



Hourly Rounding Coupled with the 4 Ps

Edith M. Jamison

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Dedication

This scholarly project is dedicated to my mother, Julia R. Kirk. My mother once told me as I was in the midst of a very challenging life event, "Hold on to the truth and stand your ground. Remember, challenges and bumps in the road are just inconveniences on the way to the goal you've set for yourself. The thing about inconveniences, they only last for a minute." Thank you, mommy, for being my inspiration, always believing in me, and for being that listening ear when I needed to hear my thoughts out loud. Thank you for leaving a legacy for your children of truth, strength and love. And thank you, mommy, for having the strength, long ago, to clip my wings and let me fly. I love you always.

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Executive Summary

One out of every three adults over age 65 falls annually in the United States (U.S.). This number increases two-fold by age 80 (Hornbrook et al., 1994). Fall injuries account for 2.8 million emergency visits and 800,000 hospital stays in the U. S. annually (Ganz & Latham, 2020). Despite the existing fall prevention protocol at the Veterans Healthcare Administration (VHA) Community Living Center (CLC), the average number of falls exceeds the national standard for falls in similar facilities. The national benchmark for patient falls in rehabilitation is 7.15 falls per 1,000 patient days. (AHRQ, 2020). In the first quarter of 2021, there were 25 falls in the VHA CLC, nine resulting in serious injury.

Project Object

The project objective was to bring the fall rate of the VHA CLC within or below the national benchmark by initiating and implementing the evidence-based hourly rounding process with the 4 P's (potty, pain, position, and possession). The fall prevention program focuses on veterans' safety and well-being in the short-term and long-term care environments in collaboration with frontline nursing staff.

Scope of Problem

Falls increase a patient's hospital length of stay (LOS) by up to 22 days and could cost between \$30,000 to \$150,000 per incident (CDC, 2015). The Center for Medicare & Medicaid Services (CMS) discontinued reimbursement for fall-related injuries in 2008, leaving hospitals to bear the financial burden (Fehlberg et al., 2017). In addition, falls lower healthcare organization's ranking and payment reimbursement systems (Goldsack et al., 2015). In 2015,

medical costs attributed to non-fatal falls in the U.S. were \$50 billion, and approximately \$754 million was spent on fatal injury falls (Florence et al., 2018).

An older adult falling in any environment, whether at home or in any healthcare setting, is not a normal part of aging (Debunking the myths of older adult falls, 2021). A fall increases residents' hospital LOS and impacts their discharge plans to return home. Residents are further impacted by fall-related fears, including the fear of falling again, social isolation, decreased mobility, depression, loss of independence, or death. It is important that residents are in a healthcare environment that promotes a culture of safety and resident well-being.

Project Plan

Hourly rounding using the 4 P's is a targeted, evidence-based intervention shown to reduce the incidence of falls by 50% (Althobaiti, 2019). All VHA CLC nursing staff received training on hourly rounding using the 4 P's. The process then was implemented. The minimal cost of training staff and implementing the 4 P's process was offset by reducing the number of falls in the VHA CLC, resulting in increased patient safety and satisfaction, decreased fall-related costs, and increased ranking and payment reimbursement from CMS. The process could be expanded to other areas of the VHA for further patient impact and cost savings.

Hourly Rounding Coupled with the 4 P's

Epidemiologic studies have found that falls occur at a rate of three to five per 1000 bed days, and the Agency for Healthcare Research and Quality (AHRQ) estimates that 700,000 to one million hospitalized patients fall each year (Agency for Healthcare Research and Quality [AHRQ], 2020). Patients residing in long-term care (LTC) facilities or CLCs are at the highest risk

for falls (Patient Safety Network, 2019). Hospital and LTC falls resulting in injuries such as fractures, head trauma, and death have a devastating effect on the patients, their families, and the facility. While falls with or without injury remain a common occurrence in both the acute care and LTC environments, the focus of this project is to reduce falls in the Veteran Healthcare Administration (VHA) Community Living Center (CLC) by incorporating the 4 P's (pain, potty, position, and possession), into the current hourly rounding process.

Problem Statement

For decades, the national benchmark for patient falls was 2.2 per 1000 bed days of care. However, using data from the National Database of Nursing Quality Indicators, one study found that fall rates varied substantially across units. The intensive care unit (ICU) had the least at 1.30 falls/1,000 patient days, and rehabilitation had the highest at 7.15 falls/1,000 patient days. (AHRQ, 2020). While the CLC at the VHA hospital averages six falls per month, the CLC experienced 25 falls during a recent quarter, with nine resulting in serious injury. The purpose of this project was to decrease falls in the CLC by one fall per month, intending to achieve and maintain falls within or below the national benchmark in the VHA CLC for the first quarter of the fiscal year (FY) 2020-2021 through the second quarter of FY 2021-2022. Decreasing the fall rate would improve patient safety outcomes and reduce the financial burden of fall-related injuries to the VHA.

Significance

The population of residents in the VHA CLC consists of veterans who have served in wartime and peacetime. In addition to co-morbidities of diabetes, congestive heart failure (CHF), and other medical issues, they also have cognitive issues such as dementia, depression,

and post-traumatic stress disorder (PTSD). The CLC at the project site does not use restraints, bed alarms, or wander guards in its quest to keep residents free of falls. The facility has deemed bed, chair, and ankle alarms as restraints that, when activated, could startle these residents and trigger confusion, combativeness, and fear. Therefore, implemented fall prevention processes and initiatives must be sensitive to the residents' cognitive level while providing a safe environment for their overall well-being.

Environmental Context of the Problem

The AvaSys is a telemonitoring system utilized at the project site for real-time visualization of residents at high risk of falling. The audiovisual system allows the staff member to closely monitor residents from another location. The system is installed in the resident's room, allowing the staff member to visualize and communicate with the resident. The monitoring staff member could ask the resident if they need assistance, offer to call the nursing staff for them, encourage the resident to use the call light, and instruct the resident not to get up without assistance. The AvaSys system includes a stat alarm whereby unit staff could be alerted when a resident gets up without assistance and quickly intervene to prevent a fall. The monitor shows real-time activity only and does not record. The system has a privacy mode to allow personal care to take place. Additionally, residents who require closer observation, or cannot be redirected and are at high risk for falling, are placed on one-to-one sitter status as an additional fall prevention measure. Despite the fall prevention measures in place and the AvaSys telemonitoring system, falls at the project site continued to occur, and quality measure goals were not met.

