of Purposeful Hourly Rounding on the Incidence of Patient Falls

by

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A thesis submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the
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Abstract

The purpose of this study was to evaluate the effectiveness of purposeful hourly rounding on the incidence of patient falls. Purposeful hourly rounding is a vital component of the nursing care delivery model that is impacting the fall rates. Providing structure and emphasis to the hourly rounding process assist in the evaluation of the desired outcomes as it relates to patients falls. As healthcare organizations experience the concept of public reporting, patient safety has become an increasingly important concern. Purposeful hourly rounding can improve quality, safety, and the patient's perception of their care. The results of this study found there was not a statistical significant difference in the incidence of patient falls with the implementation of hourly rounding.

Keywords: purposeful hourly rounding, fall rates, leadership, culture of safety

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CHAPTER I

Introduction

Healthcare organizations are committed to delivering safe, high quality care to the patients they serve. They often rely on the expertise of innovative healthcare teams to ensure and promote patient safety by continually evaluating policies, procedures, and patient needs. Developing a culture of safety is imperative as healthcare organizations continue to focus on patient centered care.

Significance

The nursing profession has a significant impact on safety and quality improvements implemented in the patient care delivery model. It is imperative that staff are empowered in the decision making process. The numerous performance improvement teams include experienced nurses that provide valuable opinions on the care delivery model. However, when mistakes occur, administrators must react from the complexity, “no blame” perspective rather than from the patriarchal Industrial Age view (Dunham-Taylor & Pinczuk, 2015, p. 173).

Decreasing fall rates in the hospitalized patient has become a significant patient safety and quality initiative. When hospitalized patients fall, they are at an increased risk for injury, which contributes to increased hospital stays, longer recoveries, and possibly longer periods of time out of the work force (Nientimp & Peterson, 2013, p. 1). Although only 1% of falls occurring in hospitalized patients result in death, prevention measures are imperative to avoid injuries with falls. The Centers for Medicare and Medicaid Services do not compensate healthcare organizations for care that is associated with falls that occur during a patient’s hospital encounter. The increase in length of stay utilizes

additional resources for patients that fall during their hospitalization. Wong, Recktenwald, Waterman, Bollini, and Dunagan (2011) share that a fall with injury added 6.3 days to the hospital stay of one patient (p. 81).

Due to lack of reimbursement for patient falls that occur in the hospital setting, healthcare organizations must carefully evaluate their fall prevention protocols in an effort to reduce the financial impact this occurrence can have. According to the The Joint Commission (2015), the average cost for a fall with injury is about \$14,000. The increases in cost are comprised of additional treatment and sometimes prolonged hospital stays.

Problem Statement

When hospitalized patients fall, the perception of the healthcare team is not reflective of safe, high-quality care. It is viewed as a negative experience where responsibility is placed on the healthcare organization to ensure processes are implemented to decrease and prevent falls. For this research study, the researcher reviewed data on a telemetry unit with a high prevalence of falls despite a multitude of fall strategies being implemented on the unit. As a result of the continuous high fall incidences, the telemetry unit leaders implemented purposeful hourly patient rounding. In addition to the implementation of purposeful hourly rounding, the previous fall risk strategies were maintained.

The acute care telemetry unit continuously focuses on decreasing fall incidence, which is challenging and complex. For the period of October 2013 to October 2014, the telemetry unit documented 30 incidences of falls. Practice guidelines were implemented to support fall reduction strategies. These strategies consisted of documented fall risk

assessments, standardization of the patient's room to ensure safe ambulation, fall huddles, and fall contracts signed on high risk patients. The fall huddle is a multidisciplinary team approach to engage the staff and the patient on the actual fall event and the documentation. The fall contract informs the patient to call for assistance when getting out of the bed. In addition, the communication board located in the patient's room is utilized as a tool to converse in the shift handoffs. This makes certain that the healthcare team, along with the patient and their families, are cognizant of the fall risk.

