Walden University

College of Health Sciences

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Tina E. Vaughn

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Dr. Patricia Schweickert, Committee Chairperson, Health Services Faculty
Dr. Amy Swango-Wilson, Committee Member, Health Services Faculty
Dr. Faisal Aboul-Enein, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2014

Abstract

Impact of Nurse-Initiated Intentional Rounding on Patient Satisfaction Scores on a

Surgical Unit

by

Tina E Vaughn

MSN/Ed, Walden University, 2006

BSN, National University, 2003

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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August 2014

Abstract

This project focused on nurse-initiated intentional rounding (NIIR) as a new nursing approach to patient care. NIIR anticipates the needs of patients as nurses perform hourly checks on their patients, thereby improving the overall patient experience, and increasing patient satisfaction. This DNP project included a summative program evaluation of the use of NIIR on a 33-bed surgical unit *(N = 629 patients)*, guided by the John Hopkins Nursing Evidence-Based Model and Guidelines (JHNEBP). The program evaluation included comparisons of mean patient satisfaction scores 3 months prior to implementation of NIIR, and 3 months after implementation. The results of the evaluation showed an increase in overall mean satisfaction scores after implementation, with improvement in all 10 care dimensions. The highest percent increases in satisfaction scores were related to dimensions of cleanliness/quietness (47.5% increase), overall hospital rating (27.8% increase), would recommend hospital (23.9% increase), communications concerning medication (22.1% increase), and pain management (21.8% increase). The results were translated into visual scorecards for a dashboard view to be presented to stakeholders of the organization. NIIR can change the way nursing care is delivered, from a type of reactionary delivery of care to a proactive, patient-centered focused care. NIIR aligns with the Institute of Medicine goals of supporting patient centered care, keeping the patient informed, encouraging patient participation, and returning control of healthcare choices to the patient. NIIR promotes social change as a new model of nursing care, meeting the patient's needs proactively and improving the patient's overall hospital experience.

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Dedication

I dedicate this body of work, first and foremost, to my Lord and Savior Jesus Christ, and to His Holy Spirit, which has guided me and given me the knowledge, skills, and endurance needed to complete this doctoral journey. I also dedicate this work to my husband, Ken, who has loved me and supported me throughout this DNP process. I could not have completed my degree without his patience, encouragement, and ever abiding love. Thank you, sweetheart, for your eternal love, to the moon and back, many times over.

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Section 1: Overview of the Evidence-Based Project

Introduction

Hospitals today are facing significant challenges with declining reimbursements and the rising financial costs in the delivery of healthcare. Multiregulatory agencies such as the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), and the Agency for Healthcare Quality (AHRQ) are mandating hospitals to meet standards of reimbursement models, which are based upon the performance of nursing staff in the delivery of patient care (Brown, Donaldson, Burns-Bolton, & Aydin, 2010). These reimbursement models are also referred to as pay-for-performance initiatives, which are considered to be a check and balance type of system, requiring healthcare organizations to meet quality benchmarks.

The performance of the hospital's overall organization and the pay-for-performance initiatives serve as drivers to improve the quality of patient care by providing financial incentives to healthcare organizations specific to patient safety and patient satisfaction (Sura & Shah, 2010). If healthcare organizations do not meet quality benchmark standards or at least show an improvement in an area related to a quality of care benchmark (such as in patient satisfaction scores), hospitals will then be given a reduction in financial reimbursement for care delivered or be denied financial reimbursement all together. Both CMS and TJC have endorsed pay-for-performance initiatives in order to (a) facilitate reduction of hospital-acquired infections (HAI), skin breakdowns, and ventilator-acquired pneumonias (VAP), catheter-associated urinary tract

infections (CAUTI); and (b) increase patient safety, increase patient satisfaction, and demonstrate an overall improvement in the quality of care delivered.

Hospital leadership across the nation are seeking a variety of measures to improve the quality of care delivered, in an era of declining revenues and increasingly expanding pay-for-performance initiatives, correlated to patient quality outcomes and more specifically to patient satisfaction. Nurse-initiated intentional rounding (NIIR) is one such measure that follows the recommended guidelines of the Institute of Medicine (IOM, 2010) supporting successful care, which is centered around meeting the patient's needs, keeping the patient informed, encouraging patient participation, and returning to the patient control in his or her health care choices.