Hourly rounding incorporating the 4 P's is an evidence-based process that allows for frequent "eyes on" the residents and allows staff to anticipate a resident's care needs. Hourly rounding allows staff to be more visible and accessible to the residents, promoting greater patient satisfaction in the residents knowing who is caring for them throughout a shift. While staff at the project site encourage residents to use their call light for assistance, hourly rounding decreases frequent call light use. Hourly rounding cultivates trust between the staff members and the residents by allowing the staff to establish a routine to meet residents' needs. Hourly rounding incorporating the 4 P's improves patient health outcomes, increases patient satisfaction, and decreases the facility's financial burden caused by a fall-related injury.

Implementation of hourly rounding incorporating the 4 P's of fall prevention positively impacted the fall prevention initiatives at the facility and decreased the patient fall rate at the VHA CLC. A study by Ciccu-Moore et al. (2014) found a 39% decline in the fall rate due to implementing the 4 P's with hourly rounding. Fabry (2014) noted that the hourly rounding strategy of including the 4 P's enhanced patient safety by preventing some falls in hospitals. Althobaiti (2019) also noted that conducting the 4 P's during hourly rounding could reduce falls by 50%. In addition to the negative patient impact, falls and falls with injuries are very costly to healthcare facilities. Fall injured patients in the U.S. result in \$50 billion yearly in medical costs. The U.S. Senate Special Committee on Aging has estimated that by the year 2030, hospital injury costs will be \$100 billion annually (Collins, Casey, 2019). However, as mentioned above, the fall rate could vary depending on a unit's census and bed days of care. Falls in U.S. hospitals range from 2.22 to 3.07 per 1000 patient hospital days and vary depending on the unit, unit census, and bed day of care (Walsh et al., 2018).

The VHA CLC at the project site is a 102-bed unit akin to a LTC facility within a community. There are four units housed under the VHA CLC umbrella: post-acute, long-term antibiotic treatment, wound care management, and pain management. Hospice-palliative care provides end-of-life management and respite care; Rehabilitation offers strengthening, physical therapy and helps those experiencing failure to thrive; The dementia unit offers Alzheimer's and behavioral health management. The mean age of the patient population is 72, with varying levels of mobility, cognition, and co-morbidities.

The Department of Veterans Affairs (VA) has actively focused on patient falls since 2000, in line with the Healthy People 2010 goals. Fall prevention initiatives continue as part of the VA's overall strategic plan and budget analysis. The VA leadership and stakeholders are supportive of any process implemented by staff members to increase patient safety and decrease falls. The VA National Center for Patient Safety, the CMS, the Joint Commission, and the AHRQ provide patient fall prevention toolkits and guidance to support fall prevention initiatives. The fall prevention toolkits are on government websites and may be viewed and shared with the public as evidence-based best practice (EBP) guidelines.

SWOT Analysis

Utilizing the strengths, weakness, opportunities, threats (SWOT) analysis (Appendix A), project strengths and weaknesses were identified and articulated with the VHA CLC team members, leadership, and stakeholders. The project's strength included decreased patient bed days of care, increased patient satisfaction, and decreased financial burden to the facility. The strengths also included anticipating and meeting patient needs with effective, efficient time management, utilizing the fall prevention tool, decreased call light usage, improved

patient/nurse relationships, and a potential decrease in the overall fall rate. Additional strengths, weaknesses, opportunities, and threats are indicated in the diagram below.

Figure 1

SWOT Analysis

STRENGTHS (+)	WEAKNESSES (-)
Increases patient safety	Staff unaware of fall guidelines
Decreases potential for falls with or without injuries	Staff lack of knowledge regarding the 4 P's
Anticipates resident needs	Resident lack of education regarding fall safety/prevention measures
Decreases bed days of care	Staff knowledge of hourly rounding
Decreases the financial burden a fall with injury has on a facility	Unit fall rate above the national benchmark
Increases staff/resident engagement	Lack of effective hourly rounding
Easily incorporated into facility resident safety strategic plan	
OPPORTUNITIES (+)	THREATS (-)
Creating unit-based fall prevention champions	Push back from staff
Provide fall prevention education and training	Resident non-compliance with fall prevention strategies
Provide hourly rounding and 4 P's education and training	Inconsistent rounding by staff
Increase staff/patient communication and engagement	Lack of leadership support
Increase customer service satisfaction scores	Inadequate fall prevention education and training
Increase patient safety	

Faith Integration

Nursing is demonstrated in the Holy Bible as compassionate care characterized by the fruit of the Spirit, namely love. Christian nursing “is a ministry of compassionate care for the whole person in response to God’s grace which aims to foster optimum health and bring comfort in suffering and death for anyone in need” (Shelly & Miller, 2006, p. 244). As this definition is applied to the holistic care process and patient-centered care initiatives, one can see that Christian nurses follow Jesus’ example of caring and servanthood. Matthew 25:40 states: “Truly I tell you, just as you did it to one of the least who are members of my family, you did it to me” (Holy Bible: English Standard Version, 2001). Christian nurses embrace the idea that their gifts are blessings from God they share with patients for their healthcare benefit. Christian nurses also understand that, even though they work in the secular world, they remain a part of the body of Christ and are always accountable to God (Shelly & Miller, 2006). Healthcare and God are both concerned with the well-being of the whole person.

The healthcare community has been tasked with ensuring that each patient admitted to a facility is free of any hazard or obstacle that might predispose the patient to falls. The Institute of Medicine (IOM) describes patient safety as preventing harm to the patient (Institute of Medicine [IOM], & Committee on Quality of Health Care in America, 2000). The primary behavior utilized by nursing staff in the fall prevention process is rounding on patients at a minimum every two hours. LeLaurin and Shorr (2019) stated that “rounding is a proactive approach to meeting patients’ needs that involves bedside checks at regular intervals” (LeLaurin & Shorr, 2019, p. 274). One of the first lessons taught to nurses, nursing assistants,

managers, or providers is that rounding on patients is a way to assess a treatment regimen's effectiveness and the patient's overall condition.

Residents admitted to the CLC, and every day after that, are educated about the risks of falling and instructed and encouraged to use the call light to call for assistance. Unfortunately, not all residents follow the instructions regarding call light use and fall risks. The resident tries to move about unassisted, resulting in a fall. As more evidence-based practice is published regarding fall prevention and merged into initiatives and processes facilities already have, LTC facilities become more effective with fall prevention. Additionally, educating and training the frontline staff and residents on fall prevention creates a culture that focuses on patient safety and quality care. Ecclesiastes 4:10 states: "For if they fall, one will lift up his fellow man. But woe to him who is alone when he falls and has not another to lift him up!" (Holy Bible: English Standard Version). Christian nurses want to meet the patients' spiritual and physical needs. The Christian nurse practices for the glory of God, lifting the patients' spirits, soothing their troubled hearts, and keeping them safe and free of injury while in care.