Purpose

Healthcare quality teams are endlessly researching evidence-based care initiatives in fall prevention. One of the major performance improvement initiatives to prevent falls is the implementation of purposeful hourly rounding. As a result of high fall rates, the telemetry unit implemented purposeful hourly rounding on all patients. Hourly rounding is a process that the healthcare teams implement to ensure the needs of the patient are assessed every hour. Hourly rounding incorporates behavioral and environmental components. The focused hourly assessment includes the completion of the evaluation of the "4P's": pain, positioning, potty, and proximity of personal items. Research demonstrates that patients in hospitals fall because they are attempting one of the "4P's". Attending to patients' comfort, safety, and environmental needs may also prevent adverse events like falls, pressure ulcers, or unrelieved pain; and contribute to patients' satisfaction with nursing care (Halm, 2009, p. 581). Given the severity of risks patient falls poses on patient recovery, health care costs, and length of hospital stay, hourly rounding must become a priority of nursing research (Nientimp & Peterson, 2013, p. 3).

Nurse leader rounding is an advantageous tool to observe what is actually occurring on the units. The leaders of the telemetry unit designed the education and competency module for hourly rounding. All patient care staff in the clinical area was educated on the expectation of the hourly rounding. The implementation and education model for completion of the rounding documentation was validated in the simulation lab by the clinical educators. The education model focused on the hourly rounding to include the 4 P's: pain, potty, positioning, and possessions. The telemetry unit placed an additional "P" for their staff to utilize as the 5th "P". The 5th "P" signifies that the nurse has ensured the patient does not need anything before they exit the room and the expectation of hourly rounding is communicated to the patient.

Rounding creates a transparent culture that encourages participation of the care team and their patients. Sound nursing and management theories, along with evidence-based management practices, equip the nurse administrator with tools to foster a culture of collaborative decision-making and positive patient and staff outcomes (Roussel, 2013, p. 25). The Institute of Medicine has recognized the importance of the nurse administrator's implementation of a professional practice model that includes: 1) Patient-centered care, 2) Work in interdisciplinary teams, 3) Utilize evidence-based practice, 4) Monitor quality improvements, and 5) Incorporate informatics.

Research Question

This research study aimed to answer the following question:

What is the effect of purposeful hourly rounding on the incidence of patient falls?

Theoretical Framework

While this research study did not include elements of a theoretical framework, Imogene King's Theory of Goal Attainment would be useful in the implementation of purposeful hourly rounding.

King's Goal Attainment Theory accentuates the interrelationships of the patient and the nurse. The nurse and patient participate in goal settings and achievements based on outcomes that are necessitated. The Theory of Goal Attainment demonstrates nine major concepts: Nursing, Health, Individuals, Environment, Perception, Communication, Interaction, Transaction, and Stress.

At least four of these nine concepts may be useful in the implementation of purposeful hourly rounding including: Nursing, Health, Individuals, and Communication.

“The concept “Nursing” is defined as a process of action, reaction, and interaction whereby the nurse and client share information about their perceptions in the nursing situation” (McEwen & Willis, 2011, p. 163). Due to the increase in the tasks and the nurse to patient ratio it is easy to treat the physical diagnosis and move on to the next patient. It is important to include the patient in their plan of care and confirm their understanding.

“The concept “Health” is described as a dynamic life experience of a human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of one's resources to achieve maximum potential for daily living” (McEwen & Willis, 2011, p. 163).

“The concept “Individuals” is defined as persons exhibit common characteristics such as the ability to perceive, to think, to feel, to choose between alternative courses of

action to set goals, to select the means to achieve goals, and to make decisions” (McEwen & Willis, 2011, p. 163).

“The concept “Communication” is defined as a process which information is given from one person to another either directly in face-to-face meetings or indirectly” (McEwen & Willis, 2011, p. 163). Imogene King’s concepts focus on the methodology to help nurses in the nurse-patient relationship. Communication and collaboration foster the relationship to drive optimistic outcomes. The nurses communicate with their patients the goal of hourly rounding, the definition of the 4P’s and importance of safety while they are hospitalized.

The Theory of Goal Attainment illustrates the nurse – patient interaction is necessary for the accomplishment of goals. Nurses purposely interact with the patients to mutually established goals, and to explore and agree on means to achieve goals (Alligood & Tomey, 2010, p. 294). Mutual goal setting is based on nurses’ assessment of their patients’ concerns, problems, and disturbances in health, their perceptions of problems, and their sharing information to move toward goal attainment (Alligood & Tomey, 2010, p. 294).

Definition of Terms

Purposeful hourly rounding also is referred to as intentional rounding or comfort rounding. Purposeful hourly rounding is a proactive approach of communicating with patients and families with the intent of anticipating their needs. Hourly rounding facilitates the healthcare teams’ workflow to be effective and concentrate on the fall prevention tactics.

