THE IMPACT OF NURSE ROUNDING ON PATIENT SATISFACTION IN A WOMEN’S POSTPARTUM UNIT

RESEARCH PAPER

SUBMITTED TO THE GRADUATE SCHOOL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

MASTER OF SCIENCE

BY

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DECEMBER 2013
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Chapter I

Introduction

Patient satisfaction is a fundamental factor that has become a critical piece of the healthcare reimbursement program. It is important to any hospital when trying to maintain excellent patient service, patient loyalty, and financial stability in our worsening economy. According to the Centers for Medicare and Medicaid Services (CMS), Medicare reimbursements will now be dependent on patient satisfaction levels. CMS plans to base 30% of hospitals scores under the value based purchasing initiative on patient responses to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which measures patient satisfaction. “The HCAHPS is a 27 item survey instrument and data collection methodology for measuring patients’ perceptions of their hospital care and experience” (HCAHPS, 2012, p.1).

According to a study by Zamora, patients’ hospital care experiences are calculated by the core measures of the HCAHPS survey, which include:

- How well nurses communicated with patients.
- How well doctors communicated with patients.
- How responsive hospital staff were to patient needs.
- How well caregivers managed patients’ pain.
• How well caregivers explained patients’ medication to them.
• How clean and quiet the hospital was.
• How well the caregivers explained the steps patients and families need to take to care for themselves outside of the hospital (discharge instructions).
• Overall rating of the hospital. (pp. 118-119)

“The Hospital Value Based Purchasing (VBP) program links a portion of IPPS hospitals’ payment from CMS to performance on a set of quality measures. The Hospital VBP Total Performance Score (TPS) for FY 2013 has two components: the Clinical Process of Care Domain, which accounts for 70% of the TPS; and the Patient Experience of Care Domain, 30% of the TPS. The HCAHPS survey is the basis of the Patient Experience of Care Domain.” (HCAHPS, 2012, p. 3) Beginning in October 2012, under CMS's Value-Based Purchasing (VBP) plan, Medicare will: (a) Withhold 1% of its payments to hospitals which perform poorly on HCAHPS measures, and (b) Place withheld funds into a pool to be distributed as bonuses to hospitals which score above average on several measures (CMS, 2012). Three overall goals have led to the creation and implementation of the HCAHPS survey. First, the survey was designed to generate comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to patients. Second, survey results shared with the public were intended to create incentives for hospitals to improve the quality of care provided. Third, public reporting serves to improve public liability in health care by allowing the public to link quality of hospital care with patient satisfaction (HCAHPS, 2012).

To meet the high standards on patient satisfaction and reimbursement placed by CMS and HCAHPS, hospitals will be required to increase the excellence of care and
communication provided to each individual patient. One tactic, nursing rounds, is now being implemented as a patient satisfaction intervention. According to Christine Meade, chief researcher in the nationwide Studer studies on hourly rounding, increased nursing presence leads to better quality of care which in turn has a positive effect on patient satisfaction scores (Leighty, 2006). Hourly rounding is an autonomous nursing patient satisfaction intervention and quality improvement tool. Hourly rounding provides the nurse with a scheduled observation time that proactively meets the patient’s comfort, safety, and personal needs.

**Background and Significance**

Hourly rounding is a concept that has been explored multiple times in research studies. The majority of information on intentional nurse rounding comes from development and testing in US hospitals in the last 10 years (Halm, 2009). The evidence focuses on “before and after” measures of call bell usage, falls and pressure ulcer incidence (Halm, 2009).

The concept of hourly rounding to improve patient safety is not new, but it is currently undergoing a revival (Olrich, Kalman, & Nigolian, 2012). Intentional nurse rounding has been developed as an evidence-based structured process in the US by the Studer Group (2007). Studer Group partnered with the Alliance for Health Care Research (ACHR) to conduct the largest study ever completed that provides evidence that certain nursing staff behaviors reduce call lights and allow staff to respond more efficiently to patient requests. As reported in the September 2006 American Journal of Nursing, Studer Group’s research subsidiary, the Alliance for Health Care Research (AHCR), completed a rigorous study that analyzed the impact of Hourly Rounding SM on patients in 27
nursing units (telemetry, surgical and medical-surgical) from 14 hospitals nationwide using a specific protocol (Studer, 2007). This study, headed by researchers Meade, Bursell & Ketelsen (2006) hypothesized intentional nursing rounds on inpatients within medical, surgical, or medical surgical units would produce a decrease in call light usage while also increasing patient satisfaction and patient safety. When baseline data was collected, researchers learned that the top reasons patients used the call light were: bathroom/bedpan assistance (15%); IV/pump alarm (15%); pain medication (10%); needed a nurse or CNA (9%); and position assistance (4%), as well as accidental hits of the call light (13%) and miscellaneous reasons (13%) (Studer, 2007).

According to multiple research studies, the benefits of intentional rounds would increase if a predetermined set of questions or checks, referred to as the ‘four Ps’, was implemented. The aim of the ‘four Ps’ would be to reduce the incidence of falls, pressure ulcers, and call light usage, while increasing communication, patient satisfaction, and nurse satisfaction (Studer, 2007). The ‘four Ps’ would include:

- Pain: assess patients’ pain score and need for pain intervention.
- Position: assess patients’ need for help with repositioning & comfort levels.
- Potty: patients’ toileting needs.
- Placement: proximity of patients’ call light, phone, urinal, etc.

Meade et al. (2006) found that after initiation of one and two hour rounding protocols, checking the patient’s 4 Ps (pain, positioning, potty, possessions), there was an overall reduction in call light usage by 40-50%; overall patient satisfaction increased 71%, patient falls were reduced by 33%, and hospital acquired pressure ulcer cases were reduced by 56%. By rounding hourly on patients, the units reduced the following
requests: bathroom by 40%, pain by 35%, positioning by 29%, IV/pump alarms by 40%, and miscellaneous by 39% (Studer, 2007).

This clearly demonstrates that when nurses follow recommended behaviors and actions during hourly rounds that it does become an effective tool. Consistent hourly rounding is a fundamental tool in improving patient safety and quality of care (Ford, 2008).

Statement of Problem

Blakley, Kroth, and Gregson (2011) believed that service excellence is the key driver in an organization's patient satisfaction levels. “This qualitative descriptive study focused on patient satisfaction and how to increase patient satisfaction levels through nurse rounding and was conducted using data from semi-structured interviews with parents who had participated in patient rounding.” (p. 328)

Purpose of the Study

The purpose of this study is to examine if intentional nurse rounding, incorporating the 4-P Program, done every 2 hours, would have an effect on both patient and/or nurse satisfaction.

Research Questions

1. What is the impact of intentional, regular, and consistent nurse rounding on a patient's satisfaction with the hospital experience?

2. To what extent do nurses experience less call light usage if they regularly round on patients?

3. To what extent do patients report more effective pain management if nurses round regularly?
Definition of Terms

**Patient Satisfaction: Conceptual.**

Patient’s level of satisfaction with the hospital experience depends largely on their perception of how effectively the nursing staff met their basic needs. (Blakley et al., 2011)

**Patient Satisfaction: Operational.**

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a standardized survey instrument for measuring patients’ perspectives on hospital care. The HCAHPS survey computes patient satisfaction through specific core measures such as nurse responsiveness, communication with nurses and physicians, pain management, quietness of the environment, and cleanliness.

**Patient Rounding: Conceptual.**

Patient Rounding is conceptually defined by Blakely et al. (2011) as the process of proactively meeting the patient needs by a nurse making a routine visit to patient rooms to check on specific items and perform basic self-care tasks on a regular, consistent basis.

**Patient Rounding: Operational.**

Patient Rounding is operationally defined by Blakely et al. (2011) as a process that will occur every 2 hours from 7 am to 7 pm and every 4 hours from 7 pm to 7 am, checking the patient’s 4-Ps with implementation measured by patient rounding logs.
Conceptual Framework

The conceptual framework of this study will be based on Stringer’s Action Research Framework of Look, Think, and Act Model (2007). Stringer (2007) defines Action Research as “a systematic approach to investigation that enables people to find effective solutions to problems they confront in their everyday lives” (Hansen & Brady, 2011, p. 82). Action research centers on finding the answers to real life problems encountered by actual people. The foundation of this framework includes, in the following systematic order: Look, Think, and Act. The Look component involves assessment and data acquisition. The Think component encompasses reflection, evaluate, and review. The Act component includes planning, implementation, and evaluation. The framework is never ending process; a constant cyclical framework (Stringer, 2007).

Stringer’s Action Research Framework of Look, Think, and Act Model can be applied to the intentional rounds intervention discussed in this paper. Using this process and appropriate tools, these agents can examine what is happening, adjust procedures, actions, and messages based on what they see, and adapt to changes both inside and outside the system.

Phase 1

- Look – Review evidence based research articles, review needed changes.
- Think – selecting, organizing, and sorting information; reflect on survey results, HCAHPS scores, call light logs, and decide on plan of action.
- Act – formulate a focused problem & implement changes to solve problem. Implement intentional hourly rounding on unit.

Phase 2

Think – Identify pros/cons of intentional hourly rounding.

Act – Implement changes as needed to make intentional hourly rounding successful.

Action research is a proven and well-established form of research. Essentially, it is an evidence based form of enquiry or problem solving that “…involves a spiral cycle of planning, acting, observing and reflecting” (Stringer, 2007, p. 9). Most importantly, the process is continuous, evolving, and complex. As each set of activities is completed, the participants “will find themselves working backward through the routines, repeating processes, revising procedures, rethinking interpretations, leapfrogging steps or stages, and sometimes making radical changes in direction” (Stringer, 2007, p. 9). In essence, action research addresses relationships, communication, participation, and inclusion, and potentially leads to benefits for all stakeholders involved in the process (Stringer, 2007).