Theoretical Framework

Kurt Lewin theorized a three-stage model for organizational change known as unfreezing-change-refreezing. For an organization to move forward, "change initiatives (unfreezing) are needed to destabilize the status quo, implement the alternative (change), and restabilize (refreeze) the environment" (Kaminski, 2011, p. 26). Lewin's three-stage model was used as the framework for this project's implementation of hourly rounding incorporating the 4 P's. Lewin's change theory was applied to this project as follows: Unfreezing- the change initiative needed to destabilize the status quo was initiated. To change any behavior or process,

one must identify stakeholders, gain support, and attain frontline staff buy-in. Stimulating interest and identifying barriers to the change process from stakeholders or staff also is crucial to getting the change process started. Providing education and information indicating the benefits of the change processes is vital. Providing real-time opportunities for input into developing training tools (surveys, data logs), what the process is, and what is working and what is not working encourages ownership of the change initiative.

Lewin's unfreezing phase represented the project's implementation of the hourly rounding incorporating the 4 P's, which was both a process and behavioral change for the staff. Implementing this project required a change in how staff rounded on the residents. The frontline staff pushed back and resisted implementing the fall log as a part of the new rounding process incorporating the 4 P's. Frontline staff felt the project fall log was "one more thing" for them to do. Staff members could not visualize that they were not adding to but refining the care routine they already performed, and the additional process made rounding purposeful.

Implementing this project proved to be a status quo change for many of the staff members; thus, fall "champions" were enlisted to assist in providing real-time application and further education regarding the process to their peers. One-on-one guidance and instruction were provided to all the staff, including the off-tour staff. Staff members were encouraged to provide real-time input and offer suggestions regarding the hourly rounding fall prevention log. As the project was implemented, a slow, steady improvement in fall prevention was evident. As frontline staff observed or witnessed the falls decreasing in the VHA CLC, they began to grasp the value and benefits of the project. During the second quarter of the facility's fiscal year, the

VHA CLC went two consecutive sixty-one-day periods without a fall. The positivity generated by this information energized staff and motivated them to set a goal of ninety days without a fall.

Finally, applying Lewin's refreezing stage facilitates restabilizing the environment. The process change implemented by this project became the new routine, and sustainability was established. Frequent communication with unit stakeholders, ancillary team support personnel, frontline staff, and facility leadership were critical elements of the implementation and change processes.

Literature Review

A literature search via the Cinahl, PubMed, Google Scholar, Agency for Healthcare Research and Quality (AHRQ), and Center for Disease Control and Prevention (CDC) databases yielded over 125 articles and studies regarding fall prevention, patient safety, hourly rounding, and the use of the 4 P's. Many of the articles reviewed and referenced were outside the standard five-year time frame for research. Even though the research was conducted outside the desired timeframe, the subsequent information and pilot studies addressed initiatives and best practices regarding medication, mobility, cognition, education, and patient safety, from a nursing and resident perspective, all of which applied to this project and its value to the field of nursing, a promoting positive commitment to improving the quality of healthcare by providing safe, evidence-based, patient-centered, timely, efficient, and equitable care (Petrus et al., 2013).

Seventy-five articles and studies were consulted related to nursing homes, LTC, and assisted living facility (ALF) environments. Thirty of the articles reviewed spoke specifically to hourly rounding incorporating the 4 P's. Out of those 30 articles, 25 were selected that were

the most relevant to the population of residents in the VHA CLC. Keywords and phrases included were the following: patient safety, fall prevention, falls in nursing homes, fall prevention initiatives, hourly rounding, 4 P's, patient satisfaction, and older adult falls. Common themes identified from the literature review included the anticipation of patient needs, increased nurse/patient relationships, increased patient satisfaction, decreased call light usage, fall prevention behavior change, the effectiveness of hourly rounding, education of staff and patients regarding hourly rounding and the 4 P's, and the financial impact of fall-related injuries to a facility.

McLeod and Tetzlaff (2015) described hourly rounding as a “proactive, systematic, nurse-driven, evidence-based intervention that helps anticipate and address patient needs” (p. 6). The authors supported the theme of hourly rounding incorporating the 4 P's. Hourly rounding decreases patient anxiety, fosters the nurse-patient trust relationship, decreases facility bed days of care, decreases call light usage, and increases patient satisfaction with the quality of care provided (McLeod & Tetzlaff, 2015). Zubkoff et al. (2018) described fall prevention implementation process phases, the need for leadership support, and the need for staff behavioral changes. The pre-work phases involved getting leadership support for the project, and the action phases involved getting data via observational means and post-fall huddle documentation (Zubkoff et al., 2018). The authors concluded that while some months' falls had decreased, the overall fall aggregate did not change. However, when processes were implemented and consistently applied, there was a decrease in falls. While the 4 P's process was not explicitly stated, when determining why a patient fell, the authors found that

anticipating patients' needs, which is part of the 4 P's process, and changing staff members' rounding behavior, were instrumental in decreasing patient falls (Zubkoff et al., 2018).

Bragg et al. (2016) supported the theme of anticipating patient needs in fall prevention. The study affirmed that there is considerable evidence that systematic and proactive nurse rounding decreases patient anxiety, the incidence of falls, and call light usage (Bragg et al., 2016). One of the study's strengths was that nurses consistently conducted hourly rounding. The researchers also concluded that while patients perceived hourly rounding as a positive intervention, there remained a need to educate the patients regarding hourly rounding and its connection to fall prevention and patient safety (Bragg et al., 2016). The study supported the theme of education and training on hourly rounding coupled with the 4 P's among staff and patients to increase knowledge and perceived value regarding fall prevention and patient safety (Bragg et al., 2016). Hourly rounding coupled with the 4 P's is a process and behavior change that impacts the nurse/patient relationship, hospital bed days of care, the unit's fall rate, and the ability to provide quality patient care that is safe and efficient.

Project Objectives

The VHA is committed to patient safety and improving the outcomes of our country's Veterans. The VHA has multiple systems in place to promote a safe patient environment. The project objectives are aligned with the organization and VHA CLC initiatives to achieve the outcome of decreasing falls with or without injury.

The objectives were:

1. All VHA CLC unit staff received education and training on hourly rounding incorporating the 4 P's by December 31, 2021.

2. All VHA CLC units will implement and perform hourly rounding coupled with the 4 P's by April 30, 2022.
3. By sixty days post project implementation, the VHA CLC will decrease falls by a minimum of one fall per month based on data from FY 2020/2021 compared to FY 2021/2022 ending September 30, 2022.
4. By December 2022, 100% of the nursing staff will consistently perform hourly rounding coupled with the 4 P's in addition to the current fall prevention processes.
5. By FY 2022/2023, the CLC fall rate will consistently be less than or equal to the national fall rate guidelines for long-term care facilities.