Summary

As healthcare organizations are striving to deliver safe, high quality care, the literature demonstrates that purposeful hourly rounding impacts quality and safety outcomes. Intentional rounding consists of decreasing the patient's anxiety, addressing the 4 P's (pain, potty, position, and possessions), assessing for a safe environment, and setting expectations when staff will be returning. Developing and implementing a culture of safety is imperative as healthcare organizations continue to focus on patient centered care.

CHAPTER II

Literature Review

A literature review was conducted by searching a variety of databases and search engines. These databases included ProQuest, Area Health Education Center (AHEC) digital library, and the search engine Google. Key terms for the search included purposeful hourly rounding, intentional hourly rounding, falls, patient's perception and patient safety.

Literature Related to Problem Statement

Literature indicates purposeful hourly patient rounding impacts the percentage of falls in organizations and significantly influences the perception of care experienced by patients. Falls embody a serious threat to the safety of the patients in hospitals. The evidence reviews the strategic approach to hourly rounding in fall reductions within organizations. Halm (2009) discussed the standardized rounding tools and the reduction of falls. This also resulted in the decrease of call bells and addressing the pain management opportunities. Salmon (2012) evaluated the practice of hourly rounding in the fall reduction strategy. This review demonstrates the nursing efficiency, decrease paperwork, and improvement exceeding the patient's expectation. Nurses that are efficient in their daily multitasking are at the bedside; therefore impacting the incidence of falls.

Fisher, Horn, and Elliot (2014) conducted a study on a 34-bed orthopedic medical-surgical unit which was chosen as a pilot unit for a falls prevention performance improvement team. The team identified three areas for improvement: increased staff education around rounding using the 4P's for fall prevention, increased accountability by

staff members for patient safety, and enhanced equipment to alert staff about impending unsafe actions by patients, which would allow for a urgent response. The pilot program, which started in April 2010, was designed to review the concerns. The study compared pre-implementation fall rates with post-implementation fall rates. The data prior to the hourly rounding implementation demonstrated the fall rate for eight quarters with a mean of 5.42/1,000 patient days with a standard deviation of 1.38. The data post implementation demonstrated the fall rate for eight quarters with a mean of 3.94 with a standard deviation of 1.22. An independent-samples t-test of this data provided a *P*-value of 0.04, demonstrating a significant improvement in the falls rate.

Sherrod, Brown, Vroom, and Sullivan (2011) conducted a study with the implementation purposeful rounding on a 36-bed medical-surgical unit. The unit was selected for the reason of high patient fall rates. The sample population comprised patients cared for one year pre and post implementation of hourly round with the 5 P's: potty, position, pain, possessions, and patient focus. The purpose of this study was to evaluate the effectiveness of a purposeful rounding program specific to decreasing total falls and falls with injury. A purposeful rounding script was written to highlight the key phrases for staff to utilize with the patients. The findings demonstrated that the fall rates were unchanged; 4.3 falls per 1,000 patient's days to 4.5 falls per 1,000 patient days (Sherrod et al., 2011).

Kessler, Claude-Gutekunst, Donchez, Dries, and Snyder (2012) evaluated the impact of hourly rounds on patient safety and fall rates. The study was on a 30-bed medical-surgical unit within Lehigh Valley Health Network (LVHN). The healthcare team implemented the hourly rounding concept. This study analyzed the development

and implementation of that protocol and strategies that impacts effective rounding. The staff and leaders performed an assessment of patients' expectations while hospitalized. Patients were contacted after discharged from the hospital, asking them and their families what they liked and about their concerns during the hospitalization. The trends were evident: patients expressed a need for pain management, improved response to call bells, and attentive care. The leader reviewed the trends and implemented purposeful hourly rounding. The staff met every two weeks following implementation to discuss strengths and weakness of the hourly rounding implementation. The unit leader created staff champions that validated rounding and created paper rounding logs for staff to sign on every patient. Over a six year period falls decreased from 5.46 per 1,000 to 2.19 per 1,000 patient days. The unit teams developed specific strategies on hourly rounds to sustain fall reductions.

