

MANAGEMENT OF THE BEHAVIORAL HEALTH PATIENT AT RISK FOR FALLS USING HOURLY ROUNDING

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Purpose and PICO Question

The purpose of this project is to investigate best practice interventions to decrease fall rates on the behavioral health unit at El Camino Hospital. PICO - In an acute adult inpatient behavioral health unit, will hourly rounding on high fall risk patients by direct care staff (to include a prompted voiding protocol) significantly reduce the occurrence of falls?

Background and Evidence Review

Incidence of falls on psychiatric units is higher than that on acute care medical surgical units. Patients are often on medications (anti-depressants, sedatives or hypnotics, anxiolytics, and antipsychotics) that contribute to increased fall risk. Yet, the treatment for this specialized psychiatric population supports an active program, which potentiates their fall risk. Prior implementation, a fall risk care plan was in place which incorporated fall risk assessment, the identification of the fall risk patient with a bracelet and signage outside the door, call bell at the bedside, and non-skid socks. Rounds were done by a designated safety officer (a non-RN) every 15-30 minutes depending on the patient, focused on those at risk for suicide, danger to others, or elopement. Upon review of falls reports in 2008, behavioral health had 40 falls, the 2nd highest in the hospital, with 12/40 (30%) related to toileting.

Methods

The 21 bed adult behavioral health unit is staffed with RN's, LVN's (licensed vocational nurses) and LPT's (licensed psychiatric technicians). The intervention of hourly fall rounding was implemented. The protocol included proper identification of fall risk patients, checking that the bed was locked and in lowest position, items were within reach, and assessing for pain, anxiety, agitation, dizziness, and orthostatic changes. Staff was to check for a clutter-free environment with a clear path to the bathroom. A verbal prompt to ask patients about toileting needs included assisting and waiting until the patient finished to ensure safety. Education was given to staff in small groups during hand off communication shift change report, 1:1 in-services, emails, and frequent verbal reminders regarding the proper way to complete and document hourly rounding, and use of the Fall Prevention Binder and Fall Critique Form. The outcomes were measured by the number of falls that occurred during the 2 month implementation.

Results

During the two month period prior to the intervention, 20 falls occurred with 6 related to toileting. There was a decrease to a total of 9 falls with none related to toileting during the two month implementation period.

Conclusion

Despite challenges to initiate change into the work flow, results from this study assisted the staff to see how a small test of change could improve outcomes and increase patient safety. The unit will incorporate hourly rounding into daily practice, review trends from fall critique forms and continue involvement with the hospital falls committee. A task force to evaluate appropriateness of the current fall risk assessment tool hopes to continue the evaluative work of fall prevention.

Selected References

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