Problem Statement

Hospitals today are facing significant challenges with declining reimbursements and the rising costs of healthcare. Reimbursement models are based upon the hospital's performance in the delivery of care including patient safety and patient satisfaction (Brown et al., 2010). Healthcare organizations are competing for patients; at the same time, they are expected to deliver quality of care that is measurable as well as meets the pay-for-performance initiatives. One of the more recent pay-for-performance initiatives facing healthcare organizations is that of patient satisfaction. Healthcare organizations are examining models of nursing that will increase patient satisfaction scores, as well as deliver quality of care and increase patient safety. NIIR is one model of care that may be considered to improve patient satisfaction scores. To determine the effectiveness of this model, the effects of NIIR on patient satisfaction scores were explored in this DNP

program evaluation. NIIR is a descriptive, systematic process that is directed towards the overall care of the patient in an acute care setting, with the goal of improving quality of care, increasing the efficiency of the staff, and increasing the overall safety of patients (Upenieke, Akhavan, & Kotlerman, 2008).

Purpose Statement and Project Objectives

The purpose of this project was a program evaluation to determine whether the implementation of NIIR by nursing staff on a 33-bed surgical unit has a positive effect on improving patient satisfaction scores. The need for implementing this program evaluation was determined through observation of declining patient satisfaction scores in the previous 6 months, as reported by the National Research Corporation (NRC, 2013). NIIR has been shown in some literature to increase patient satisfaction through decreasing the number of patient falls, medication errors, and negative patient care outcomes and improving the patients' perception of their hospital experience (Meade, Bursell, & Ketelsen, 2006). The IOM (2010) has suggested that all healthcare organizations have a plan in place, to improve the health care of all patients. NIIR may be a step to establishing a methodology of assessing patients' needs routinely, thereby improving their satisfaction and improving the healthcare organization's patient satisfaction scores. The objective of the DNP project was to evaluate the effects of NIIR as a new nursing practice process and to determine whether NIIR has a positive effect on improving patient satisfaction scores.

Significance to Practice

NIIR is a process that healthcare organizations may consider using in order to improve patient safety, improve clinical outcomes, and improve patient satisfaction scores. Hospitals are facing a growing interest and pressure by the consumer over the quality of care that is being delivered to them, including the issues of patient safety. The premise of pay-for-performance is based upon the preventable outcomes of patients admitted to hospitals for care. Examples of preventable outcomes are the acquisition of a new disease, an infection, a skin breakdown, or a fall that occurs during hospitalization (AHRQ, 2011). Diseases such as methicillin-resistant Staphylococcus aureus (more commonly known as MRSA), VAP, urinary tract or intravenous line infections, and poor pain management are further examples that reflect preventable patient outcomes in most cases (AHRQ, 2011). These adverse patient outcomes are believed to be a reflection of poor nursing care and are deemed preventable by multiregulatory governmental agencies (AHRQ, 2011).

NIIR is a process of purposeful, directed communication and evaluation of patient needs proactively during hourly rounding (Haack, 2009). In NIIR, the nurse anticipates the patient's needs through hourly checks instead of waiting for the patient to alert the staff to his or her needs. The NIIR process allows the nurse to address patient needs, including the patient's pain and the need to use the bathroom, and allows evaluation of skin and surgical wounds and invasive tubes such as urinary catheters, nasogastric tube, and chest tube or wound vacuums. Checking intravenous lines for patency and intact dressings, as well as checking IV pumps, solution bag levels, and patient positioning are

all additional areas of patient assessment addressed when nurses practice NIIR (Berg et.al.2011). Not only does this directed communication and proactive patient evaluation improve quality of care, but it also may contribute to improved patient satisfaction (Ford, 2010).

Patients are viewed as customers, or consumers, and monetary reimbursements to hospitals can be based upon quality driven benchmarks, such as in the case of patient satisfaction scores, which are directly correlated to the performance of the staff. Patient satisfaction is growing critical to acute care hospitals within an industry that has become increasingly competitive to capture revenue (Tea, Ellison, & Feghali, 2008). The effect of NIIR on patient satisfaction scores was explored in this DNP program evaluation. NIIR is a systematic process that is directed towards the overall care of the patient in an acute care setting, with the goal of improving quality of care, increasing the efficiency of the staff, and increasing the overall safety of patients (Upenieke, Akhavan, & Kotlerman, 2008). Program evaluation of NIIR is needed to provide evidence that there is a direct correlation between NIIR as a new nursing change process resulting in positive patient satisfaction scores. Program evaluation is an essential component in the translation of evidence into clinical practice (Gawlinski, 2007).