Waszynski (2012) evaluated fall reduction and rounding practices in a volunteer program. Two years of the Fall Prevention –Safety Monitor Volunteer Program at Harford (CT) Hospital has yielded significant results (Waszynski, 2012, p. 21). This study demonstrated a 46% decrease in fall reduction. The analysis of the data revealed a relationship with the increase volunteer rounding and an increase of staff compliance with the fall prevention protocol. The nursing staff connected with the volunteers of the organization on the completion of the safety rounding checklist.

Olirich, Kalman, and Nigolian (2012) documented a quasi-experimental study at 506-bed teaching hospital in the northeast United States. Two medical-surgical units were selected based on their similar size, significant fall rates, and mix of postoperative and medical patients. Data was collected for patient pre and post falls implementation of

hourly rounding. One unit was designated as the experimental unit and one the control. The experimental unit was chosen to be involved in the study. In addition, the experimental unit served as its own control, with data compared before and during the intervention. The sample consisted of all patients discharged from the units during the one year study period (N= 4,418). Data consisted of the number of falls and was collected for six months before the implementation and six months after the implementation. Before hourly rounding, the fall rate on the experimental unit was 3.37/1,000 patient days. The rate decreased to 2.6/1,000 patient days with the hourly rounding implementation. The data demonstrated a 23% reduction in falls which was significant clinically. Patient fall rate on the control unit increased during the intervention time period. At the conclusion of the study, the staff was engaged and felt empowered to implement changes on their units to impact outcomes.

Brosey and March (2014) reviewed the impact of hourly rounding during a three month period on a medical surgical unit. Hourly rounds were implemented for a designated time period each day for every two hours. Patients were assessed for pain, potty, positioning, and their environment. At the conclusion of the study and hourly rounding, falls decreased from 7.02 to 3.18 per 1,000 patient days.

Ford (2010) studied the use of a proactive hourly rounding strategy to improve the patient experience and decrease fall rates at a 311-bed hospital that is part of the University of Maryland Medical System, located in the Baltimore and Washington, DC, area. The hospital had a recent expansion of the emergency and critical care services, and added women's care services. As a result, nurse leaders determined it was crucial to maintain and/or exceed the high standard of care as expansion continued. The

implementation of hourly rounding and the concentrated focus on the 4P's, demonstrated improvement through proactive rounding. At the conclusion of the study, no falls were reported. It is possibly due to the higher frequency of patient contact and the healthcare team standardizing the rounding process. However, no additional data were collected because of the brevity of this study (Ford, 2010).

Lowe and Hodgson (2012) conducted a descriptive study on hourly rounding in a high dependency unit. The trial was conducted at The Leeds Teaching Hospitals NHS Trust to evaluate patient safety outcomes, to include fall reduction, as it relates to the practice of hourly rounding. The Leeds Teaching Hospitals NHS Trust is one of the many organizations that participate in the Safety Express, a pilot program of the Department of Health's Quality, Innovation, Productivity and Prevention safe care coalition (Lowe & Hodgson, 2012, p. 35). The unit contains 14 beds with a staffing ratio of one nurse to two patients. The unit contains various types of patients with different diagnosis with an average age of 62 years. The trial was completed over a two week period with a specific rounding tool in comparison to the fall incident reports. The rounding tool concentrated on the 4 P's, which ensured the patients expectations were met, especially the patients that were reluctant to ask for assistance. During the trials, no patient falls were reported on this specific unit.

Craft (2013) conducted a study at a hospital in Fargo, North Dakota that reduced falls by 25% at the end of 2012. Following the 25% reduction the, hospital achieved a 50% reduction in falls a month later. This organization focused on a cardiac telemetry unit and the implementation of a rounding tool with two key strategies. The two strategies are comprised of two of the 4P's; potty and proximity of personal items. The

tactics that were hardwired to the staff during this study consisted of staff accountability, communicating daily fall outcomes, staff training the patient on the call light utilization, and conducting a post fall huddle. The staff systematically documented the fall risk levels on the white communication boards in the patient's room during rounding. As a result of this study, from January to September 2012, the telemetry unit reduced the fall rate from seven falls per one thousand patient days to 2.4 per one thousand patient days.