Methods

The VHA monitors all fall incidents among its 152 medical facilities and 1,400 community-based outpatient clinics. Currently, clinical healthcare information is stored in the secure digital data quality repository known as the VHA corporate data warehouse. Each VHA medical center inpatient and CLC unit self-reports veteran falls to the Veterans Service Integrated Network (VISN) 22 Inpatient Evaluation Center (VA IPEC). From there, the data is fed into the VHA corporate data warehouse. This data processing system has helped transform the VHA into a healthcare industry benchmark leader.

The project lead and the CLC nurse educator collaborated on several steps prior to project implementation. The first step was to review the current fall assessment tools utilized in the VHA CLC to determine the educational needs of the nursing staff. The review yielded four strategies for education and implementation purpose: (1) Assessment and reassessment of patient risk factors for falls; (2) Visual identification of patients at high risk; (3) Communication

of patients' fall risk status to nursing staff members; (4) Education of patients, families, and staff about fall prevention (Lancaster et al., 2007).

The second step was to devise a training plan and education tools for each training session. A mandatory staff learning needs assessment (see Appendix A) was administered to all registered nurses (RNs), licensed vocational nurses (LVNs), and nursing assistants (NAs). The tool asks four questions regarding the healthcare giver's knowledge and understanding of hourly rounding, the 4 P's, and residents identified as high risk for falling. The data obtained from the knowledge assessment was used to ensure the education training met the audience's learning needs.

The training was divided into two (2) four-hour increments over two days: 08-12:00 and 12:30-16:30 (Kettner et al., 2017). The VA incorporates one eight-hour day per month for any mandatory training into each person's work schedule to be used as needed. No additional overtime or compensatory time was required to cover the training.

The training program was standardized, enabling all nursing personnel, RNs, LVNs and NAs to participate in the process. Standardization also allowed the project to be easily adapted into the medical center's existing annual competency and new hire orientation process. All annual training, checklists, and orientation are monitored and tracked by the education coordinator. Training on hourly rounding with the 4 P's was incorporated into the CLC unit's annual competency package. The education coordinator is responsible for any updates. New employees receive training on hourly rounding incorporating the 4 P's during unit-specific orientation.

The final step was the development of a post-implementation survey tool (see Appendix B) to measure the knowledge, understanding, and effectiveness of the training provided to the team. The tool was also used to identify and resolve any gaps in the process.

Implementation

The project implementation began with staff education and training, which took place in September 2021. The training was conducted by the project lead and the VHA CLC education coordinator on-site in the CLC conference room. Ten to fifteen staff members attended each four-hour education/training session. At the end of each session, the staff members returned to the CLC unit to complete the workday.

The data collection began in October 2021 immediately following training and continued through the end of May 2022 in FY 2021-2022. Project process data was obtained through the use of the pre-implementation assessment tool, the Hourly Rounding/4 P's Log (see Appendix C, D), the patient's admission fall-risk assessment (see Appendix E), and in the event of a fall, the post-fall huddle sheet (see Appendix F). Additional feedback was obtained from the staff regarding the tool's effectiveness and the ease of incorporating it into the current routine.

Gaining and sustaining staff engagement was crucial to the project's success. During the implementation phase, there was intermittent pushback from frontline staff. Staff also voiced considerable concern regarding the mechanics of an additional piece of documentation and the process of assessing and responding to the 4 P's with their current rounding process. The project lead encouraged additional team huddles as needed, and provided one-on-one opportunities with the staff to guide them in the best way of incorporating the tool into their

current routine. The one-on-ones assisted the staff in recognizing the project's benefits while directly applying and promoting unit teambuilding.

The unit activities/morale committee was tasked with creating fun, competitive fall prevention activities that kept staff engaged in the project. A fall prevention vision board (Appendix I) was created and posted in the CLC common and is an important part of the ongoing safety process used to engage and maintain staff interest. The vision board provided the staff and others with tangible evidence regarding the progress the unit was making in decreasing the unit fall rate. The fall prevention vision board was placed in the CLC common area and remains an important part of the ongoing safety process. The board provides daily outcome data to residents, families, and staff. The board is a visual of what strategies the VHA CLC implemented to decrease the fall rate on the unit. Information on the vision board includes a trending fall map showing the number of falls on the unit month-to-month, how many days between falls, the date of the last fall on the unit, and the 4 P's. Staff members eagerly honed in on the board when returning to work to see if the number of days without a fall had increased or if the number had returned to zero due to a fall. The fall champions identified in the planning stage were tasked with providing any additional support or guidance their peers might require, and keeping the vision board current.

The current process on the CLC is for the RN to fill out the fall risk assessment tool on each patient upon admission and place the document in the patient's chart. The assessment provides information regarding the patient's fall risk, fall history, fall frequency, and if the patient had sustained an injury at any time. In the event of a fall on the unit, the post-fall huddle sheet (Appendix F) supplies the date, time, location of the fall, and the patient's activity

level at the time of the fall. The post-fall huddle sheet also identifies if any devices such as a walker, wheelchair, or intravenous (IV) equipment were in use at the time of the fall.

All fall data is tracked and reviewed by the QM coordinator monthly, and a quarterly unit report is given to the facility patient safety manager. In addition to reviewing the unit data, the project lead reviewed the fall data results with staff during the mandatory monthly staff meetings during the implementation of the project. The data showed trends, staff rounding commonalities, and resource deficits that negatively impacted fall prevention. Resource deficits can include personnel.

Finances and Resources

While falls among older adults may be anticipated, they are costly to healthcare facilities because they add to the person's hospitalization stay and undercut safe patient care. The AHRQ estimates that 700,000 to one million hospitalized patients fall annually (Patient Safety Network, 2019). Since falls have been classified by CMS as preventable events or never events, these falls cost the U. S. healthcare system \$50 billion annually, with Medicare and Medicaid paying 75% of the medical costs (Falls, 2019). The negative impact of a fall on a resident includes functional decline, loss of independence, reduced QOL, and the fear of falling again, which leads to decreased mobility, increased anxiety, depression, helplessness, and social isolation (Vaishya & Vaish, 2020).

According to Fay (2021), an inpatient (non-ICU) hospital stay costs \$3,726 per day. A fall with injury increases the daily cost to \$11,373, increasing the burden for additional nursing hours per patient day (NHPPD) needed to care for the residents. Additional costs related to the fall injury include possible surgical procedures, radiology exams, physical and occupational

therapy treatment, nutritional reassessment, and medication adjustment costs, all contributing to the fall event's cost. A six-to-fourteen-day hospital stay extension could result in a financial cost to the facility upwards of \$159,222 for one patient who falls and sustains an injury. The Expense and Revenue worksheet (Appendix H) estimates the cost of implementing this project. Implementing this fall prevention project mitigated the facility's financial burden and the resident's psychological and physical impact. The average cost of a fall with injury is \$159,222; Reducing a fall in the VHA CLC by one per month would save the VA \$1,910,644 over twelve months.