Project Question

The project question for this program was whether implementation of intentional rounding for patients on a surgical unit by nursing staff improved patient satisfaction scores.

Evidence-Based Significance of the Project

The evidence-based significance for NIIR is growing. Although the current literature is fairly limited, it is clear that further evidentiary studies should be pursued (Kolin et al., 2010). NIIR supports the healthcare partnership between the patients and their healthcare providers, and the nurse appears to be a critical indicator of the patient's perception of not only the hospital experience, but of the care received (Ford, 2010). Shared decision-making and the interaction between the nursing staff supporting NIIR, along with improved communications with patients and their families, appears to be significant in improving patient satisfaction scores.

NIIR has additional benefits such as increasing patient safety; decreasing the number of hospital-acquired infections, such as MRSA, ventilator-acquired pneumonias, urinary tract or intravenous line infections, and skin breakdowns (pressure ulcers); and decreasing falls that occur during hospitalization, which is very significant to both the patients and the healthcare organizations. NIIR can also support consistency and continuity of the patient care delivered, resulting in positive patient outcomes and improved patient satisfaction scores (Leighty, 2006).

Implications for Social Change in Practice

The implications for NIIR to be a catalyst for social change may be significant. Acute care hospitals across the United States (and internationally) are looking at ways to improve the quality of care delivered to their patients, as well as to increase the satisfaction to the patients by enhancing their overall experience during their hospitalization. The Centers for Disease Control and Prevention (CDC, 2005) have

reported the rising costs of falls with injuries to patients may reach over $43.8 billion by 2020. Research has shown that NIIR has been a significant factor in decreasing the number of patient falls (Ford, 2008). The improved patient safety, along with the decreased number of patient falls, may translate to a substantial decrease in expenditures for accidental injury and/or death of patients and result in cost savings to the healthcare organization.

NIIR can increase not only the patient satisfaction, but also the satisfaction of the nursing staff who are involved as frontline providers of patient care. Nurses are trained to do no harm and to support their patients, not only as care providers, but also as advocates for change. NIIR can become a standard of nursing care across the nation and in all acute care settings, just as taking a set of vital signs or inserting an IV has become a standard of nursing care. NIIR can become a best practice in nursing care delivery and can result in a positive relationship between patients and staff within the practice environment.

Definition of Terms

Intentional rounding (IR) and Nurse-initiated Intentional Rounding (NIIR): The concept of intentional rounding (IR), or hourly patient rounding, is described by Woodard (2009) as occurring every one to two hours, with specific attention to the patient's needs for pain medication, positioning in bed, toileting needs, and presence. IR is a process of purposeful, directed communication and evaluation of patient needs proactively during hourly rounding. In NIIR, the nurse anticipates the patient's needs through hourly checks instead of waiting for the patient to alert the staff to his or her needs.

Rounding: Requires healthcare professionals to adopt certain behaviors that carry out scheduled checks of patients.

Rounding communication: A set dialogue script, which addresses the needs of the patient as noted previously and concludes with a question by the nursing staff, such as, "Is there anything else I can do for you? I have the time." This purposed question assures the patient that the nursing staff always has time to care for the patient.

AIDET: A five-step process or communication tool to enhance dialogue between staff, patients, and their families. The process includes the following:

A: Acknowledge everyone in the room.

I: Introduce yourself, making eye contact.

D: Duration of the procedure.

E: Explain all of testing.

T: Thank the patient and show your appreciation (cite).

Surgical unit: One unit of the hospital in this study, consisting of 33 beds, that provides care for patients preoperatively and postoperatively. Care provided may range from basic nursing care to complex nursing care. The average length of stay per patient in this unit is 3.5 days.

Patient: The patient refers to either a male or female adult or minor child who has been admitted to the surgical unit as an inpatient. Patient satisfaction scores for minors are dependent upon the legal guardian's response to the survey and not the minor.

Patient satisfaction: The concept of patient satisfaction is the satisfaction of the patient as it relates to the quality of care provided. The measurement of patient satisfaction in this study was the Hospital Consumer Assessment of Healthcare Providers and Systems Hospital Survey (HCAHPS) survey measurements, indicating patient

satisfaction scores are meeting benchmarks, exceeding benchmarks, or falling below benchmarks, as set by the organization. HCAHPS scores reflect patient satisfaction quantitatively.