Strengths and Limitations of Literature

In the review of literature, the strengths are demonstrated in the organizations that implemented a structured hourly rounding program. The leaders validated and focused on trends that impact fall rates: patients expressed a need for pain management, improved response to call bells, and attentive care. These organizations recognized the need for staff champions that are engaged and empowered to monitor the implementations strengths and weaknesses. It was found that there continues to be ongoing efforts in researching evidence-based care initiatives in fall prevention and efficient hourly rounding care models.

The major limitations of the selected studies included small sample sizes and brief length of time for the studies. There were challenges encountered with transforming processes and continuing to be vigilant to reinforce the efforts. In addition, it was noted that there was difficulty collecting data due to there being a need to increase manual data collection, inaccurate rounding logs, staffing models, and inconsistent staff education.

Summary

Preventing falls in hospitalized patients are constant challenges the healthcare team faces every day. There are numerous studies on hourly rounding processes that demonstrate the improvements and opportunities with purposeful hourly rounding and fall reductions. Decreasing patient falls continue to place emphasis on the need to answer call lights timely and continue hourly rounding utilizing the 4P's. The reviewed studies demonstrated optimistic outcomes of purposeful hourly rounding on patient safety and decreasing fall rates. It is imperative that nurses are engaged in improving patient outcomes to ensure hourly rounding is not seen as just another task. It should be recognized as a proactive approach to anticipate the needs of the patient and increase the efficiency of the nurse workflow.

CHAPTER III

Methodology

The purpose of this study was to determine the effect of hourly rounding on the incidence of patient falls. This chapter provides an overview of research design, setting, and sample, protection of human subjects, data collection procedure, and data analysis methods.

Research Design

Data for this study was collected by conducting a retrospective data review to determine the incidence of falls one year before and after the implementation of an hourly rounding program.

Setting

This study was conducted at a 241-bed acute care facility in the southeastern United States. The facility is a non-profit, community, rural based hospital. The region is entitled to the same level of access, technology and compassion as larger cities. 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 their commitment to health education, and through our contributions to organizations. Fall rates were reviewed on a 32-bed telemetry unit within the hospital. The unit is staffed with registered nurses, certified nurse assistants, monitor technicians, and managers. The telemetry unit cares for all adult patients in the need of a cardiac monitor; however, the most common diagnosis is chest pain and congestive heart failure. The average daily census of the unit is 24 patients with an average length of stay of 3.2 days.

Sample

The sample consisted of all documented falls between October 2013 and December 2015. Hourly rounding was implemented in November 2014 and fall rates one year before and after implementation were compared.

Protection of Human Subjects

Permission to conduct the research was granted by the Institutional Review Board at the researcher's academic facility and by the research institution. Due to the nature of the study consent from participants was not necessary. The researcher received incidence rates of falls without any patient information or circumstances surrounding the fall from the Risk Management department.

Instruments

There was no specific instrument used for this research study. The researcher received a fall rate pre and post implementation of the purposeful hourly rounding.

Data Collection Procedure

An acute care telemetry unit, with documented high fall rates, was chosen to determine the effectiveness of purposeful hourly rounding behaviors. Purposeful hourly rounding education was conducted and implemented in November 2014. To evaluate the effectiveness of hourly rounding, the researcher compared fall rates for October 2013 – October 2014 to fall rates for December 2014 – December 2015. Data was supplied from the Risk Management team.

Data Analysis

The researcher used an excel spreadsheet to analyze the data.

CHAPTER IV

Results

While the concept of hourly rounding is not new, it is undergoing resurgence in hospitals throughout the United States (Olrich et al., 2012). Falls and fall related injuries are alarming for all healthcare organizations. Purposeful hourly rounding is an initiative that provides the opportunity to improve patient safety, fall rates, and the quality of care. This chapter outlines the findings of the effect of purposeful hourly rounding on the incidence of patient falls.

Sample Characteristics

The sample characteristics of individual patients or circumstances surrounding each fall were not reviewed.

Major Findings

The sample consisted of all documented falls between October 2013 and December 2015. The data for this study was collected by conducting a retrospective data review to determine the incidence of falls one year pre and post implementation of purposeful hourly rounding.

Fall data demonstrated a fall rate of 30 in the 12 months prior to implementation of purposeful hourly rounding and a fall rate of 27 in the 12 months after implementation of purposeful hourly rounding. These results are illustrated in Tables 1 and 2.