Results/Outcomes

Daniels (2016) noted the following: "Purposeful and timely rounding is a best practice intervention to routinely meet patient needs, ensure patient safety, decrease the occurrence of patient preventable events, and proactively address problems before they occur" (Daniels, 2016, p.248). A pre-implementation survey was given to all nursing staff in the VHA CLC to assess their knowledge of hourly rounding and the 4 P's. The survey results were reviewed by the project lead and the nursing education coordinator to determine the content for training. The survey review was followed by the scheduling of the four-hour training sessions for all CLC nursing personnel.

Unit fall champions were identified two weeks before project implementation. The project lead and the fall champions reviewed the hourly rounding/4 P's data collection logs (Appendix C & D). The fall champions served as preceptors providing support and guidance to their peers as they incorporated the data collection log into their rounding routine. As needed, the project lead met with each team or individual to facilitate the smooth incorporation of the

fall log into their rounding routine and answered any questions regarding the process staff might have.

Several unexpected challenges had to be overcome as the project was being implemented. Firstly, the project site required additional documentation regarding the hours when the project was being implemented. Secondly, there was unanticipated staff pushback. To mitigate the risk of losing project momentum and the successful implementation of the project, additional staff huddles and one-on-ones with the project lead and staff provided instruction and guidance for using the fall prevention logs and the hourly rounding process. Lastly, a number of the staff tested positive for the COVID-19 virus, requiring prolonged absences from the unit, combined with an increase in the resident census. There also were a number of staffing challenges throughout the medical center, including the CLC. Staff who were floated to the CLC to cover for those absent were surveyed to determine their knowledge of hourly rounding incorporating the 4 P's. They were also given a short in-service on hourly rounding and the 4 P's to keep the project momentum going.

Project success was demonstrated by data analysis for each of the project objectives. The first objective was to decrease the fall rate in the VHA CLC to less than the national average of 3.2 falls per 1,000-bed days of care. After the implementation, the quarterly fall rates were 1.9/1000, 2.0/1000, and 4.9/1000. Two of the three quarters were below the national average, indicating that the first objective was partially met.

The second objective of the project was to increase the number of days between fall incidents. An independent samples *t*-test was conducted to compare the mean number of days between fall incidents at pre- vs. post-implementation. The results are displayed in Table 1. The

overall mean days between fall incidents pre-implementation were 39.83 (SD = 27.85) days which increased to a mean of 45.14 (SD = 50.01) days between fall incidents post-implementation, $t(18) = -.24$, $p = .812$. The increase in mean days was not statistically significant. However, the data showed a 13.3% increase in the average number of days post-implementation. The project objective was to increase the number of days between fall incidents, so this objective was met.

Table 1

Independent Samples t-Test Results on Fall Incidence

Variable	Pre		Post		$t(18)$	p
	M	SD	M	SD		
Number of Days between Fall Incidents	39.83	27.85	45.14	50.01	-.242	.812

Note: M = mean; SD = standard deviation

The third objective was to continually provide staff with current fall prevention education and training. As a result of this project, the guidelines now reflect that newly hired staff are oriented to the hourly rounding incorporating the 4 P's process, and the process is part of annual competencies. Additionally, all updates, process changes, new evidence, or training will be provided by the CLC nurse educator. Thus, the project's third objective was met.

The fourth objective was to empower the staff to feel more control over preventing falls. This was measured using the post-assessment tool for the staff with a total of six items using "yes" or "no" response choices. The goal was to have at least 75% of staff answer each item with a positive response as indicated by a "yes." Descriptive statistics (n , %) were computed for each item to determine the percentage with a positive response. The results are presented in Table 2. A total of 39 staff completed the tool, including 30 females (76.9%) and

nine males (23.1%). As shown, the goal of 75% was met for all items. The final item showed 100% agreement that the hourly rounding education and training met staff needs.

Table 2

Staff Post-Assessment Tool Results (N = 39)

Staff Assessment Item	<i>n</i> responding "Yes"	% responding "Yes"
Did the Hourly Rounding assist you to meet the patient's need?	30	76.9
Do the 4 P's address patient potential needs?	30	76.9
Did the Hourly Rounding log assist you in anticipating the needs of the patient?	37	94.8
Were you able to easily merge the Hourly Rounding Log with your rounding routine?	35	89.7
Does the Hourly Rounding Log assist with Fall Prevention?	36	92.3
Did the Hourly Rounding education/training meet your needs?	39	100.0

Although improvement occurred for all outcomes, there were gaps between actual and expected outcomes. For the post-implementation fall rate, one quarter did not achieve the goal of fewer than 3.2 falls per 1000 bed days. Similarly, the days between falls increased after the implementation, although it was not statistically significant as expected. Fortunately, the staff assessment responses exceeded the goal of 75% with positive responses. The project did significantly decrease the falls in the VHA CLC by 50% from FY 2020-2021 to FY 2021-2022, proving that teamwork and staff engagement continue to yield positive fall prevention outcomes. Given these analytic data results, the project overall has been deemed successful

Table 3

Fall Outcomes by Month

Unit	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
1SOUTH	11.9	2.3	5.3	0.0	2.6	4.6	0.0	4.8	7.6	1.4	0.0	0.0	1.7	3.0	0.0	3.6	1.7	0	2.9	1.76
1S-R												0.0	3.6	0.0	11.6	0.0	0	11.5	0	2
1SO-PC	0.0	0.0	0.0	18.2				0.0	10.4	7.9	0.0	5.1	0.0	0.0	3.9	0.0	0	0	0	0
1SW	6.9	2.1	6.5	4.6	2.8	4.1	6.8	0.0	2.5	4.3	6.0	0.0	1.8	2.5	0.0	1.2	0	0	5.9	1
CLC																				
Total (Avg)	9.2	1.9	4.7	3.4	2.7	4.4	2.3	3.2	6.0	3.0	2.0	0.7	1.8	1.4	2.8	1.2	0.83	11.5	3.1	1.9

Implication for Practice

Making rounds on patients could be traced back to Florence Nightingale. During the Crimean War, Ms. Nightingale was called to Scutari, Turkey, to care for wounded British soldiers. The soldiers referred to Ms. Nightingale as the “Lady with the Lamp” because she made ward rounds during the night, providing emotional comfort and care to the soldiers (Alligood & Pfettscher, 2021, p. 53). Hourly rounding coupled with the 4 P’s enables the nursing staff to assess the overall well-being of residents, ensures the environment is safe from obstacles that place the resident at risk of a fall and ensures the resident’s physical care needs are met. By implementing hourly rounding coupled with the 4 P’s, nursing can enhance the fall prevention initiatives put in place to keep our residents safe and decrease the fall rate on any unit.