Limitations

The study is limited to a small sample size on only one unit in one hospital. Patients and nursing staff may have predetermined expectations which could impact the results. Findings will reflect conditions only on the Women’s & Children’s Unit, not necessarily that of other nursing units within the same hospital.

Assumptions

1. Intentional nurse rounding will increase patient perception of care received.
2. Intentional nurse rounding will lead to increased patient satisfaction scores.
3. Intentional nurse rounding will decrease call light usage, patient falls, and pressure ulcers.

Summary

According to the Centers for Medicare and Medicaid Services (CMS), Medicare reimbursements will now be dependent on patient satisfaction levels. “CMS plans to
base 30% of hospitals scores under the value based purchasing initiative on patient responses to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which measures patient satisfaction” (HCAHPS, 2012, p.1). With so many changes in healthcare mandates, nurses and physicians must utilize evidence based practice to improve patient safety and satisfaction. Intentional nurse rounding, an evidence based practice, incorporating the 4-P program, done every 2 hours, will help to impact the patient’s perception of care and increase the patient’s feeling of safety and satisfaction with care received. With this process, patients are positioned in the center of care and become the ultimate beneficiaries.

This study is a modified replication of Blakely et al.’s (2011) study. The findings of this study will provide valuable guidance and feedback concerning hourly rounding nursing care and interventions aimed at improving patient care, with a result of increasing patient satisfaction, leading to higher hospital reimbursement rates.
Chapter II

*Literature Review*

**Introduction**

“Patient satisfaction is a high priority for hospitals that face constant pressure to maintain high quality service, top clinical care, and financial viability” (Blakley et al., 2011, p. 327). “The contemporary health service is under pressure and subject to calls for innovation to improve operational efficiency and quality and safety of patient care” (Gardner, Woollett, Paly, & Richardson, 2009, p. 287). “The Centers for Medicare and Medicaid Services (CMS), a significant payer for hospital services, collect and publish consumer satisfaction data online that allow consumers to evaluate and compare individual facilities” (Blakley et al., 2011, p. 327). Blakley, et al. (2011) believed that service excellence is the key driver in an organization's patient satisfaction levels. “This qualitative descriptive study focused on patient satisfaction and how to increase patient satisfaction levels through nurse rounding and was conducted using data from semi-structured interviews with parents who had participated in patient rounding” (Blakley et al, 2011, p. 328). The purpose of this study is to examine if intentional nurse rounding, incorporating the 4-P Program, done at designated times, would have an effect on patient satisfaction.
This is a modified replication of Blakley, et al.’s (2011) research, “The Impact of Nurse Rounding on Patient Satisfaction in a Medical-Surgical Hospital Unit.” The conceptual framework of this study will be based on Stringer’s Action Research Framework of Look, Think, and Act (2007).

**Research Questions**

1. What is the impact of intentional, regular, and consistent nurse rounding on a patient's satisfaction with the hospital experience?
2. To what extent do nurses experience less call light usage if they regularly round on patients?
3. To what extent do patients report more effective pain management if nurses round regularly?

**Organization of the Literature**

The literature review consists of studies which address the relationship of nursing rounds and the impact on patient and/or family satisfaction. The literature review is organized into four sections: (a) organizing framework, (b) rounding: patient and family satisfaction, (c) rounding: family involvement and communication, and (d) rounding: pain management, call lights, and patient safety.

**Conceptual Framework**

The conceptual framework of this study will be based on Stringer’s Action Research Framework of Look, Think, and Act Model (2007). Stringer (2007) defines Action Research as “a systematic approach to investigation that enables people to find effective solutions to problems they confront in their everyday lives” (Hansen & Brady, 2011, p. 82). Action research centers on finding the answers to real life problems
encountered by actual people. The foundation of this framework includes, in the following systematic order: Look, Think, and Act. The Look component involves assessment and data acquisition. The Think component encompasses reflection, evaluate, and review. The Act component includes planning, implementation, and evaluation. The framework is never ending process; a constant cyclical framework.

Stringer’s Action Research Framework of Look, Think, and Act Model (2007) can be applied to the intentional rounds intervention discussed in this paper. Stringer’s (2007) action research interacting spiral, describes action research as a “simple, yet powerful framework” consisting of a “look, think, and act” routine. During each stage, participants observe, reflect, and then take some sort of action. This action leads them into the next stage (Mertler & Charles, 2011). Using this process and appropriate tools, these agents can examine what is happening, adjust procedures, actions, and messages based on what they see, and adapt to changes both inside and outside the system. Mertler & Charles’ (2011) action research outcomes: (a) action research deals with your problems, not someone else’s, (b) action research is very timely; it can start now—or whenever you are ready—and provides immediate results, (c) action research provides educators with opportunities to better understand, and therefore, improve educational practices, (d) action research can also promote the building of stronger relationships among colleagues with whom we work, and (e) action research provides educators with alternative ways of viewing and approaching educational questions and problems and with new ways of examining our own educational practices (Mertler & Charles, 2011). “The clear strength of action research is that it is reflective and collaborative and that it
can ultimately lead to improvements in educational practice” (Mertler & Charles, 2011, p.22).

**Rounding: Patient & Family Satisfaction**

Maintaining and increasing patient satisfaction in today’s healthcare system is vital to the patient’s satisfaction with care received during a hospital stay, as researched by Gardner, et al. (2009). According to the Centers for Medicare and Medicaid Services (CMS), “Medicare reimbursements will now be dependent on patient satisfaction levels” (HCAHPS, 2012, p.1). The authors feel that implementing hourly patient comfort rounds is just one step being used to increase and maintain patient satisfaction scores associated with the patient’s hospital experience (Gardner et al., 2009).

The conceptual framework for the Gardner et al. study (2009) was based on the Quasi-Experimental Design. The design was a nonrandomized parallel group trial design. The main concept was comfort where rounding equaled treatment. The study was completed over an 8-week period, using both a control and experimental acute surgical wards in Brisbane Australia. The study sample was comprised of 61 patients (29 female, 32 male) in the intervention ward and 68 patients (27 female, 41 male) in the control ward. Seventy-five percent of the intervention sample and 70% of the control sample were aged 42 years. The mean length of stay was 6.9 days for the intervention ward and 8.5 days for the control ward (Gardner et al., 2009). All participants gave consent for the study and received information when requested.

The aim of the pilot study was to test the effect of a 1 hourly patient comfort round intervention on patient satisfaction and on nursing perceptions of the practice environment. The following hypotheses were tested:
1. An acute surgical ward that has 1-hourly patient comfort rounds will record higher patient satisfaction scores than a ward without patient comfort rounds.

2. An acute surgical ward that has 1-hourly patient comfort rounds will record more positive nurse perceptions of the practice environment than a ward without patient comfort rounds. (Gardner et al., 2009, p. 289)

“A Patient Satisfaction Survey (PSS) instrument was developed and used in conjunction with the Practice Environment Scale of the Nursing Work Index (PES-NWI). The PSS instrument obtained good reliability and flexibility, when examined by researchers. The PSS questionnaire included nine statements related to the following: (a) Having needs met in a timely fashion, (b) individualized care, (c) timely attention to call bells, and (d) nursing care” (Gardner et al., 2009, p. 289).

Patients used a response scale, ranging from ‘strongly agree’ to ‘strongly disagree’. The PSS questionnaire was completed by the patient upon discharge from the unit. The effect of the comfort round intervention on nurse perceptions of the practice environment was measured using the Practice Environment Scale of the Nursing Work Index (PES-NWI), a previously validated Instrument .23–.25 (Gardner et al., 2009). This scale gained the nurse’s perception of the work environment, including the following areas, which produced 5 subscales.

1. Nurse participation in hospital affairs
2. Nursing foundations for quality of care
3. Nurse Manager ability, leadership, and support of nurses
4. Staffing and resource adequacy
5. Collegial nurse-physician relations
“The responses for these subscales were scored on a 1-4 range, with a lower score equaling a more negative perception and a higher score equaling a more positive perception. This questionnaire was given to nurses at three different designated times: week prior to implementation of comfort rounds, the fourth week of the rounding project, and 2 weeks after the completion of the study” (Gardner et al., 2009, p. 292).

The results from the PSS showed no significant differences concerning the PSS results between the experimental and control groups of patients, with most answers landing in the ‘agree’ to ‘strongly agree’ choice. Overall, the PSS questionnaire showed that patients felt good nursing care was received during the hospital stay. The results from the Practice Environment Scale suggest that, “overall, nurses who participated in the comfort rounds experienced improvements in their perceptions of quality of care, resource adequacy, and professional relations” (Gardner et al., 2009, p. 292).

This study established that patient centered care, along with implementing comfort round interventions, did have a positive effect on nursing satisfaction. This finding trickled down to the patient level as well. The implementation of comfort round interventions led to fewer call lights, patient falls, and patient injuries. The patients perceived that good nursing care was provided more often with dependability. The study did result in the development of a reliable and flexible Patient Satisfaction Survey instrument that can be used for larger studies in the future.

Patient satisfaction is an important subjective finding in the health care setting. Health care organizations are constantly looking for evidence based innovative approaches to increase patient satisfaction scores. One strategy called *hourly rounding* is a suggested method to address these issues (Studer Group, 2007). “Hourly nursing rounds
are innovative, proactive approaches that assist in nursing care organization that has rendered positive results. The nurse’s focus becomes patient-centered, which leads to higher patient satisfaction scores” (Ford, 2010, p. 188).