Consumer Assessment of Healthcare Providers and Systems Hospital Survey, *(HCAHPS)*: The HCAHPS survey includes 27 items, of which 18 contain aspects related to the hospital experience; however, only 10 of these measures are publicly reported by CMS: nurse communication, physician communication, responsiveness of hospital staff, pain management, communication about medications, discharge information, cleanliness of the hospital environment, quietness of hospital environment, overall rating of hospital, and willingness to recommend hospital.

Hourly rounding documentation log: An auditing tool utilized by the nursing staff to document that IR has taken place (see Appendix A).

NRC Picker: A National Research Corporation, founded by Harvey Picker, MD, and Harvard Medical School. NRC -Picker is a third party surveyor company, hired by healthcare facilities to survey discharged inpatients on a monthly basis. Surveys may be done by phone, e-mail, or traditional mail and follow the HCAHPS questions mandated by federal legislation, specific to patient experiences of care delivered during hospitalization. Survey results are publicly reported at www.hospitalcompare.HHS.gov. NRC - Picker is an HCAHPS-approved vendor, having met the HCAHPS participation requirements in order to administer the HCAHPS survey.

Value –Based Purchasing: A CMS initiative that rewards acute care healthcare organizations with incentive payments based on the quality of care they deliver to

Medicare patients. Public reporting and financial incentives for improved performances serve as a driver to improve clinical quality, patient centeredness, and efficiency.

Nursing Care: The delivery of cost effective quality care to all persons, regardless of culture, religion, or ethnic background, addressing the spiritual, emotional, and physical well-being of the person as a whole individual, while following the guidelines of the organization's mission statement, values, and vision.

Nursing staff: Nursing staff for this IR pilot study were defined as registered nurses, clinical supervisors, charge nurses, patient care techs, nursing assistants, and unit secretaries.

Assumptions

In this program evaluation of NIIR and its effect on patient satisfaction scores, I assumed that the nursing staff and their application of NIIR, in conjunction with their nursing interventions, would have a direct influence on the level of satisfaction experienced by the patient. In addition, it was assumed that the nursing staff, and the application of their intentional communication with both patients and the patient's family, would have a direct influence on the level of satisfaction experienced by the patient and the patient's family. The nursing staff and their positive attitude towards application of NIIR and patient care were assumed to have a direct influence on the level of satisfaction experienced by the patient. It was also assumed that assigned staff remained consistent with the process of NIIR when utilization of float nurses might have occurred. Float nurses were assumed to have support in the process of NIIR by charge nurses and the clinical nursing supervisor of the surgical unit to ensure that the NIIR process continues

as designed. The final assumption was that the nursing staff were engaged in the process of NIIR and that NIIR was perceived as a benefit to the staff, as well as to the patients and their families. The program evaluation of NIIR showed that NIIR has a direct positive effect on increasing patient satisfaction scores.

Limitations

The program evaluation of NIIR was limited to one surgical 33-bed unit in one small community hospital. Stakeholders, such as leadership, as well as front line nursing staff, might have had formed opinions, or preconceived ideas, or even previous experiences, which possibly could have had an unknown influence on the results of the program evaluation of NIIR. The program evaluation was limited to the sample size of patients surveyed at one hospital and on one specific unit. The healthcare organization limits the applicability of the findings in this study to other inpatient units, other healthcare settings, or other states. Program evaluation of NIIR and the effects on patient satisfaction scores were reflective of only former inpatients who voluntarily responded to the NRC Picker survey and who were patients on this one 33 bed surgical unit.

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Summary

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Patient satisfaction has become a governmental mandated pay-for-performance initiative (Sherrod, Brown, Vroom, & Sullivan, 2012). Patient satisfaction scores appear to be directly correlated to the overall performance of the nursing staff. The nursing staff appears to be an essential component or indicator of the overall performance of acute care hospitals in their delivery of care, within an industry that is already increasingly competitive to capture revenue (Tea et al., 2008). NIIR is a process that invites patients

into an interaction with their nurses and other nursing staff through hourly checks of the patient that may also include a scripted dialogue, utilizing the steps of AIDET in order that no patient need is left unaddressed. Examples of patient needs would be (a) if they had any pain, (b) if they needed to go to the restroom, (c) if they needed to be repositioned in the bed, and (d) the environment of the room, whether it is too hot or too cold. NIIR takes place every hour, and on every shift, with the only exception being if the patient is away from the unit or is sleeping (Sherrod et al., 2012). Therefore, it was important to evaluate whether this program of NIIR has met the goals of improving patient satisfaction scores.