As healthcare facilities continue to provide holistic, patient-centered care to residents, hourly rounding incorporating the four P’s would strengthen a facility’s patient safety goal. The evidenced-based process of hourly rounding coupled with the 4 P’s has proved to be effective and could be implemented in any acute or LTC facility. By building upon established best practices and continually educating and training staff, healthcare organizations can provide safe, quality care to an already vulnerable population of residents.

Recommendations

For the project to remain successful and sustainable, continued leadership and support are required to promote a culture of safety and quality care. Frontline staff must remain engaged and invested in the project, which includes maintaining the multidisciplinary team approach for fall prevention on the unit and continued staff education and training (Miake-Lye et al., 2013). The unit vision board and unit fall prevention activities, maintained and updated by the fall champion and the activity/morale team, continue to keep the staff engaged in the project. Friendly unit fall prevention competition has kept staff interested and motivated in the project. While getting staff buy-in for the project is necessary, encouraging staff to take ownership of the fall prevention process and initiatives is just as crucial to patient safety and fall prevention process sustainability. Having the staff members actively participate in all aspects of the fall prevention process by educating and training each other is one way to sustain the project. The goal of the fall rate on the unit to be less than or equal to the national benchmark of 3.2 patient falls per 1,000 bed days of care has been incorporated into the VA patient safety strategic plan. Incorporating the hourly rounding coupled with the 4 P's process sets the standard for keeping residents safe and preventing falls.

Conclusion

The project's intent was to introduce a fall prevention process that would decrease the fall rate and falls with or without injury in this high fall risk population of residents. The project was successful as it changed the behavior of the staff regarding rounding by adding the 4 P's as a fall prevention measure. Healthcare organizations are never going to eliminate 100% of all

falls. However, through evidence-based initiatives, processes, education, and training, falls can be significantly decreased in any healthcare organization.

The CLC staff went from accepting the status quo and thinking falls were inevitable regardless of staff intervention to a staff who took ownership of the new fall prevention process and realized the hourly rounding coupled with the 4 P's process produced positive outcomes. Utilizing the updated fall process enhanced facility fall prevention measures and relieved some of the financial burdens to the facility. The successful outcome of this fall prevention project enabled the medical center and the CLC to see increased customer service scores, improved nurse/resident relationships, and most importantly, provided a safer healthcare environment for all residents.

References

- Agency for Healthcare Research and Quality [AHRQ]. (2020). Preventing falls in Hospitals: How do you measure fall rates and fall prevention practices? Department of Health and Human Services. <https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/measure-fall-rates.html#>.
- Althobaiti. (2019). Impact of the use of the 4P's in hourly rounding on reductions in patient falls inwards. *Journal of Contemporary Scientific Research*, 3(7), 1-7.
- Bragg, L., Bugajski, A., Marchese, M., Caldwell, R., Houle, L., Thompson, R., Chula, R., Keith, C., & Lengerich, A. (2016). How do patients perceive hourly Rounding? *Nursing Management*, 47(11), 11-13.
- Center for Disease Control and Prevention [CDC]. (2015). Home and recreation safety: Costs of falls among older adults. <http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html>.
- Ciccu-Moore, R., Grant, F., Niven, B., Paterson, H., Stoddart, K., & Wallace, A. (2014). Care and comfort rounds: Improving standards. *Nursing Management*, 20(9), 18-23. <https://doi.org/10.7748/nm2014.02.20.9.18.e1140>
- Collins, S. M., & Casey, R. P. (2019). Falls prevention: National, State, and local solutions to better support seniors. Special committee on aging United States Senate.
- Daniels, J. F. (2016). Purposeful and timely nursing rounds: A best practice implementation project. *JB I Database of Systematic Reviews and Implementation Reports*, 14(1), 248-267.

Debunking the myths of older adult falls. (2021, July 13). The National Council on Aging.

<https://www.ncoa.org/article/debunking-the-myths-of-older-adult-falls>.

<https://www.ncoa.org/article/debunking-the-myths-of-older-adult-falls>

Fabry, D. (2014). Hourly rounding: Perspectives and perceptions of the frontline nursing staff. *Journal of Nursing Management*, 23(2), 200-210.

<https://doi.org/10.1111/jonm.12114>

Falls. (2019). Agency for Healthcare Research and Quality [AHRQ]. psnet.ahrq.gov/primer/falls

Fay, B. (2021). Hospital and surgical costs. Debt.org. <https://www.debt.org>

Fehlberg, E. A., Lucero, R. J., Weaver, M. T., McDaniel, A. M., Chandler, M., Richey, P. A., Mion, L. C., & Shorr, R. I. (2017). Impact of the CMS no-pay policy on hospital-acquired fall prevention related practice patterns. *Innovation in Aging*, 1(3), 1-7.

<https://doi.org/10.1093/geroni/igx036>.

Florence, C. S., Bergen, G., Atherly, A., Burns, E., Stevens, J., & Drake, C. (2018). Medical costs of fatal and nonfatal falls in older adults. *Journal of the American Geriatrics Society*, 66(4), 693-698.

Ganz, D. A., & Latham, N. K. (2020). Prevention of falls in community-dwelling older adults. *The New England Journal of Medicine*, 382, 734-743.

Hornbrook, M. C., Stevens, V. J., & Wingfield, W. I. (1994). Preventing falls among community-dwelling older persons: Results from a randomized trial. *Gerontologist*, 34(1), 16-23.

Hospital and surgical costs. Debt.org. <https://www.debt.org>

Institute of Medicine, & Committee on Quality of Health Care in America. (2000). To err is human: Building a safer health system. National Academies Press.

- Kaminski, J. (2011). Theory applied to informatics-Lewin's Change Theory. *Canadian Journal of Nursing Informatics*, 6(1), Editorial. <https://cjni.net/journal/?p=1210>.
- Kettner, P. M., Moroney, R. M., & Martin, L. L. (2017). Designing and managing programs: An effectiveness-based approach: An effectiveness-based approach (5th ed.). SAGE.
- Lancaster, A. D., Ayers, A., Belbot, B., Goldner, V., Kress, L., Stanton, D., Jones, P., & Sparkman, L. (2007). Preventing falls and eliminating injury at Ascension health. *The Joint Commission Journal on Quality and Patient Safety*, 33(7), 367-375.
- LeLaurin, J. H., & Shorr, R. I. (2019). Preventing falls in hospitalized patients: State of the science. *Clinics in Geriatric Medicine*, 35(2), 273-283.
<https://doi.org/10.1016/j.cger.2019.01.007>
- McLeod, J., & Tetzlaff, S. (2015). The value of purposeful rounding. *The Essence of Nursing*, 6-7.
www.AmericanNurseToday.com
- Miake-Lye, I. M., Hempel, S., Ganz, D. A., & Shekelle, P. G. (2013). Inpatient fall prevention programs as a patient safety strategy. *Annals of Internal Medicine*, 158(5), 390-396.
<https://doi.org/10.7326/0003-4819-158-5-201303051-00005>
- Patient Safety Standards. (2017). Center for Medicare and Medicaid Services [CMS].
<https://www.cms.gov>.
- Petras, D. M., Dudjak, L. A., & Bender, C. M. (2013). Piloting patient rounding as a quality improvement initiative. *Nursing Management*, 44(7), 19-23.
- Pfettischer, S. A. (2021). Florence Nightingale: Modern nursing. In Alligood, M. R. *Nursing theorists and their work* (10th ed., pp. 52-70). Elsevier Health Sciences.