This study was relevant to the work of Meade, Bursell, and Ketelsen (2006). Staff at Baltimore Washington Medical Center (BWMC) tested hourly nursing rounds on several units. The study’s purpose was to determine if patient satisfaction increases significantly as the new strategy was implemented (Ford, 2010). Following the Meade et al study (2006), the authors used the quasi-experimental conceptual framework. “The setting was Baltimore Washington Medical Center, a 311-bed facility that is part of the University of Maryland Medical System, in Baltimore, Maryland. BWMC’s 2,600 employees cared for more than 200,000 patients in 2009” (Ford, 2010, p. 188).

Patient satisfaction scores at BWMC are currently monitored by the Jackson Healthstream Organization, using the new Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS). “This tool was co-developed by the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality (AHRQ). It provides a nationally standardized and publicly reported benchmark of patients’ perception of their care” (Ford, 2010, p. 189).

A specific set of measures are addressed during each rounding session. These actions, generally clustered into four areas, were designed to meet patient needs and foster a relationship with each patient (Meade et al., 2006).

1. **Pain**: The provider asks the patient, “How is your pain?” After identifying patient pain intensity, the provider offers appropriate measures as needed, including position changes, guided imagery, deep breathing exercises,
diversion activities, and medication. (As needed medications are offered to the
patient when the dose is due for administration). Other comfort measures such
as mouth care are implemented, and fluids are offered.

2. **Personal needs:** The provider asks the patient, “Do you need to use the
bathroom?” Toileting times are scheduled with the patient, with assistance
offered as needed. The provider remains with the patient who requires
assistance to the bathroom or bedside commode and then assists the patient
back to the chair or bed.

3. **Positioning:** The provider checks patient positioning and inquires, “How can I
make you more comfortable?” Risks of skin breakdown are identified when
the provider turns the patient, performs hygiene, provides skin care, fluffs
pillows, and straightens linens. Turning schedules are observed, with all
patients who cannot turn independently assisted with repositioning at least
every 2 hours. This includes keeping heels up to help reduce heel pressure.

4. **Placement:** The provider verifies accessibility of possessions and asks, “Do
you need us to move the call light, phone, water pitcher, trash can, over-bed
table, or any other possessions within reach?” Items used most frequently
must remain within easy reach of the patient. (Ford, 2010, p. 189)

Following the same format as Meade and colleagues’ study (2006), this study’s
unit maintained call light logs on patients for a 2-week period prior to implementing the
nurse rounding process. “The researcher received approval to test hourly rounding out on
her assigned patients for a 3-week period. Quantitative call light data were collected
during this time, along with data from rounding logs and discharge phone calls made to
those patients within 48 hours of discharge. To serve as controls, a random sample of patients who did not receive hourly rounds also were tracked for call light use and results of the follow up discharge phone survey. Results were analyzed and compared to the national data” (Ford, 2010, p. 189).

“During the 3-week period, the researcher rounded on up to nine patients per day (maximum of six patients at any given time). The 51-patient sample included 29 females (57%) and 22 males (43%). Patients ranged in age from 21 to 90, with the mean age 58. All patients were alert, oriented, and able to communicate their needs to nursing staff, and received hourly rounding by one nurse” (Ford, 2010, p. 189).

Call light logs from the case study showed a 52% decline in call light use after initiating hourly rounding. This decrease in call light use corresponded with results of the national study (Meade et al., 2006), and has substantial implications for nursing. With less interruption by call lights, units are quieter and nurses have more time to concentrate on patient care and charting. No falls were reported during the study period; possibly due to the higher frequency of patient contact (Ford, 2010). “Discharge phone calls were made to patients who had participated in the hourly nursing rounds; positively rating satisfaction with overall care. Patient comments on specific areas of nursing care reflected the perception of receiving superior care by nursing staff, including pain management, comfort, and safety. Other responses included patients’ satisfaction when staff members took the time to listen to them” (Ford, 2010, p. 190).

“With continued implementation of nurse rounding, the patient begins to expect a nurse at designated times and will use the call light less frequently” (Ford, 2010, p. 190). This allows the nurse to spend more quality time with the patient during nursing rounds.
Hospitals that incorporate hourly rounding note positive improvements in patient safety, noting that patient falls occur less frequently (Meade et al., 2006). When staff members become accountable and round on patients every hour; addressing basic needs, such as toileting and placement of personal items, then risks for falls decrease. Patients are less likely to get out of bed when these personal needs are met in a timely fashion (Ford, 2010).

Hourly rounding is about engaging the patients – going in and finding out their needs and accomplishing tasks (Leighty, 2006). “As proven by this study, hourly nursing rounds contribute in several key areas to the achievement of high levels of patient satisfaction; while increasing quality of care and patient safety” (Ford, 2010, p. 190).

Patient satisfaction is crucial to any hospital when trying to maintain excellent patient service, patient loyalty, and financial stability. Blakley, Kroth, and Gregson (2011) believed that service excellence is the key driver in an organization's patient satisfaction levels. “This study focused on patient satisfaction and how to increase patient satisfaction levels through nurse rounding. The purpose of this study was to examine whether intentional nurse rounding, done every 2 hours, would have an effect on either patient or nurse satisfaction” (Blakley et al., 2011, p. 330).

The conceptual framework for the Blakley et al. study (2011) was based on Stringer’s Action Research Framework of Look, Think, and Act Model (2007). “Nurses on this medical-surgical unit initiated a program of rounding every two hours as part of a broader organizational initiative. The initiative focused on three key areas: (a) nurse communication, (b) pain management, and (c) cleanliness of the room and bathroom. They used the 4 Ps (Pain, Position, Potty, and Placement) as a guideline for interacting
with patients during rounds. Nurses paired with Nursing Assistants during rounding to facilitate addressing needs they identified, such as repositioning or ambulating to the bathroom” (Blakley et al., 2011, p. 330).

The study was only conducted at West Valley Medical Center in Caldwell, Idaho. “Study participants included an unlisted number of medical-surgical nursing staff and (n=301) medical surgical patients hospitalized during a six month period, October 2008 – June 2009” (Blakley et al., 2011, p. 329-330). “The sample included 2 groups, totaling 301, medical-surgical patients with one group hospitalized during the first 3 months of the 6 month timeframe (n=200) and the other group hospitalized during the second 3 months of the timeframe (n=101)” (Blakley et al, 2011, p. 331). The inclusion criterion for the patient was being on the medical-surgical unit during the six month study period. The nursing staff surveyed was employed and practicing on the medical-surgical unit during the six month study period.

The following research questions were investigated in this study:

1. What is the impact of intentional, regular, and consistent nurse rounding on a patient's satisfaction with the hospital experience?
2. What is the impact of rounding on the delivery of patient care from the nursing staff's perspective?
3. To what extent do nurses experience less call light usage if they regularly round on patients?
4. To what extent do nurses find the rounding process helpful in practice?
5. To what extent do patient’s report a more positive hospital experience if nurses round regularly?
6. To what extent do patients report more effective pain management if nurses round regularly?

7. How is medication administration affected by nurse rounding?

8. To what extent do patients report their nurse demonstrated care and concern during hospitalization if their nurse rounded regularly?

(Blakley et al., 2011, p. 328)

“In this study, the authors (Blakley et al., 2011) used the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) to measure patient satisfaction scores” (Blakley, et al., 2011, p. 329). The HCAHPS survey contains 18 items on care and additional patient rating items that encompass eight key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, and quietness of the hospital environment (Centers for Medicare & Medicaid Services, 2012). “In addition to the HCAHPS survey, two other patient satisfaction data collection tools were used during the 4-P rounding process. This included answers to informal questions asked during rounding and rounding logs maintained by nursing staff” (Blakley et al., 2011, p. 239).

“Analysis of patient comments from rounding prior to the implementation of the 4-P rounding process revealed overall patient satisfaction scores with a mean of 3.5 on a scale of 1-4, where 1 = completely dissatisfied and 4 = completely satisfied. At the end of the 6 month study, after implementation of the 4-P rounding process, with the (n=301), patient satisfaction scores increased to a mean of 3.6/4.0. Following the
implementation of the 4-P rounding process, patients surveyed frequently described staff as kind, considerate, and compassionate” (Blakley et al., 2011, p. 331).

“Another data collection tool, the staff survey, was used to test the practice of the 4-P Nurse Rounding Process, which included four questions concerning the 4-P rounding process: (a) Were you able to incorporate 4-P rounding every 2 hours into your practice? (b) What system problems have you identified with the 4-P rounding system? (c) What call light changes have you observed since 4-P rounding started, and (d) Do you have any specific comments you’d like to share about the 4 P process and/or how can it be improved” (Blakely et al., 2011, p. 329). According to staff responses on the survey, the 4 P rounding process did make a difference in the number of call lights answered by staff members. Staff expressed that overall, call light usage decreased. It was noted, however, that when call lights were used, the need was of greater importance than just comfort or assistance. Staff reported that patients were using call lights less and for more serious needs. “Patient complaints, citing staff rudeness, also decreased 43% between the 3rd and 4th quarters in 2008 as the 4-P rounding program was introduced (Blakley et al., 2011, p. 331).

Blakely, et al. (2011) concluded “staff using the 4-Ps system of nurse rounding; better meet patient’s basic needs and that regular rounding increased patient satisfaction scores” (Blakely et al., 2011, p. 331). The authors, however, did identify difficulty in continued implementation, maintaining the process as census fluctuates, and staff turnover occurs. “In June 2009, the 4-P rounding program became a part of a larger initiative designed to improve patient engagement and increase HCAHPS scores” (Blakley et al., 2011, p. 332).
Rounding: Family Involvement & Communication

Involvement of family members and good communication skills are critical when interacting with patients, especially younger populations. According to Latta, Dick, Parry, and Tamura (2008), many hospitals and healthcare workers decide on treatment options without consulting or including family members in the decision making process. This decreases the opportunities for physicians and other healthcare workers to communicate with family members. Teaching rounds involve parents in care of the child. It is important to understand the parent's perspective and/or perceptions of nursing rounds. “The purpose of this qualitative study was to describe parents’ responses to being involved in scheduled rounds conducted in a children’s teaching hospital” (Latta et al., 2008, p. 293).