Section 2: Review of Scholarly Evidence

Literature Review

For this literature review, I used MEDLINE, PubMed, and Cumulative Index of Nursing and Allied health literature (CINANHL) and Nursing and Allied health sources. Search terms used were the following: *intentional rounding*, *hourly rounding*, and *patient satisfaction, patient satisfaction scores, patient's perceptions, nurse and patient communications, nurse to patient relationships, and program evaluation of hourly rounding*. The utilization of these terms yielded numerous articles related to intentional rounding, hourly rounding, patient satisfaction, hospital regulations, and consumer awareness.

Today's healthcare consumers are requiring more complex care, which results in a growing demand on healthcare providers to meet the needs of patients in providing safe and cost-effective quality care (Lueckenotte & Conley, 2009). Healthcare organizations

are looking at ways to improve their customer service, based upon the relationship

between their staff, the environment of their organization, and the patients' perceptions of

their experience while hospitalized (Wooley et al., 2012). The body of evidence

underlying the practice of IR is fairly new, but it is growing, and pay-for-performance

initiatives are serving as drivers for healthcare organizations in improving the quality of

care being delivered.

Outcome measurements based upon patient satisfaction scores are the most

currently used methodology in pay-for-performance initiatives within acute care

facilities. Evidence-based nursing practice reviewed in the literature appears to be in

general support of IR, not only as an adjunct to improving patient satisfaction scores, but

also as a tool in improving communication between staff, patients, and patient families.

The literature review lends itself to support of IR in reduction of falls, skin breakdowns,

and urinary tract infections and decreased call light usage (Neville, Lake, & LeMunyon,

2012). There is also literature that magnifies the role of the nurse as a critical indicator or

measuring stick when it comes to quality improvement efforts (Wattenbarger, 2013, p. 6).

The role of the nurse has led healthcare organizations to explore creative ways to market

their nurses, and other employees, in order to meet the pay-for-performance initiatives in

improving patient satisfaction scores.

Patients develop perceptions of a healthcare organization from the first time they

enter into the healthcare system, during their time of stay, and up to the time of discharge.

These perceptions are often determinants of the overall care received. IR was developed

by the Studer group (Studer, 2005) as a technique to organize one's current workflow,

with an additional goal of increasing customer service, resulting in customer satisfaction.

Patient's perception of satisfaction or dissatisfaction with care appears to be directly

related to a nurse's responsiveness to the patient and whether the nurse offers any

comforting measures (Castledine, Grainger, & Close, 2005). There appears to be certain

commonalities with the process of intentional rounding across all healthcare settings

(Deitrick, Baker, Paxton, Flores, & Swavely, 2012). For example, during IR, the nurse

begins by introducing him or herself to the patient and explains the process of IR. During

each visit by the nurse to the patient on the hour, the nurse will assess the patient's

comfort and personal needs, such as toileting, repositioning, pain, and the environment of

the room (too cold or hot). At the conclusion of each visit, the nurse is to address the

patient, asking one last time if there are any unmet needs.

The role of the bedside nurse is a critical indicator in how the patient views the

hospital experience, and translates to reimbursement monies for healthcare organizations.

Ford (2010) asserted that the patients value their nurse to patient relationship, including

the amount of time a nurse is at the patient's bedside, and that IR is a strategic tool to

improve patient satisfaction scores. The idea is that IR is more than just a checklist

(Mason, 2012); when IR is utilized by nursing staff, there is a reduction in patients using

their call lights because the patient's needs are being anticipated, and patient outcomes

are improved through proactive intentional care. Mason (2012) suggested that the nurse

recognizes patient care issues earlier than other practitioners because of the time spent

rounding on the patient and that IR should be the foundation of all patient care delivered.

Nurses proactively taking care of patients leads to better care by anticipating the patient's needs. The patient's hospital experience will often depend upon the nursing staff and the care they delivered (Meade, Bursell, & Ketelsen, 2006). Meade et al. (2006) conducted a 6-week nationwide study in a quasi-experimental, nonequivalent group design, where baseline data were taken during the first 2 weeks. Data were collected and analyzed from 27 nursing units in 14 different hospitals where nursing staff performed IR, either at one or 2-hour intervals, following a very specific protocol. Their findings reflected a statistical reduction in patient's use of call lights, reduction in falls, and increase in patient satisfaction scores.