Table 1

Fall Rates Prior to Implementation of Purposeful Hourly Rounding

Month	Quantity of Falls
October 2013	2
November 2013	2
December 2013	2
January 2014	3
February 2014	3
March 2014	1
April 2014	3
May 2014	3
June 2014	2
July 2014	3
August 2014	4
September 2014	2
October 2014	0
TOTAL	30

Table 2

Fall Rates Post Implementation of Purposeful Hourly Rounding

Month	Quantity of Falls
December 2014	3
January 2015	3
February 2015	3
March 2015	4
April 2015	4
May 2015	1
June 2015	4
July 2015	0
August 2015	0
September 2015	2
October 2015	0
November 2015	2
December 2015	1
TOTAL	27

A paired-samples t test was conducted to compare the incident of falls prior to implementation of hourly rounding and after implementation of hourly rounding. The mean fall rate prior to implementation was 2.3 ($sd = 1.06$), and the mean fall rate after the implementation was 2 ($sd = 2.3$). No significant difference from before and after implementation of hourly rounding was found ($t(12) = 2.08, p > .05$).

Summary

The purpose of the analysis was to determine the effect of purposeful hourly rounding on the incidence of patient falls. The study illustrated the total amount of falls occurred before and after implementation of the purposeful hourly rounding. In this study an evidence-based standardized fall prevention program resulted in a decrease of falls on the telemetry unit one year post the implementation; however, it was not statistically significant.

CHAPTER V

Discussion

Healthcare organizations have opportunities to develop creative strategies to impact fall rates and reduce harm to patients. Purposeful hourly rounding is demonstrated in the literature as an effective tactic in preventing falls. The challenge is in the implementation across the organization and a multidisciplinary approach to ensure success.

Implication of Findings

The purposeful hourly rounding initiative was implemented December 2014; however, there are opportunities in the process that need to be improved. Rounding is a culture change at the facility and thus will likely take longer to embrace as part of the normal routine, so another possible cause for the results of the study could be improper or incomplete implementation of rounding. Taking this into consideration, additional education and training could be undertaken to ensure rounding is carried out as intended. Hardwiring and sustaining the consistent practice of hourly rounding is crucial to effect change in patient safety.

Limitations

Limitations of this study included a localizing data to one unit and not collecting patient information or the circumstances surrounding the fall. After rounding expectations are established and hardwired, the leaders must continue to validate to ensure it occurs with every patient. The study prompted rounding logs to be maintained which created an additional task that had to be completed and validated by the leaders.

Implications for Nursing

Effective communication plays a critical role in the strategies to enhance the partnerships between the patient and the healthcare team. Ineffective communication among healthcare team plays a part in patient harm and adverse events. Nursing interventions and implementation strategies become influential in preventing negative patient outcomes. This study provided the opportunity to develop, implement, and evaluate the hourly rounding program on the telemetry care unit. The nurses purchased whiteboards in every patient's room to utilize in place of the manual rounding logs. The whiteboard consists of hourly rounding documentation, individualized fall risk strategies, and the plan of care based on the patient's diagnosis. In addition, this created a transparent environment for the healthcare team and the patient. The opportunity for the nursing team is hardwiring and sustaining the transparent communication and evidence based rounding strategies.

Recommendations

Further study is required in falls research related to the benefits of purposeful hourly rounding. The fall study has only been conducted on one unit in the organization that implemented and validated the hourly rounding initiative. The implementation of purposeful hourly rounding is considered a transformation in the culture of nursing. The data reviewed for this study used one unit's data pre and post rounding implementation. It may be more beneficial to compare every unit to give a more accurate view of the effect of rounding on patient falls. The researcher also recognized the rounding process needs to be added to the new teammate clinical orientation program to ensure that all new teammates are knowledgeable of the hourly rounding tools and expectations of the unit.

Conclusion

Healthcare teams are continually researching the evidence based care initiatives in fall prevention. Decreasing patient falls necessitate the emphasis placed on the need to continue hourly rounding. Purposeful hourly rounding is increasingly being implemented in healthcare organizations to create relationships and partnerships with patients to ensure there is a safe environment. Nurses are accountable for patient safety, which includes identifying and recognizing the patients that are high risk for falls. When the patients are identified, it is important that they are actively involved in making decisions about their plan of care and sharing the responsibility with the healthcare team. The shared decision-making is what ensures the patients are attentive to the fall risk strategies and working toward the same goal.

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