“The conceptual framework for the Latta et al study (2008) was based on a qualitative descriptive study using data from semi-structured interviews and qualitative analysis” (Latta et al., 2008, p. 293). Children’s Hospital and Regional Medical Center in Seattle, Washington was the setting for the study. (Latta et al., 2008) “Eighteen parents of 18 children, agreeing to be interviewed, were consulted following participation in patient rounding. Patient rounding was designed to include the primary care physician, resident physicians, medical students, patient’s primary care nurse, and unit care coordinators. Parent interviews were done on an individual basis, with questions and answers being recorded and transcribed. Parents were asked the following 12 questions concerning experiences with the rounding process, expectations concerning patient care, satisfaction with the rounding process, favorite types of communication, and any suggestions for improving the rounding process” (Latta et al., 2008, p. 293).
Strategy 1: The parent’s experience: Determine the experience of parents related to their participation in rounds on the in-patient medicine service.

1. Did you get the information ahead of time that told you what to expect during rounds?
2. Tell us about your experience during rounds today. How did it go for you?
3. What did you like or dislike about your experience in rounds?
8. How comfortable did you feel with the rounding process?
9. What did the doctors or nurses do to help you feel comfortable and included?
10. What else could they have done to help you feel comfortable and included?
11. Were they any other things that the doctors or nurses said or did that worked well for you?
12. Were there any other things that the doctors or nurses said or did that did not work for you?

Strategy 2: The parent’s expectations: Determine what parents are expecting to accomplish by participating in rounds.

4. What did you want to accomplish when you talked to the doctors and nurses today?
5. Did you get what you wanted from the doctors and nurses?

Strategy 3: Quality of communication: Determine what style of communication is most helpful to parents to enable them to understand the plan of care for their child.

6. What did the doctors and nurses do to help you understand the plan of care for your child?
7. What else could they have done to help you understand the plan for your child’s care?

(Latta et al., 2008, p. 294)

The transcribed answers were analyzed by the qualitative content analysis technique. “The research investigators decided on coding responses into three categories: (a) Quality of the parental experience, (b) Parental expectations, and (c) Quality of communication. These specific responses were given and placed into one of these categories and given a code” (Latta et al., 2008, p. 294). The researcher and three other reviewers compared categorical coding and reached a 100% consensus on responses and coding. All coded responses were rank ordered according to frequency of responses.

“During this coding process, three primary content themes were identified: (a) Communication, (b) Participation, and (c) Teamwork” (Latta et al., 2008, p. 294). Communication is vital to all areas of patient care. The first primary theme, good communication involves talking, listening, and understanding by both parties. “Of 290 total responses, communication was the most common theme that emerged, with a total of 152 responses coded under this general theme. Of these 152 responses, 66 were classified as exchange of information, most specifically, information related to the patient’s plan of care” (Latta et al., 2008, p. 294). “Parents repeatedly expressed there need to ask and respond to questions, hear what was happening currently, and be informed about the plan of care for the day and the future” (Latta et al., 2008, p. 294).

Parents understand best when healthcare workers use everyday terms rather than medical jargon. Talking at the patient’s level is most efficient and helps the parent to feel as if they understand the diagnosis, plan of care, and expected patient outcomes. “Eighty
six of the communication responses were categorized as communication leading to understanding. Being able to understand their child’s condition was the biggest accomplishment parents wanted during their hospital stay” (Latta et al., 2008, p. 294).

The second major study theme was participation. Latta et al. (2008) found that parents placed great importance on participating in the rounding process. Also, parents felt listened to, understood, and respected by the healthcare team. Parents felt like a member of the team and felt more comfortable when they were asked their opinion, their permission, or whether they had questions (Latta et al., 2008).

The third most common theme during the study was teamwork. “Seeing the team work together, hearing the discussion of their child’s care by the entire team, and being included as part of a team were mentioned 33 times in the course of the interviews” (Latta et al., 2008, p. 294). “Teamwork occurs when communication and participation coexist. Parents became active participants in the team-and in the child’s care. Negative feelings were reported when the rounding process was not implemented; parents did not feel they were part of the child’s health care decisions” (Latta et al., 2008, p. 295).

Latta and partners (2008) concluded that incorporating parents in the rounding process and the child’s care was viewed positively. Benefits of patient rounding were increased communication, active participation, teamwork, and satisfaction by the parents and the healthcare team. “All 18 participants described the overall experience as positive, and 17 of 18 described themselves as "comfortable" with inclusion in rounds.” (Latta et al., 2008, p. 295) Parents felt most comfortable when healthcare workers used simple, everyday language to discuss their child’s condition and plan of care. In this study, patient rounding increased parent satisfaction with the hospital and healthcare team.
A new trend evolving in the health care field is family-centered care. This care involves respecting and supporting the patient and family’s perspectives, decision making processes, and choices for care received. (Cypress, 2012, p. 53) The purpose of this article was to review research studies related to family presence on medical rounds; reviews that focused on both adults and pediatric patients in the critical and noncritical care settings. (Cypress, 2012, p. 53) This care delivery model accommodates family members by including them in the decision making process, recognizing their needs, supporting them as caregivers, improving their access to information, and providing comfort as needed. (Cypress, 2012, p. 53)

At the request of the Society of Critical Care Medicine and the American College of Critical Care Medicine (ACCM), the AACC task force of 2004 to 2005 developed guidelines to define evidence-based practices for support of families in the delivery of patient-centered care in the ICU. Family presence on medical rounds is one of the guidelines recommended by ACCM for the aspect of family-centered on the ICU. During the rounding process, the patient and family are engaged and become the focal point of care. (Cypress, 2012, p. 53)

For this study, a patient intervention-comparison-outcome (PICO) format was used to identify a specific question for literature review. The PICO question that guided this study is: “In critical and noncritical pediatric and adult patients (P), does family presence on rounds (I) compared with non-inclusion of family members (C) lead to positive outcomes and increased satisfaction (O)?” (Cypress, 2012, p. 53-54) A search of MEDLINE, CINAHL, OVID, Psych Info, and Cochrane electronic databases and Central Register from 1988 to 2010 was undertaken. This range of time covered 22 years of...
reviewed literature on the topic. Only articles in English were identified in the search. 
(Cypress, 2012, p. 54)

The review set forth several inclusion criteria. First, a report has to be about family presence on rounds in pediatric and adult critical and noncritical care units. Individual reports had to have experimental or non experimental designs, including qualitative, quality improvement (QI) reports, and systematic reviews. Articles that were not relevant to the key questions, outcomes of interest, or setting or that failed to meet specific methodological criteria were removed. Ninety percent of the articles reviewed were excluded from the sample. The studies for this review were judiciously selected by the researcher and her mentor, a doctoral prepared expert investigator with expertise in evidence based practice and knowledge translation. Each abstract was read, and duplicate articles were eliminated. Full copies of articles considered to meet the inclusion criteria were obtained for review and analysis and independently assessed for methodological quality using the Scottish Intercollegiate Guidelines Network (SIGN) 50 methodology checklist. A final selection was completed, and articles that did not meet specific clinical criteria were rejected. A total of 113 articles were reviewed, and 19 were included as samples. The results of the literature search represent 10% of the total articles reviewed. The newly revised SIGN 50 methodology was used for categorization of levels of evidence found in this review. (Cypress, 2012, P.55)

A total of 19 reports that met the inclusion criteria were selected for the review. These studies included 2 randomized controlled trial (RCTs), 1 quasi-experimental design, 12 observational studies, 1 qualitative descriptive, 1 mixed methods research, 2 QI reports, and 4 anecdotal notes. Eight prospective observational studies were conducted
in the PICU, 1 in the neonatal ICU, 6 in pediatric medical units, and 2 in an adult inpatient internal medicine ward. Of the 2 QI reports, one was a survey done in PICU, and one was in pediatric medical-surgical units. Sixteen study results were obtained through surveys, 2 used semi-structured interviews, and 1 study used survey and in-depth interviews. (Cypress, 2012, p.55-56)

Through this review of literature, the author found that family satisfaction was unanimously improved with the implementation of the rounding process. Families reported increased feelings of inclusion, respect, and having a better understanding of their child’s care. (Cypress, 2012, p. 56) One of the literature reviews, a study by Phipps and colleague (2007), found that family presence on rounds is beneficial, and it does not interfere with education and communication process. The authors concluded that families had a better understanding of the patient’s condition and plan of care. Nurses signified satisfaction with the communication and facilitation of relations with families. (Cypress, 2012, p. 56) Another study, by Cameron et al., (2009) conducted in a large, urban tertiary children’s hospital, concluded that the health care staff learned pertinent information from the parents when they participated in the rounds. Eighty-one percent of parents who chose to join the rounds reported that participation increased their overall satisfaction with their child’s care. (Cypress, 2012, p. 56) In a study by Latta and colleagues, (2008) inclusion of parents on rounds was also seen positively by parents in an inpatient medical unit at a large academic children’s hospital. Parents liked being included in the child’s plan of care, while having open communication with the healthcare team, and participating in the decision-making process. Jarvis and colleagues (2005) found that parents were very supportive of involvement in decision making for
their child because they learned more about their child’s history and health and had a greater opportunity to offer input (96%), ask questions, and be a part of the discussion. (Cypress, 2012, p.57) Nurses responded that family presence during the rounding process increased communication with families and increased sense of parent education. In a study by Bramwell & Weinding, (2005) most parents (73%) wanted to be present at rounds and viewed their participation to be an important dimension of their parenting role. (Cypress, 2012, p.57)