The relationship between the staff and the patient appears central to the outcomes of hourly rounding, and patients have reported a stronger connection with greater communication and a sense of their needs being met by the nurse who cared for them (Abraham, Fillmore, & Sobaski, 2008). Several studies have shown that when focused IR is done, that patients experience greater pain management and safety (Haack, 2009) by nursing initiated questions regarding the patient's comfort and need for analgesic relief.

Healthcare organizations today are competing for patients, now referred to by many organizations as *customers*. Customer service is a critical driver in patient satisfaction scores, and there appears to be a relationship between patient satisfaction scores and IR, resulting in financial gain for the organization (Blakely, Kroth & Gregson, 2011). Customer service has driven many healthcare organizations to look for outside help from healthcare to customer service training organizations, such as the Quint Studer Group. Creating service improvement as a practice change introduces the nursing staff to

the reasons why customer service, and improving customer service, is so critically important to patient satisfaction scores (Gage, 2013).

The means to improving the delivery of quality care in today's competitive healthcare organizations requires a cultural change in which all members of the healthcare team engage in creative ways to meet the patients' overall needs (Mullan, 2007). Education to the process of IR is critical to staff engagement, as well as for consistency in staff participation in the implementation and the practice of IR (Hutchings, Ward, & Bloodworth, 2013). Because improving customer service is foundational to improving patient satisfaction scores, the leadership of the healthcare organization are key stakeholders in leading the changes that are needed when implementing IR as a new practice. All change requires planning, and strategies that would lead to sustainability from the very onset of planning a change (Parsons, 2011), and must include early engagement of staff.

Nurses have reported that a critical element to successful implementation of IR is the support and inclusion of the nurses and the leadership, from the onset of the planning stages of IR through the completion of implementation of IR (Bourgault et al, 2008). The healthcare team members should share in a common goal of improving the quality of care delivered, by sharing the same vision, within a caring environment that supports an exchange of ideas (Taylor, 2007).

The process of NIIR supports meeting the patient's needs by nurses becoming proactive, as opposed to reactive, in their approach to patient care when meeting the patient's needs. Blakely, Kroth, and Gregson (2011) supported this by their research

conducted on a medical surgical inpatient unit, where data were collected through a variety of means (i.e., observation, surveys, interviews, and patient satisfaction data obtained from HCAHPS scores that were updated and published quarterly). The results supported that IR did increase patient satisfaction scores.

The concepts of NIIR, to some, may be viewed as nothing new, but that NIIR is just experiencing a revival in hospitals today due to required benchmarking and pay-for-performance initiatives (Olrich, Kalman, & Nigolian, 2012). NIIR may be experiencing resurgence in hospitals, as Olrich et al. (2012) suggested, but as a strategic tool to improve patient satisfaction scores, it remains a relatively new concept. However, NIIR is being developed within healthcare organizations in all patient care areas due to the growing need for improved patient satisfaction scores. Most recently, the TJC has evaluated emergency departments for patient wait times, as well as patient satisfaction. Baker (2010) conducted a study evaluating the results of patient rounding, as it relates to patient satisfaction in the emergency department. Baker reported that patients felt less isolated and did not feel abandoned when nursing staff made contact with them on a regular basis, even if no real or perceived needs were present.

NIIR can be implemented, and adapted to any patient care area, from critical care units, obstetrical units (Brewer, Shoulders & Emmons, 2010), to outpatient units, such as gastrointestinal labs, outpatient surgery centers, and outpatient chemotherapy units. Nurses who have been traditionally task oriented in their delivery of care, prior to implementation of NIIR, are now becoming patient centered, post implementation of NIIR (Harrison, 2012). The results of implementation of NIIR, across all nursing units, is

not just the shift to proactive nursing care, but also an increased focus on the overall safety of the patient, prevention of falls, improved pain management, as well as a sense of personal confidence from the patient's perspective, knowing that somebody will be checking on them frequently (Harrision,2012)

NIIR is supporting the premise that rounding on patients is having a positive impact on both patient safety and patient satisfaction (Woodward, 2009). Woodward (2009) described NIIR as occurring every two hours, with nursing staff paying specific attention to the patient's needs for pain medication, positioning in bed, toileting needs, and presence. Woodward offered a detailed description of the sense of uncertainty of patients when nurses are not available to help them, suggesting that the patient perceptions of the quality of nursing care are dependent upon the availability of staff. Woodward examined the difference between the following variables: rate of falls, patient satisfaction and frequency of call-light use, pre-implementation and post-implementation of a routine rounding intervention. Woodward identified that falls and patient satisfaction were needed areas of improvement.

