CASE STUDY

Reducing Patient Falls through Purposeful Rounding at Overton Brooks VA Medical Center

Introduction

During 2022, the Overton Brooks Veterans Affairs Medical Center partnered with Lone Star Communications (LSC) to address a critical patient care safety concern: reducing fall rates, particularly those involving major injuries. The initial phase included the use of existing technology for rounding reminders, and incorporation of the 5 P's (Pain, Potty, Position, Possessions, Pumps & Plugs) by the nursing units as part of the rounding process. These efforts culminated in a Purposeful Rounding Project, completed by the second quarter of 2023, aimed at enhancing patient safety and reducing falls across multiple nursing units.

Background

Falls are a common problem in hospital care, occurring at a rate of 3-5 per 1000 bed days.[1] They can cause patient harm and can directly increase costs by over $35,000 per fall.[2] Despite intensive research and quality improvement efforts, falls continue to be a problem in many hospitals. Evidence-based practices for fall prevention programs are available through the Agency of Healthcare Research and Quality (AHRQ).[3] Consistent execution of patient interventions has been greatly enhanced with regular patient rounding and nurse rounding has been shown to be a positive intervention in reducing falls.[4,5]

The Problem

- **Inconsistent Use of Technology for Rounding:** Nursing staff were not using the existing Rauland equipment reliably throughout the medical center, leading to a lack of consistent positive outcomes. Staff perceived the use of technology as another task in their already busy day and did not realize the benefits of use and how it could make their shift easier.
- **Lack of Compliance with the Rounding Process:** There was lack of adoption of the rounding process, which to be done correctly, includes the use of the 5 P's. The lack of consistency caused increased calls for help, which in turn took more time away from nurses to complete all the tasks necessary for safe care.

Purposeful Rounding Promotes

- **Increased Patient Safety and Satisfaction:** Regular, purposeful rounding improves patient safety, including fall rates, by addressing patient needs proactively. It also enhances satisfaction through consistent engagement, fostering better communication and trust between nurses and patients.
- **Reduction in Call Light Usage:** Proactive rounding decreases the need for patients to use call lights, addressing their needs before they escalate.

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Why Does Improving Patient Safety Matter?

- **Improved Clinical Outcomes:** Improving patient safety by proactively meeting care needs can lead to better outcomes including reduced falls and reduced pressure ulcers.5
- **Improved Financial Strength:** Improved patient safety can lead to increased reimbursement rates and reduced costs associated with adverse events.

The Solution

Based on the above challenges, the nursing leaders in collaboration with Lone Star, identified a multi-faceted evidence-based practice approach to improve the fall rates by utilizing existing technology and including the 5P's in a new rounding process. Two pilot units were chosen for this initial project, based on their approach to innovation and the presence of nurse leaders. This improvement project included:

1. **Staff Terminals**: A staff terminal was installed with a standard configuration in each patient room to be utilized for logging rounds. It also served as a reminder for staff that the next rounds were due in a particular room. The terminal would trigger a pink flashing light in the corridor as a visual cue for nursing staff and therefore hold them accountable for their rounding. Nursing staff purposely chose not to utilize sound associated with this light trigger so they would not contribute to alarm fatigue.
2. **Rounding Protocol**: Nursing staff were trained to enter patients' rooms on an hourly basis, using the staff terminal to log their visits and assess the 5 P's. After each visit, staff would reset the terminal to remind them when to return.
3. **Training and Accountability**: Staff received comprehensive training on the importance of purposeful rounding, supported by regular safety meetings led by clinical champions to ensure compliance and discuss outcomes. To offer further support, nurse leaders were chosen on the units to model behavior and answer questions. They were also responsible for rounding completion, ensuring proper adoption. A target of 70% was set to ensure that the new process was becoming part of daily practice.

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Results

The initiative led to significant improvements:

- **Reduction in Fall Rates:** The outcome objective of reducing patient falls was successful. Overton Brooks VA Medical Center reported a statistically significant decrease in patient falls on the pilot units that implemented the purposeful rounding intervention. The fall rate went from 3.92 falls during the pre-intervention period to 1.94 during the post-intervention evaluation.
- **Increased Compliance/Decreased Use of Nurse Calls:** After four months of implementation, adoption rates for rounding on the pilot units were at 80% and continued to be above the threshold throughout this project. Data extracted from the staff terminal logs provided insight into rounding frequency and effectiveness. Nurses recognized that rounding gave them more time by reducing the volume of patient calls.
- **Staff Engagement**: The visible light cue and regular leadership engagement fostered a culture of accountability among the nursing staff, promoting adherence to the rounding process. The actual improvement in falls and decrease in Nurse Call use-rate offered positive reinforcement and excitement for this change, such that multiple other nursing units wanted to participate in this improvement.

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Conclusion

The Purposeful Rounding Project at the Overton Brooks VA Medical Center exemplified how leveraging existing technologies can lead to meaningful improvements in patient safety and care quality. By focusing on proactive patient engagement and ensuring nursing staff accountability, the hospital successfully reduced falls. “We were grateful to see that staff were embracing rounding and the use of technology,” said Abe Brown, MSN RN. This case study serves as a model for other healthcare facilities looking to implement similar initiatives aimed at improving patient outcomes through systematic and purposeful care strategies.

References:

1. AHRQ, Falls, (2019). Fall Prevention Toolkit
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3. Agency for Healthcare Research and Quality (AHRQ). Fall TIPS: A patient centered fall prevention toolkit. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html
4. Al-Anati, A. et al. 2024). Structured interactions between nurses and patients through intentional rounding: A scoping review. *International Nursing Review*, 71: 492-503.
5. Gliner, M., et al. 2022-3. Patient Falls, Nurse Communication and Nurse Hourly Rounding in Acute Care: Linking Patient Experience and Outcomes. *Journal of public health management and practice;* 28(2), E467-E470.