Shelly, J. A., & Miller, A. B. (2006). Called to care: A Christian worldview for nursing (2nd ed.).

IVP Academic.

Vaishya, R., & Vaish, A. (2020). Falls in older adults are serious. *Indian Journal of Orthopaedics*,

54(1), 69-74.

Veterans Administration National Center for Patient Safety. (2019). www.patientsafety.va.gov.

Walsh, C. M., Liang, L., Grogan, T., Coles, C., McNair, N., & Nuckols, T. K. (2018). Temporal

trends in fall rates with the implementation of a multifaceted fall prevention program:

Persistence pays off. *The Joint Commission Journal on Quality and Patient Safety*, 44(2),

75-83.

Zubkoff, L., Neily, J., Quigley, P., Delanko, V., Young-Xu, Y., Boar, S., & Mills, P. D. (2018).

Preventing falls and fall-related injuries in state veteran's homes. *Journal of Nursing*

Care Quality, 33(4), 334-340. <https://doi.org/10.1097/ncq.0000000000000309>

HOURLY ROUNDING/4 P's STAFF ASSESSMENT TOOL

1. How would you describe Hourly Rounding?
2. What are the 4 Ps?
3. How are residents identified as being a risk for falling?
4. What tasks do you complete/look for when rounding on your patients'?

APPENDIX B

HOURLY ROUNDING/4P's STAFF POST ASSESSMENT TOOL

1. Did the Hourly Rounding assist you to meet the patient's need?

YES NO

2. Do the 4 P's address patient potential needs?

YES NO

3. Did the Hourly Rounding log assist you to anticipate the needs of the patient?

YES NO

4. Were you able to easily merge the Hourly Rounding Log with your rounding routine?

YES NO

5. Does the Hourly Rounding Log assist with Fall Prevention?

YES NO

6. Did the Hourly Rounding education/training meet your needs?

YES NO

APPENDIX C**HOURLY ROUNDING/4P'S LOG (DAY SHIFT)**

TIME	06-07	07- 08	08- 09	09- 1000	100- 1100	1100- 1200	1200- 1300	1300- 1400	1400- 1500	1500- 1600	1600- 1700	1700- 1800
ROOM #												
PAIN												
POTTY												
POSITION												
POSSESSION												
ROOM #												
PAIN												
POTTY												
POSITION												
POSSESSION												
ROO #												
PAIN												
POTTY												
POSITION												
POSSESSION												
COMMENTS												

APPENDIX D**HOURLY ROUNDING/4P'S LOG (NIGHT SHIFT)**

TIME	1900- 2000	2000- 2100	2100- 2200	2200- 2300	2300- 2400	MN- 0100	0100- 0200	0200- 0300	0300- 0400	0400- 0500	0500- 0600	0600- 0700
ROOM #												
PAIN												
POTTY												
POSITION												
POSSESSION												
ROOM #												
PAIN												
POTTY												
POSITION												
POSSESSION												
ROO #												
PAIN												
POTTY												
POSITION												
POSSESSION												
COMMENTS												

APPENDIX E

ADMISSION FALL RISK ASSESSMENT

History of Falling:

No = 0

Yes = 25

Secondary diagnosis of any kind listed on chart:

No = 0

Yes = 15

Ambulatory Aid (Used during walking):

None/Bedrest/Nurse Assist/Wheelchair = 0

Crutches/cane/walker = 15

Furniture = 30

Intravenous Therapy/Saline Lock:

No = 0

Yes = 20

Gait:

Normal/Bedrest/Wheelchair = 0

Weak = 10

Impaired = 20

Mental Status of resident's own ability:

Oriented to own ability = 0

Overestimates/forgets limitations = 15

Score:

Score > 45 Fall Risk Protocol initiated?

Yes/No

Appendix F

ACUTE CARE AND COMMUNITY LIVING CENTER (CLC) FALL REDUCTION PROTOCOL

FALL RISK ASSESSMENT TOOL:

- Morse Fall Scale

FALL SCALE SCORES:

- Low Risk Patients with a Morse Fall Risk Score less than 25 (0-24)
- Moderate Risk Patients with a Morse Fall Risk Score 25-44
- High Risk Patient with a Morse Fall Risk Score 45 or greater

COMPLETE AND DOCUMENT ASSESSMENT ON ALL PATIENTS/RESIDENTS:

- Within 24 hours of admission, transfer/change in condition, and following a fall.
- With shift assessment/reassessment utilizing the 24-Hour Flow Sheet and /or CPRS based note on unit location (Acute Care).
- Monthly review by physician, nurse, and clinical pharmacist during medication and treatment review (CLC).
- Patients who are considered “High Risk” (45 or greater) will be provided yellow wristband, yellow gown, and a pair of yellow socks. Also, evaluate appropriateness of assigning an 1:1 Patient Safety Attendant.
- Adjust fall prevention and management strategies after fall event.

CARE PLAN THE FALL RISK SCORE, INDIVIDUALIZED INTERVENTIONS AND GOALS:

Low Risk < 25 (0 - 24)

Implement Universal Fall Precautions for **ALL** Patients

1. Provide Patient/Resident/Family Education/ Re-education at admission throughout hospitalization:

- Orientation to surroundings
- Purpose and use of call light
- Use of non-skid slippers

Moderate Risk (25 - 44)

High Risk (45 or Greater)

Interventions may be selected based on yes/positive response to individual question(s) in Morse Scale (History of Falling; Secondary Diagnosis; Ambulatory Aid; IV; Heparin Lock; Transfusions; mental status.)

1. CONTINUE UNIVERSAL PRECAUTIONS AS INDICATED TO THE LEFT

- Requesting assistance for daily activities (such as getting out of bed; toileting; transfers)
- Purpose and use of assistive devices and mobility aids if needed
- Review tripping hazard of lines/tubing's as indicated.