NIIR interventions, when implemented, appear to have a positive influence in the area of fall reduction. A study by Tucker, Bieber, Attlesey-Pries, Olson, and Dierkhising (2012) indicated that when structured nursing rounds, or interventions, are put into clinical practice, there appears to be a reduction in fall rates. The study was done to examine falls as an adverse event for patients in an acute care setting. The purpose of this study was to evaluate the adopting of NIIR by the nursing staff, in order to reduce the risk and the incident of patient falls within two inpatient orthopedic units. The study took

place over a three month period, with patient fall rates compared at three months prior to implementation of NIIR, and compared again at a three month period during the initial implementation, and then compared again at a three month period one year following the implementation of NIIR. The interventions provided hourly to the patients during the study, including toileting assistance, patient physician, call light placement, evaluation of the need for pain medication, asking the patient if the nurse can do anything before they leave, and expressing to the patient that a member of the staff be back to check on them, within an hour. The study did not include a control group or random assignment with the authors conceding that the attention to falls, rather than the implementation of rounding may have influenced the fall rates. The conclusion of the study was that within the period in which NIIR was implemented, there may have been an influence in fall reduction.

Sherrod et al. (2012) conducted a study on purposeful rounding in a 36 bed medical surgical unit, chosen as the pilot area due to the high number of patients who are experiencing falls, along with low patient satisfaction scores in the nursing services category. The objective of the study was to evaluate if purposeful rounding had an effect on several key measures, such as fall rates, falls with injuries, hospital acquired pressure ulcers, and the patient satisfaction scores with nursing services. Sherrod et al. utilized purposeful questions by the nursing staff related to the five Ps, also known as potty, position, pain, possessions, and patient focus. Patients were introduced at the first contact, with an explanation of what purposeful rounding would be. Staff members, documented in the EMR system as to whether the patient's needs were met, no needs identified, out of the unit, or sleeping. Press Ganey was the third party surveyor who

surveyed the patients in the study. Results indicated a 4.5 overall point increase in the nursing services area post implementation of purposeful hourly rounding (Sherrod et al., 2012).

Keeping patients safe from harm is one of the national patient safety goals, as well as measures that the IOM recommends, such that hospitals have sound processes in place to routinely assess patient safety and quality of care being delivered (IOM, 2010). Lowe and Hodgson (2012) reviewed the application of NIIR as a method of keeping patients safe from harm by reducing the risks of falls and pressure ulcers. The authors piloted a study in a 14 bed dependency unit with one nurse to patient ratio. This unit is described as a step down unit from intensive care, and provides care for a variety of patient such as postoperative patients. The authors had done a limited literature review prior to implementation of their study, but could find no documentation of a study done on IR in an intensive care unit or in the critical care step down unit. Nurses are trained on the unit to be addressing the need to the patient, such as pain, potty, position, and presence (environment of the room). A rounding log was utilized, and handed out at the beginning of each shift by the charge nurse. This application of NIIR was a 2-week trial, and during this period of time there were no patient falls reported. The study appears to be very limited, by the admission of the authors themselves, and the results were based primarily on staff feedback. The authors also conceded that a longer study needed to be completed.

The goal of the healthcare organization is to efficiently use the staff they have, while meeting the needs of their patients and delivering quality care. Literature supports

an increase in patient satisfaction scores when using other staff to respond to call lights, and not limiting the response to patient call lights to nurses only (Sobaski, Abraham, Fillmore, McFall, & Davidhizar, 2008). Patient communication is a critical indicator in patient satisfaction scores, and several studies have reported that the call light, and the response of the nursing staff, is considered a form of communication and one aspect in which patients feel they are in control (Tzeng, 2011). The length of time for a staff member to respond to the call light may affect the patient's perception of the care that they are receiving (Deitrick, Bokovoy, Stern, & Panik, 2006).

The Studer Group conducted pilot study, which included 14 hospitals from across the nation, regarding the use of call lights, over a one-year period. The study revealed that the majority of patient call lights, which nurses responded to, were for non-urgent needs; the authors recommended that other staff members, such as nurse's aide or unit clerks answer call lights. The study also revealed that due to the excessiveness of the call light, negative consequences arose among nurses such as "workflow inefficiency, staff frustration and burnout, and suboptimal quality of care" (AHRQ, 2011, p. 1). The authors concluded that when IR was initiated, a reduction of call light use and patient falls were noted, as well as elimination of pressure ulcers and an increase in patient and staff satisfaction.