Family-centered rounds hold a potential to create a patient centered environment, enhance medical and nursing education, and improve patient outcomes. (Cypress, 2012, p. 63) These structured interdisciplinary family-centered rounds can improve patient and family satisfaction. Having family present during this rounding process may lead to positive outcomes such as increased communication with staff and physicians, patient and family autonomy, participation in decision making, formal discussions with physicians, increased positive attitudes and decreased family stress; all leading to increased satisfaction scores. (Cypress, 2012, p. 60)

**Rounding: Pain Management, Call Lights, & Patient Safety**

Satisfaction is the perception of the patient. Because nursing services play a major role in patient satisfaction, quality of care, and safety, organizations continually must seek new ways to improve these critical services. (Ford, 2010, p. 188) Hospitalized patients often require assistance with basic self-care tasks, such as using the toilet, ambulating, and eating, and usually communicate their needs by using the call light.
Therefore, a patient’s perception of the quality of nursing care largely depends on the nurse’s ability to meet the patient’s needs. (Meade et al., 2006, p. 59)

The impetus for the Meade et al study (2006) was twofold: to verify the authors’ observations as researchers and practitioners regarding the amount of time nurses spend responding to call lights and how this affects patient-care management, and to address the dearth of empirical evidence surrounding this topic, in order to better assist hospitals and nurses to improve daily operations and patient safety. (Meade et al., 2006, p. 59) One strategy called hourly rounding is a suggested method to address these issues (Studer Group, 2007). Hourly rounding is a new, proactive approach to organizing nursing care that has garnered positive results; its focus on patient-centered care has led to notably improved patient satisfaction scores. (Ford, 2010, p. 188)

The authors hypothesized that nursing rounds on medical, surgical, and medical–surgical units, conducted on a regular schedule by nursing staff that perform a specific set of actions, would (1) reduce call light use, (2) increase patient satisfaction, and (3) improve patient safety, as measured by the frequency of patient falls. (Meade et al., 2006, p. 60) The purpose of this study was to examine the frequency of call light usage, the reason behind the call light usage, and how 1 or 2-hour rounding affected the use of call lights, patient satisfaction, and safety (Meade et al., 2006, p. 60)

The design used for the Meade et al study (2006) was based on a quasi-experimental design with nonequivalent groups. Hospitals participated in the study if they met the following requirements: (1) Per Diem employees from outside agencies were 5% or less, (2) they had a medical surgical unit, and (3) the unit had a strong Nurse Manager who could endure the data collection process. Twenty-two hospitals (46 units) met the
requirements and participated in the study. All hospitals had a control group and an experimental group, with similar types of patients in each group. Fourteen states were represented in the study, representing both urban and rural populations. (Meade et al., 2006, p. 68)

There was a nonrandom assignment of hospital units to the experimental and control groups. The sample was stratified according to type of unit, unit size, and frequency of rounding. (Meade et al., 2006, p. 60) In this case, chief nursing officers and nurse managers at the participating hospitals assisted in the assignment of each unit to one of the three study groups: control, “one-hour rounding,” and “two-hour rounding.” (One-hour rounding was defined as rounds being performed once an hour between 6 am and 10 pm and once every two hours between 10 pm and 6 am. Two-hour rounding was defined as rounds being performed once every two hours during the entire 24-hour period.) The decision to perform one-hour or two-hour rounding was made by each hospital, after discussions with the principal investigator (CM), who ensured that the sample was stratified according to type of unit (medical, surgical, or combined medical–surgical), unit size, and frequency of rounding. In several cases, units were asked to change to a different rounding protocol to ensure that the sample was balanced. (Meade et al., 2006, p. 60)

There were two conditions in each experimental group: baseline measurement that lasted for two weeks and either one-hour rounding or two-hour rounding, which lasted for four weeks. The measurement of call light use was divided into two-week time periods so that the interventions (1-hour and 2-hour rounding) could be compared with the baseline. Therefore, at each hospital, the study lasted six consecutive weeks, and hospitals could
choose to begin at any time from January 15 to April 1, 2005, to minimize interference with hospital operations. Final data from all participating hospitals were collected by June 1, 2005. (Meade et al., 2006, p. 60)

Of the 22 hospitals (46 units) that participated in the study, data from eight hospitals (19 units) were excluded from analyses because of poor reliability and validity of data collection. Hospitals and units were excluded if rounding logs revealed that more than 5% of data elements were missing, suggesting that nursing staff members hadn’t consistently performed the rounding and, therefore, had produced unreliable data. (Meade et al., 2006, p. 62) Observations made in the first two weeks served as a baseline measurement of call light frequency and the reasons for call light use. (Meade et al., 2006, p. 62)

The rounding conditions were implemented over the next four weeks. All members of the nursing staff, including RNs, CNAs, LPNs, patient care assistants, and patient care technicians (PCTs), were required to perform specific actions during every patient interaction in both the one-hour and 2-hour rounding conditions. As is consistent with standard hospital practices, patients were not awakened if they were sleeping, during either day or evening hours, unless it was necessary for treatment. The control group units simply collected data on the frequency of and reason for call light use as it occurred for the entire six-week period. (Meade et al., 2006, p. 61-62)

Each unit implemented the rounding schedule that would best fit its staffing patterns and patient needs. However, on 95% of hospital units, CNAs, PCTs, or nursing aides rounded on the odd hours and RNs rounded on the even hours. Nursing staff members who performed the rounding were required to complete all patient-care tasks,
unless they weren’t authorized to dispense medication or work with IVs. Additionally, all hospital units in the experimental and control groups provided the principal investigator with internal patient satisfaction and safety data (the number of falls) for the month prior to the four weeks of rounding. The mean average daily census for the one-hour control unit was 24.6; one-hour rounding unit 22.7; two-hour control unit 29.8, and two-hour rounding unit 31.9. (Meade et al., 2006, p. 62)

Call light logs were used to record the time, room number, and reasons the patients used the call lights. Data on 108,882 instances of call light use were collected from 14 hospitals (27 units) over a six-week period: the mean number of call lights answered was 4,381.7 on the 15 experimental units (total number of call lights answered was 65,726) and the mean number of call lights answered was 3,596.3 in the 12 control units (total number of call lights answered was 43,156). (Meade et al., 2006, p. 62-63)

Each shift kept a call light log, where all call light requests from patients were received and recorded. This log was kept by a unit secretary, 24-hour communication centers, or nursing staff member. After responding to the call, the nursing staff would determine the reason for the call light usage and record that reason on the call light log. This reason, 1 of 26 designated reasons in the study, would be added and/or written on the call light log per instructions. (Meade et al., 2006, p. 63)

The top seven of the 26 individual reasons for call light showed no significant differences between the control and experimental groups. The 26 individual reasons for use of the call light were further classified into five “major reason categories”: No Reason/Miscellaneous (for example, “accidentally pushed call light” and “can’t understand patient on intercom at nursing station”), Room Amenities (for example,
“move telephone closer” and “room temperature adjustment”), Non-serious Personal or Health Issues (for example, “personal needs assistance” and “beverage request”), Secondary Medical Concerns (for example, “bathroom/bedpan assistance” and repositioning and mobility assistance”), and Serious Medical Concerns (for example, “iv problems/pump alarm” and “pain medication”). Between the control and experimental groups, there were no statistically significant differences in the proportions of call light calls made in each major reason category, indicating that the groups were comparable at baseline. (Meade et al., 2006, p. 63)

Nurse Managers reviewed the rounding logs and call light logs on a daily basis to ensure compliance with the research protocol; if necessary, took action to ensure compliance. Nurse Managers also verified that rounding was being performed by asking patients. Approximately 72% of the hospitals included in this study had existing internal checks and balances to verify the accuracy of the call light records. (Meade et al., 2006, p. 68) Binomial tests revealed significant reductions ($P = 0.007$) in call light use for the one-hour rounding condition across all three time periods and for all major reason categories, except in the weeks 3 and 4 and weeks 5 and 6 periods for the major reason categories Room Amenities and No Reason/Miscellaneous. There was a decline in call light use for the two-hour rounding condition from baseline to weeks 5–6. As with the one-hour rounding condition, binomial tests revealed significant reductions across all three time periods and for all major reason categories, except in the weeks 3 and 4 and weeks 5 and 6 periods for the major reason categories Room Amenities, No Reason/Miscellaneous, and Non-serious Personal and Health Issues ($P = 0.06$). (Meade et al., 2006, p. 64) Binomial tests also revealed a significant relationship ($P = 0.06$) in
reductions across all three time periods for call light usage after implementing the 1-hour rounding process. (Meade et al., 2006, p. 68)

Patient Satisfaction Surveys were also completed. The surveys in this included the Press Ganey, NRC, and + Picker Professional Research. Each of the surveys computed a mean patient satisfaction score that ranged from 0 to 100. Mean patient satisfaction scores were based on a 5-point Likert-type scale (1 = “poor” or “strongly disagree,” 5 = “excellent,” “very good,” or “strongly agree”). The results were transformed to a 100-point scale. (Meade et al., 2006, p. 68) The mean patient satisfaction score prior to implementing hourly rounding was 79.9/100. The mean score during the hourly rounding process increased to 91.1/100 (t = 736.58, P = 0.001). The mean patient satisfaction score prior to implementing the 2 hour rounding process was 70.4/100. The mean score during the 2 hour rounding process increased to 82.1/100 (t = 657.11, P = 0.001). Both of the results were significant, showing a positive relationship between 1-hour & 2-hour rounding and patient satisfaction. (Meade et al., 2006, p. 64)