2. Provide an optimally safe environment to include:

- Place call light (answer promptly) and patient articles within easy reach.
- Place bed in low position when patient in bed.
- Use side rails as indicated/appropriately.
- Lock bed wheels.
- Lock wheelchair/gurneys if applicable.
- Provide proper lighting (night lights).
- Keep floor and bedside free of clutter.
- Clean up spills immediately.
- Modify environment for safe transfers.

3. Review Medication Profile to consider patient Safety:

- Consider peak effect for prescribed medication that affect level of consciousness, gait and elimination when planning patient care.

2. Provide continued Education/Re-Education to include:

- Instruct patient/resident family in medication time/dose/side effects and interactions/supplements as indicated.
- Reinforce physician instructions for prevention of complications related to medical diagnosis/problems.
- Review medications with patient/resident and family support person and take into account risks specific to the patient/resident as indicated.
- Review appropriate use of ambulatory device(s) (walkers, wheelchairs, canes).

3. Provide optimally safe environment to include:

- Move patient/resident to room with best visual access when possible.
- Utilize low beds and/or bed/chair alarm as SPHM preventive strategies.

4. Provide SBAR Communication at change of shift, transfer, break time to include:

- Communication of patients “At Risk” status.

5. For Stryker Patriot Beds (Acute Care):

- **Turn on iBed Awareness Feature at ALL times.**

4. Provide additional support to the patient in the following:

- Provide toileting devices (urinal/commode)
- Remain with patient/resident during toileting.
- Provide assistance with out of bed activities; utilizing transfer equipment (SPHM devices) indicated.
- Execute rounds at a minimum of hourly and/or 30 minutes; 15-minute segments as indicated.
- Consider protective devices to prevent fractures.
- Ensure all ambulatory devices are in good repair as indicated.
- Assess patients/resident’s proper use; if difficulty with device consider PM&R consult as indicated.
- Consider providing clocks and calendars for re-orientation.
- Consider diversional activities.
- Consider wandering monitoring device.
- Ask other members of health team to assist in Fall Prevention interventions (Housekeeping, Pharmacy, Respiratory Therapy, etc....).
- Evaluate for orthostasis as indicated (related to side effects of medications).

5. Provide enhanced communication regarding patients fall risk:

- Place Fall Risk signage at head of bed and out- side door (Acute Care).

6. For Stryker Patriot Beds (Acute Care):

- **Both Bed Exit System and iBed Awareness on at ALL times.**
-

Appendix G

Post Fall Huddle Sheet

Date: _____ Time of Fall: _____ Time of Huddle: _____ Room #: _____ SHIFT (circle one): DAY / NOC
 Diagnosis: _____ Pertinent Medical Hx: _____

LOCATION of FALL:

☐ Bed/ Bedside Commode ☐ Chair ☐ Gurney ☐ Hallway ☐ Room ☐ Restroom
☐ Other: _____

BACKGROUND: Fall risk factors / risk for injury (check all that apply):

☐ Altered Mental Status ☐ Pain or Discomfort: Location _____ ☐ Age (>85)
☐ Dizziness/Lightheadedness ☐ Diagnosis r/t (Hypoglycemia/ Seizure/ Hypotension/Parkinson /Dementia) ☐ Prior Fall History
☐ Change in Vital Signs ☐ Bones (Osteoporosis) ☐ Impaired Communication
☐ Medications (Benzodiazepines, Pain meds, B/P meds, hypnotics) ☐ Surgery (recent/Fracture/amputee) ☐ New infection or Illness
☐ SOB ☐ Physical condition (poor balance, weakness) (equipment)
☐ Anti -coagulation ☐ Sensory or Neural Deficit ☐ Other: _____
☐ s/p OD or intoxication ☐ ETOH use/withdrawal wanderer

Information Related to Fall Event	FINDINGS
1. Was resident on Fall precaution?	____ YES ____ NO
2. Most recent Fall Risk Assessment score?	
3. Was patient alone at the time of fall?	____ YES ____ NO
4. Describe in resident's own words what they were doing prior to fall.	
5. Elimination problems : (____ urgency; ____ diarrhea, ____ incontinence)	____ YES ____ NO
TYPE of FALL	DESCRIPTION
A. ____ Accidental Fall	____ Slip ____ Trip
B. ____ Anticipated Physiological Fall Related to: ____ loss of balance ____ impaired gait or mobility ____ impaired cognition/confusion ____ impaired vision ____ functional deficits ____ disease process ____ unrealistic assessment of their ability	
C. ____ Unanticipated Physiological Fall (created by condition that cannot be predicted, e.g. unexpected orthostasis, extreme hypoglycemia, stroke or heart attack.)	
D. ____ Intentional Fall: (Patient who voluntarily alters body position to lower level).	
NURSING OBSERVATION/ASSESSMENT	FINDINGS
Neuro checks: Glasgow Coma Scale: _____	____ Changes in MS (Mental Status) ____ Headache ____ Vomiting ____ Bleeding
Did Patient hit his/her head?	____ YES ____ NO
Fall witnessed?	____ YES ____ NO
What were the provider's findings and orders?	__ Injury __ Pain __ Functional change __ Other: _____
ACTION/RECOMMENDATION/PREVENTATIVE MEASURES	
____ Assistive device (e.g. lift, walker, cane) ____ Hip protectors ____ PT/OT evaluation ____ Bed Alarm ____ Non-skid socks ____ Removed Clutter / equipment ____ Close Observation ____ Moved patient (higher visibility) ____ Toileting plan ____ Behavioral Management Plan ____ Pain Management Assessment ____ Supplies in reach ____ Lighting	
Follow - up Plan: (Free text new interventions or family to prevent further falls).	

APPENDIX H**Expense and Revenue Worksheet**

EXPENSES			
DESCRIPTION/ CATAGORY	COST BREAKDOWN	TOTAL COST	EXPLANATION
Educator/ANM	2 Managers x 16 hours	\$1,168.00	2 days / 4 hours sessions each day
	2 Managers x 4 hours/ day	\$11,680.00	Developing training program
Training	40 (RN's, LVN's and NA's)	13 RN's + \$1,768.00 12 LVN's + 1,344.00 17 NA's + 1,700.00	All nursing staff attend one 4-hour session. No additional staff needed to cover unit.
Rounding clip boards	12	\$24.00	10 per shift for rounding documentation
Quality Manager	2 hours	\$70.00	Receive and review data daily
Printer	500 rounding logs 100 flyers	\$230.00 \$46.00	
REVENUE			
DESCRIPTION/ CATAGORY	COST BREAKDOWN	TOTAL REVENUE SAVED	EXPLANATION
Avoidance costs	20% reduction in falls in the CLC per month) Average cost for a fall with injury: \$159,222.00	\$1,910,664.00 Over a 12-month period.	Reducing the falls by one per month.

CLC FALL PREVENTION VISION BOARD