Paired t-tests were used to compare falls prior to and during the implementation of the rounding process on both the control and experimental units. The authors gave no numbers or results except to say that the t-tests showed a significant reduction in falls only with the 1-hour rounding. (Meade et al., 2006, p. 64) The control group had 18 recordable falls in the four weeks prior to rounding; 17 recordable falls during the four weeks of rounding; no significance noted. The one-hour rounding group had 25 recordable falls in the four weeks prior to implementation of the process; 12 recordable falls during the four weeks of rounding; (t=3.074 and P = 0.01); a significant decrease. The two-hour rounding group had 19 recordable falls in the four weeks prior to
implementation of the process; 13 recordable falls during the four weeks of rounding; no significance noted. (Meade et al., 2006, p. 66)

The first hypothesis was supported: regular rounding during which nursing staff performed specific actions significantly reduced patient call light use. Patient satisfaction increased during application of the rounding protocol in both the 1-hour and 2-hour rounding groups. Specifically, nurses who conducted rounds hourly saw patients more often in a 24-hour period and patient satisfaction levels were higher for the 1-hour condition, when compared with the 2-hour rounding condition. (Meade et al., 2006, p. 64) Patient falls were significantly reduced only during the one-hour experimental rounding. While the number of falls did decline in the 2-hour rounding group, the finding was not statistically significant. (Meade et al, 2006, p. 65)

On a 1 year follow up, after the implementation of nursing rounds, the patient satisfaction scores reflecting the overall care on the unit rose from 79.9% to 88.8%; the percentage of excellent ratings rose from 38.2% to 80.1%; the reduction in falls totaled 60%. (Meade et al., 2006, p. 68) This analysis suggests that one-hour rounding has a positive effect on patient and nursing staff welfare.

There are many complications associated with patient falls in any kind of healthcare setting, both for the patient and for the healthcare system. The Joint Commission’s 2013 National Patient Safety Goals is used as a guideline Weisgram and Raymond (2008) believed that the most important factor in decreasing patient falls and call light usage is to increase nurse rounding on every patient.

The Joint Commission provides is an independent, not-for-profit organization, which accredits and certifies more than 19,000 health care organizations and programs in
the United States. The Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards. (The Joint Commission, 2013) The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them. (The Joint Commission, 2013) One of the Joint Commission’s patient safety strategy goals, goal 9, centers on decreasing fall rates. Reducing the risk of harm resulting from falls (Goal #9) became the focus of the Critical Care Section for the step-down telemetry unit. This unit was identified to have greater than 75% patient movement and a high turnover rate of nursing staff. The number of patient falls in the last year was the impetus for selecting this goal. (Weisgram & Raymond, 2008, p. 429) Weisgram and Raymond’s study (2008) examined if increasing nursing rounds would decrease patient falls, reduce the risk of harm resulting from falls, and decrease call light usage on a trauma center.

The conceptual framework for the Weisgram & Raymond study (2008) was based on a quasi-experimental design. The authors reviewed literature on reducing patient fall rates and decreasing patient call light usage. Weisgram & Raymond found a study that validated the use of nursing rounds as a strategy to decrease both patient fall rates and call light usage. (Weisgram & Raymond, 2008, p. 429)

This study replicated the Meade, Bursell, and Ketelsen’s (2006) study interventions. It was conducted on the Telemetry Ward of the Madigan Army Medical Center near Tacoma, Washington; a 204-bed level two trauma center. There was no sample described in the study. A timeline was created as a guideline for the project with goal dates for specific interventions. (Weisgram & Raymond, 2008, p. 429) Data
collection for call bell usage was initiated first using a convenient check sheet placed adjacent to call monitor at the nurse’s station. When the call bell went off, the nurse documented the time and the patient care issue. The staff annotated the time a call was received and the nature of the call by checking one of six categories, such as assistance getting to the bathroom, need for medication, need for a nurse, and other care issues. This report was tabulated daily and entered into a database to capture the number, type, and time of nurse calls in a 24-hour period to provide a sense of the demand the call bell system placed on the nursing staff. (Weisgram & Raymond, 2008, p. 429) The rounding process and the Meade et al. (2006) article were discussed with the staff during multiple sensing sessions prior to implementing the program. Champions of the program were identified to facilitate the implementation process, and to encourage their peers and co-workers to support the program. (Weisgram & Raymond, 2008, p. 430)

The Nursing Rounds program consisted of the nurse or designee performing a 12-step process related to the systematic approach to patient care that is typically taught in nursing education. This emphasis on a patient-centered, organized approach to providing attentive nursing care demonstrated the ability to reduce the potential for harm from falls and enhance patient satisfaction. During these rounds, nurses performed the 12-step patient-nurse interaction, including evaluations of pain, toileting needs, positioning, and access to call light, telephone, tissues, and trash can. The program consisted of hourly rounding between 8:00 a.m. and 10:00 p.m., and rounding every 2 hours between 10:00 p.m. and 8:00 a.m. A verbal agreement was made with the patient to have a staff member return every 1-2 hours. (Weisgram & Raymond, 2008, p. 430)
The 12-step Nursing Rounds checklist entailed informing the patient of the rounding process and assessing the patient’s mental health status. The 12 steps were as follows:

1. Assess patient pain levels using a pain assessment scale. If needed, contact an RN immediately for pain relief so the patient does not have to use the call light.
2. Put the medication as needed on RN’s scheduled list of things to do for patients and offer the dose when due.
3. Offer toileting assistance.
4. Ensure patient’s ID band is on and verify the patient’s identity by name and birthday. Verify the easy ID band is on.
5. Make sure the call light is within the patient’s reach.
6. Put the telephone within the patient’s reach.
7. Put the bedside table next to the bed.
8. Put the tissue box and water within the patient’s reach.
9. Put the garbage can next to the bed.
10. Assess the patient’s position and position comfort. Ask if patient needs to be repositioned and is comfortable.
11. Prior to leaving the room, ask, “Is there anything I can do for you before I leave? I have time while I am here in your room.”
12. Tell the patient that a member of the nursing staff will be back in the room making nursing rounds in an hour (or in 2 hours during the night).

(Weisgram & Raymond, 2008, p. 430)
The outcomes being monitored included call light usage, patient falls, patient satisfaction, and nurse adherence to the 12-step hourly rounds program. Patient call light usage decreased from 120 to 20 calls in a 24 hour period. Overall, the call light usage decreased by 23%. It was noted, that when nurses were not compliant with the hourly rounds program, the call light usage immediately jumped from 20 to 69 calls over one 24 hour period. The study stated that fewer falls have occurred during the first 30 days of the new program, but more data will be collected. Nursing adherence to the 12-step hourly nursing rounds program was 84-96%. (Weisgram and Raymond, 2008, p.430)

Based on the successful results to date, the 12-step hourly rounds program has been expanded to additional medical-surgical units within the facility. If the program is effective overall, the goal is to propose implementation of this program throughout the facility as an operational systems change in accordance with the Joint Commission’s National Patient Safety Goal #9. (Weisgram & Raymond, 2008, p. 430) Short term, the study shows that hourly rounding can make a difference on call light usage and patient falls; decreasing both. This program was found to be patient centered and allowed the nurse to have an organized approach to patient care.

Another analysis on hourly rounding, as related to patient satisfaction, call light usage, and patient fall rates, was executed by Olrich and colleagues in 2012. Hourly rounding can be an important strategy in giving quality patient care. In relation to variables of patient satisfaction, call light usage, and fall rates, a medical-surgical clinical nurse specialist (CNS) at a northeast hospital examined unit data regarding fall rates and patient satisfaction for a 15- month period and call light usage for a 4-week period. (Olrich et al., 2012, p. 23) Fall rate was 1.73- 3.37 per 1,000 patient days. Call light usage
data from the computerized data retrieval system showed 2,237-4,223 individual uses of the call light within a 2-week period. Of these calls, 57.75% were related to requests for toileting, pain management, personal needs, or comfort concerns such as positioning. Post-discharge patient satisfaction data showed 25% of patients were not highly satisfied nor would they definitely recommend the hospital to others. Data demonstrated significant opportunity for improvement. (Olrich et al, 2012, p. 23)

The CNS convened a team to identify interventions to improve patient fall rates, call light usage, and patient satisfaction scores. In addition to the medical-surgical CNS, the team included a geriatric CNS, two nurse managers, a nurse researcher, and a statistician. The team decided to replicate the study by Meade and colleagues (2006). For this study, Olrich, Kalman, and Nigolian (2012) implemented an hourly rounding intervention. The purpose of this study was to determine the effect of hourly rounding intervention on fall rates, call light usage, and patient satisfaction in an inpatient medical-surgical patient population. (Olrich et al., 2012, p. 23) The design, a quasi-experimental study on a rounding protocol, demonstrates improvements in the above variables. (Olrich et al., 2012, p. 23)

The site for this quasi-experimental study was a 506-bed teaching hospital in northeast United States. Informed consent of research participants was waived by the IRB because no patient identifiers were used and only aggregate data were reported. Two medical-surgical units were selected based on their similar size, significant fall rates, and mix of postoperative and medical patients. (Olrich et al., 2012, p. 25)

Data were collected for patient falls, patient satisfaction, and call-light usage prior to the implementation of nurse rounding. One unit was designated as the experimental
unit and one the control. The experimental unit was chosen based on the nurse manager’s strong desire to be involved in the study. In addition, the experimental unit served as its own control, with data compared before and during the intervention. (Olrich et al, 2012, p. 25)

The sample consisted of all patients discharged from the units during the 1-year study period (N= 4,418). Data concerning number of falls and level of patient satisfaction were collected for 6 months before the intervention and 6 months during the intervention using occurrence reports and post-discharge patient satisfaction surveys.

Call-light data were collected from the call-light retrieval system for 2 weeks before the study and 4 weeks during the intervention. Reasons for call-light usage were documented by nurses on a log similar to the tool used by Meade and co-authors (2006). (Olrich et al., 2012, p. 25) Each shift kept a call light log, where all call light requests from patients were received and recorded. This log was kept by a unit secretary, 24-hour communication centers, or nursing staff member. After responding to the call, the nursing staff would determine the reason for the call light usage and record that reason on the call light log. This reason, 1 of 26 designated reasons in the study, would be added and/or written on the call light log per instructions. (Meade et al., 2006, p. 63) Nurse Managers reviewed the rounding logs and call light logs on a daily basis to ensure compliance with the research protocol; if necessary, took action to ensure compliance. (Meade et al., 2006, p. 68)

Two weeks prior to implementing nurse rounding, all nurses and Unlicensed Assistive Personnel (UAP) on the experimental unit attended a CNS-led educational
session about performance of hourly rounding. Medical-surgical float pool RNs and UAPs were also trained on rounding during this time period. (Olrich et al., 2012, p. 25)

Hourly rounding was performed from 6:00 a.m. to 10:00 p.m. and included all eight actions for each patient:

1. Nursing staff enter room, greet patient, and say, “Hi, Mrs./Mr. Jones, I am here to do my rounds to check on your comfort.”

2. Pain assessment using a pain intensity scale (if staff other than RNs is rounding and the patient is in pain, RNs will be contacted immediately by the person rounding so the patient does not have to use the call light for analgesia).

3. An hour prior to analgesia is due; the patient will be asked if she/he is starting to feel pain. If the answer is “yes,” the RN will schedule analgesia administration.

4. Toileting assistance will be offered.

5. A patient positioning and comfort assessment will occur, including covering the patient if needed.

6. Environmental check
   - Call light within reach
   - Telephone within reach
   - TV control and bed light switch within reach
   - Bedside table close to bed
   - Tissue box and water within reach

7. Prior to leaving the room, each staff member asks, “Is there anything I can do for you before I leave? I have time to do it.”

8. Staff also will tell the patient when rounding next will be conducted (in 1-hour).
After each round, staff completed the log kept outside the door. From 10:00 p.m. to 6:00 a.m., rounding occurred every 2 hours. If the patient was asleep, staff completed the environmental check only. The nurse managers (NM) and CNSs routinely completed leadership rounds three times a week on the experimental unit to ensure staff completed hourly rounding. They asked patients if rounding was occurring, reviewed rounding logs, and reminded staff to round. Rounding also was discussed at every staff meeting. The NMs and CNSs worked to remove barriers to rounding to help in staff success. Four months after the start of hourly rounding, all staff on the experimental unit attended a 1-hour refresher course taught by one of the CNSs. This class reinforced rounding behaviors and gave staff feedback on the rounding process. (Olrich et al., 2012)

For data analysis, three variables were analyzed: patient falls, call-light usage, and patient satisfaction. Measures of central tendency and variability were calculated for all variables. Chi-square tests and rank sum tests were used to compare baseline and post-intervention demographic characteristics and reasons for call-light usage between experimental and control units. (Olrich et al., 2012, p. 25)

Before the study, 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 rounding intervention. While this was not significant statistically ($p=0.672$), the 23% reduction in falls was significant clinically. Patient fall rate on the control unit increased during the intervention time period. (Olrich et al., 2012, p. 25)

Analysis of means (ANOM) u-charts (SAS version 9.1) were generated to determine if statistically different rates of call-light usage occurred for pre-, initial, or
post-implementation time periods. Decision limits based on alpha = 0.05 were computed from the data. In ANOM, subgroups within the decision limits are not significantly different, while subgroups outside the decision limits are significantly different. Based on this analysis, a statistically significant call-light usage occurred during the first week of the intervention. However, a statistically significant rise in call-light usage occurred in the next 2 weeks due to one delirious patient. The final week of call-light data showed no statistically significant change. The small sample size used in this study made it difficult to validate a statistically significant change. (Olrich et al., 2012, p. 25)

The proportion of patients who indicated they were satisfied with their care on each unit before and after the intervention also was calculated and compared. No statistically significant differences \((p=0.383)\) occurred in patient satisfaction between the pre-rounding and post-rounding groups. These data were garnered from post-discharge patient surveys. While rounding did not affect the patient satisfaction on the discharge surveys, anecdotal evidence from the nurse leaders’ rounds showed increased patient satisfaction. (Olrich et al., 2012, p. 25)

Study findings suggest hourly rounding by nursing personnel positively impacts the three variables studied: patient fall rates, call-light usage, and patient satisfaction. Although not statistically significant, patient fall rates decreased 23% on the experimental unit. Satisfaction scores also have the potential for showing long-term positive gains based upon patient feedback during leader rounds. Patients who had frequent admissions to the unit noted a difference after implementation of hourly rounding. They perceived the nursing staff to be more attentive. Although statistically significant differences were not identified in call light usage or patient satisfaction during the study, researchers
anticipate continued improvement with persistent re-enforcement of rounding behaviors and data collection. (Olrich et al., 2012, p. 25)

Hospital-wide patient census also decreased during the study. No attributable reasons could be correlated with this decline. Because of this, many nurses from other units floated to the experimental unit. Because they were not trained to follow the rounding protocol and appreciate the importance of rounding, many of them did not perform rounding. Based on feedback from leader rounds, hourly rounding appeared effective when the patient trusted a staff member will return. Patients who did not trust this would happen were more apt to use the call light. With a large number of nurses floating from other units, this trust was broken many times. Floating of nurses to a rounding unit should be limited as much as possible, or all staff in the hospital should be educated in the hourly rounding protocol. (Olrich et al, 2012, p. 25-26)

The major limitations of this study were a non-randomized sample and the small sample size. Because the sample was small, an outlier impacted the study perhaps to a greater degree than if there was a larger sample. The outlier, a delirious patient, used the call light 187 times in a 6-day period. He did not need a nurse but, in his delirium, kept ringing the light. This biased the call-light data significantly for the 2nd and 3rd weeks of the intervention. If the data from this patient were eliminated from the study, a significant change in call light usage the 2nd week and a lower than average number of call lights the 3rd week would have been seen. (Olrich et al, 2012, p. 26) Hourly rounding has the potential to impact call-light usage, and may have demonstrated significance had the sample size been larger. Researchers also recognized the need for staff champions, the necessity of sharing results with staff in a timely manner, and the need to train all staff in
rounding procedures. Although staff members appeared supportive of hourly rounding, staff champions were not enlisted. Neither of the CNSs was based primarily on the experimental unit; both had responsibilities for other units. Second, the temporary transfer of the NM to another unit halfway through the implementation phase possibly affected the success of rounding. Without consistent support on all three shifts, achieving change became more difficult. Finally, technical difficulties with the call-light data collection system did not allow weekly data tracking throughout the study. Lack of immediate weekly feedback on the rounding effects was detrimental in keeping staff interested in rounding. Likewise, reports of falls were not received until almost 4 months into the rounding process. (Olrich et al., 2012, p. 26)

Results of the current study show potentially promising effects of hourly rounding on patient falls, patient satisfaction, and patient call light usage. If hourly rounding is implemented correctly and has sufficient documentation and follow through, it shows great potential to increase patient satisfaction, decrease call light usage, and decrease patient fall rates. (Olrich et al., 2012, p. 26)

**Narrative about Conclusions**

Through this research, Evidence Based Research on Nurse Rounding was reviewed. The variables most commonly studied included intentional hourly and 2-hour patient rounding and implementing the 4-P process, nurse satisfaction, patient satisfaction, call light usage, patient falls/injuries, mutual respect between physicians and patients, perception of teamwork, nurse-patient/family communication, and physician-patient/family communication.
The samples in the studies included patients, family members, and nursing staff members. The intentional patient rounding was provided by the nursing staff, nursing managers, physician assistant, medical students, surgeons, and physicians. The units discussed in the studies included Medical Surgical, Children’s Teaching Hospital, Acute Surgical Ward, and a Trauma ICU.

Different measurement tools were used, including patient and nurse interviews, questionnaires, Likert Scale, Practice Environment Scale of Nursing Work Index, patient satisfaction surveys (Press Ganey, NRC and + Picker Professional Research, HCAHPS), and call light logs. In the Gardner et al.’s study (2009), the effect of the comfort round intervention on nurse perceptions of the practice environment was measured using the Practice Environment Scale of the Nursing Work Index (PES-NWI), a previously validated Instrument .23–.25. In Mangram et al.’s study (2005), the average age, gender, ethnicity, and family member distribution of the sample was valid and reliable when comparing control and study groups to each other and was representative of the population. The limitation of Mangram et al.’s study was that a small percentage (22%) of families responded. This study did suggest that further studies are needed with larger control groups.

All of the studies showed evidence that intentional patient rounding, no matter what time the rounds were scheduled, it does make a positive impact on increasing patient/family satisfaction, increasing nurse satisfaction, decreasing call light usage, and decreasing patient falls/injuries. The collection of evidence, through research, displayed that mutual respect between physicians and patients was increased, perception of teamwork was increased, nurse-patient/family communication was increased, and
physician-patient/family communication was increased. More evidence must be
developed concerning patient rounding and the effects on patient satisfaction, call light
usage, nurse satisfaction, and patient falls/injuries. Future research needs to use reliable
tools, possibly simulated from previous studies and/or creating new and reliable tools to
measure the variables. This evidence based research is critical to patient care hospital
sustainability as new Health Care policies and plans come into effect.
Chapter III

Methodology and Procedures

Introduction

Patient satisfaction is crucial to any hospital when trying to maintain excellent patient service, patient loyalty, and financial stability. Blakley, Kroth, and Gregson (2011) believed that service excellence is the key driver to an organization's patient satisfaction levels. The purpose of this study is to examine if intentional nurse rounding, incorporating the 4-P Program, done at designated times, would have an effect on patient satisfaction. This is a modified replication of Blakley, Kroth and Gregson’s (2011) research, “The Impact of Nurse Rounding on Patient Satisfaction in a Medical-Surgical Hospital Unit”.

Research Questions

1. What is the impact of intentional, regular, and consistent nurse rounding on a patient's satisfaction with the hospital experience?
2. To what extent do nurses experience less call light usage if they regularly round on patients?
3. To what extent do patients report more effective pain management if nurses round regularly?
Population, Sample, and Setting

The study will take place in Greenfield, Indiana. This study will be conducted in an East Central Indiana hospital, in the Women & Children’s Department. The projected sample is 150 postpartum patients over a 6 month period. The unit will implement the Patient Rounding process every 2 hours from 7 am to 7 pm and every 4 hours from 7 pm to 7 am. The staff will check the patient’s 4 P’s (pain, position, potty, & placement) during the rounding process, as well as answer any patient/family questions. Inclusion criteria for patients are: adults at least 18 years of age, postpartum mothers, alert and oriented, and have agreed to participate in the study. The anticipated sample to be included in the study is 100 postpartum patients, 68% of the total available patient sample. The nursing staff consists of 30 full time registered nurses, 5 part time registered nurses, 2 lactation consultants/registered nurses, and 3 PRN registered nurses. The anticipated sample to be included in the study is 30 registered nurses, 75% of the total available staff.

Protection of Human Subjects

The research proposal will be submitted to Ball State University Institutional Review Board and the Hancock Regional Hospital Institutional Review Board (IRB) following all hospital and state Rules and Regulations. Permission for the study will be obtained from the IRB Committees, the Chief Nursing Officer, and the Director of Risk Management. The Director of the unit involved will be presented with the study’s research plan prior to implementation. All staff on the involved units will be informed in writing of the study purpose and measures, and educated as to responsibility and participation expectations. All patients involved in the study will be informed of the study
by the researcher and/or nursing staff during the admission process. Patient care and management will not be affected on any level. All data will remain anonymous. No patients, nurses, or staff will be identified. Participation is voluntary among the patient population and nursing staff, with no penalty among non-participants. Patient surveys will remain confidential. Hancock Regional uses the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey to measure patient satisfaction scores, so there are no anticipated risks to this study. The benefits of this study will be assessment and evaluation of the rounding process and the impact on patient satisfaction scores.

**Methods/Procedures**

The study will first be presented to, and approved by, IRB Committees, the Unit Director, Chief Nursing Officer, and the Director of Risk Management. Participation is not mandatory. Those interested will attend an informational staff meeting that will take place 4 weeks prior to the implementation of the rounding process with the Unit Director, 2 Unit Coordinators, and the nursing staff consisting of 30 full time registered nurses, 5 part time registered nurses, 2 lactation consultants/registered nurses, and 3 PRN registered nurses. The study details, time commitment, data collection, and the rounding 4P Program will be explained and discussed during this staff meeting.

Staff training meetings will be offered weekly on the unit at suitable times for all shifts to attend starting 4 weeks prior to the implementation of the rounding process. The meetings will be 15 minutes in length. The content of the training will include the current HCAHPS patient satisfaction scores, the purpose of the study, the 4P rounding
program method, supporting evidence based practice guidelines, the 6 month research study period, rounding data collection tools, and question/answer time. The researcher will monitor the nurses during a “practice run” of the 4P rounding process prior to the nurses’ participation in the study.

The unit will implement the Patient Rounding process every 2 hours from 7 am to 7 pm and every 4 hours from 7 pm to 7 am. The staff will check the patient’s 4 P’s (pain, position, potty, & placement) during the rounding process, as well as answer any patient/family questions. During the 4P rounding, the nurse will:

1. Explain the 4P rounding process to the patient on admission or during the first rounding intervention.

2. Subsequent rounding will be started with the statement, “Is there anything you need?” The nurse will focus on the patient’s 4P’s (pain, position, potty, & placement). Actions to be taken by nursing staff during rounding include:

   a. Assess patient pain levels using a pain assessment scale.
   b. Offer medications as needed or offer dose when due.
   c. Offer toileting assistance.
   d. Assess the patient’s position and comfort and ask if there is a need for repositioning.
   e. Make sure the call light, phone, bed light switch, and TV remote control is within the patient’s reach.
   f. Place the bedside table next to the bed; within the patient’s
reach.

g.  Place the Kleenex, water, personal items, and garbage can within reach of the patient.

3. Prior to leaving the room, the nurse will ask, “Is there anything else I can do for you before I leave?” The final comment, prior to leaving the patient’s room, will be “Someone will be back within (2 hours/4 hours) to round again and check on you.”

4. Staff will initial the Rounding Log kept at the nurse’s station and will checkmark each area of care addressed during the rounding process.

5. For call light usage before, during, and after, nurses will keep a call light log at the nurse’s station to record the nature of the patient’s need in using the call light.

6. Patient will complete the HCAHPS survey within 48 hours -1 week following discharge. Data will be uploaded by the Unit Director, which will then be placed into graphs and shared with the staff, Chief Nursing Officer, Director of Risk Management, and researchers.

(Blakley et al., 2011)

**Description of Instruments**

Call light logs will be started 6 weeks prior to the study’s implementation of the 4P rounding process, to see how often and for what need the patient uses the call light. The call light logs will be kept during the 6 month intervention period to compare results, pre and post intervention. The call light logs will be kept at the nurse’s station near the intercom system. When a patient calls out, the RN will record the need/concern
on the call light log. The call light log will be printed on pink paper to insure distinction for any other paperwork. Completed Call Light Logs with documentation for each calendar day (24 hours) will be collected and submitted to the unit director on a daily basis. The results will be shared with the Unit Director, Chief Nursing Officer, Director of Risk Management, nursing staff, and the researcher.

Rounding Logs will be in a table format that allows documentation addressing each patient need with staff initials every 2-4 hours; per protocol of the research study. Rounding Logs will be posted at the nurse’s station; in compliance with HIPPA regulations. The rounding logs will be printed on blue paper to insure distinction from any other paperwork. Completed Rounding Logs with 2-4 hourly documentation for each calendar day (24 hours) will be collected and submitted to the unit director on a daily basis. The results will be shared with the Unit Director, Chief Nursing Officer, Director of Risk Management, nursing staff, and the researcher.

Hancock Regional Hospital uses the Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS), an independent site, which was endorsed by the National Quality Forum in 2005. (HCAHPS, 2012) The HCAHPS survey is administered to a random sample of adult patients across medical conditions between 48 hours and six weeks after discharge and the hospital-level results are publicly reported on the Hospital Compare website four times a year. (Medicare, 2013) Unit directors have monthly access to individual unit scores. These scores will be posted by the Unit Director and shared with Chief Nursing Officer, Director of Risk Management, nursing staff, and the researcher.
Data Collection

For data collection, rounding logs will be kept and completed per nursing staff. Call light logs will keep record of call light usage prior to and following the implementation of intentional patient rounding on the unit. Patients will receive a survey to determine their overall level of satisfaction with the care received. The targeted areas for the survey will be the following: Nursing Staff Courtesy & Friendliness, Pain Control, Overall Level of Safety, Overall Teamwork between Doctors, Nurses, and Staff, and Overall Quality of Care. The findings of this study will determine if intentional patient rounding to check the patient’s 4 P’s, done at designated times, will have any effect on patient satisfaction scores.

Conceptual Framework

The conceptual framework of this study will be based on Stringer’s Action Research Framework of Look, Think, and Act Model (2007). Stringer defines Action Research as “a systematic approach to investigation that enables people to find effective solutions to problems they confront in their everyday lives”. (Hansen & Brady, 2011, p. 82) Action research centers on finding the answers to real life problems encountered by actual people. The foundation of this framework includes, in the following systematic order: Look, Think, and Act. The Look component involves assessment and data acquisition. The Think component encompasses reflection, evaluate, and review. The Act component includes planning, implementation, and evaluation. The framework is a never ending process; a constant cyclical framework. (Mertler & Charles, 2011, p. 15)
Research Design

This is a quasi-experimental study using a non-randomized parallel group trial design (Meade, 2006). A quasi-experimental design relates to a particular type of study in which one has little or no control over the allocation of the treatments or other factors being studied. It is a research method similar to an experimental design except that it makes use of naturally occurring groups rather than randomly assigning subjects to groups. (Burns & Grove, 2009) The effect of the intervention of intentional rounding (independent variable) and the patient satisfaction outcome (dependent variable) will be examined in this study. Patient satisfaction HCAHPS scores from both before the rounding model was implemented and after the study’s completion will be analyzed and compared.

Method Data Analysis

Descriptive statistics will be used to calculate the rounding log and call light usage log before and after implementation of the 4P rounding process. The t-test will compare means (before & after implementation) from the scores of each log. A t-test is a parametric analysis technique used to determine significant differences between two samples. (Burns & Grove, 2009, p. 726)

Summary

The purpose of this study is to test the effectiveness of an intentional 4P rounding process that has previously been proven, by evidence-based studies, to have a positive impact on patient satisfaction. Implementation of purposeful rounding by nursing staff has the potential to positively influence patient safety, patient satisfaction,
call light usage, and pain control. It is a quasi-experimental post-test non-randomized parallel group trial design. Patient satisfaction will be trended pre-study and post-study and analyzed for effects of the hourly rounding intervention. The instruments used will be the HCAHPS patient satisfaction survey, a Rounding Log, created to measure performance and compliance, and a Call Light Usage Log, created to measure the top reasons patients utilize the call light. The results of this study will provide information and guide future decisions on evidence based practices to improve patient satisfaction scores.
References