Although limited, not all literature fully supports NIIR, and the effects on patient satisfaction scores, unless it has been implemented as a standard of care, and not an option for the staff. Kessler et al. (2012) offered a description of NIIR as a merry-go-round, with the statues of animals going up and down, but not reaching any destination,

and does not produce anything tangible in the way of outcomes. Kessler et al. also offered the development and implementation of protocols and strategies that have sustained an effective NIIR process for an extended period of time.

With the expansion of a new tower to the hospital where Kessler was employed, it was discovered that NIIR was not producing the results as hoped for (Kessler et al., 2012). The patient satisfaction scores were below their internal and external benchmarks, which led to a collaborative effort by the staff and the management, resulting in the creation of a transformational experience for both the patients and the staff by hardwiring hourly patient rounding into their unit as a standard of care and not an option. The staff took it upon themselves to develop an in-depth assessment of patient's desires and through telephone contact with patients discharged, asking them what they would like to change about the experience on their unit. The trend was revealed early on that patients most needed pain management, improved responses to their call lights, and someone to give them attentive care (Kessler et al., 2012).

As a result, an NIIR protocol was designed and developed by both nursing staff and nursing leaders in the shared governance culture (Kessler et al., 2012). The new standard of care on NIIR officially began in late May 2006 and remains currently in practice today, along with rounding logs, welcome letters, and posters on the units and patient rooms, as well as a sign in log in every room, which serves as a visual cue to staff, and a visual promise to the patient that their needs will be met. The quantitative results of their study were very positive, and as the staff received positive feedback, they began to embrace the standard of care with little resistance (Kessler et al., 2012).

There is evidence to show that when NIIR is implemented with staff engagement, the results appear to be very positive for both nursing staff as well as patient outcomes, on a consistent basis. Orr, Tranum, and Kupperschmidt, (2006) examined NIIR from the position of being positive for the patient outcomes, and positive for the staff, but that NIIR needs to be implemented as a standard of care, with utilization of the Studer group materials as a basis for designing implementation of NIIR. Their work described a trialing of hourly rounding on a medical surgical unit, which included scripting, overcoming barriers to implementation, facilitators, and outcomes. The study findings revealed the use of patient rounding at one hour increments as a care model, which resulted in a decrease in call light use, and an increase in patient satisfaction (Orr et al., 2006).

Rondinelli, Ecker, Crawford, Seelinger, and Omery, (2012) offered a study that identified the structures, the process, and the outcomes of intentional rounding. Telephone interviews were conducted on patients from 11 different Southern California hospitals. Patient satisfaction and patients being cared for were the two outcome themes that were initially observed. The Donabedian model of structure, process, and outcome was utilized for the research. Social action research (SAR) design was the methodology used to obtain the data related to rounding implementation. Consent to participate in the survey was agreed to via e-mail or traditional mail by the participants and telephone interviews were then set up. During the interview, open-ended questions were asked and the answers were written verbatim. Question content had to do with NIIR, specifically. The information collected in the study included only 14 participants

that responded. The researchers concluded that there were over 15 common themes related to IR, and that there is no one single strategy to implement IR across all hospitals (Rondinelli et al., 2012).

NIIR is also being utilized internationally and is not restricted to only American nurses in the delivery of patient care. Canadian staff nurses at the Royal Columbian Hospital initiated IR in 2011. Although the related literature did not offer any substantial data, the staff nurses reported noticing fewer falls, call light reduction, as well as an increase in both patient satisfaction and staff satisfaction (Johnston & Macleod, 2012). Similar to American nurses, the Canadian nurses also took the position that the implementation of NIIR gave nursing staff their time back, through proactively meeting the needs of the patients, and that the nurses are much more organized and in control of their time and activities (Halm, 2009).

Nurses in Britain also have utilized the steps of NIIR in a variety of hospitals and in multiple nursing wards (equivalent to what is commonly referred to as nursing units). Performing hourly rounding or NIIR on patients in hospital care across Britain was well supported by the Prime Minister David Cameron (Dean, 2012). NIIR has been implemented in Britain due to reports of substandard care of patients, as opposed to pay-for-performance initiatives that require an improvement of patient satisfaction scores, as is the case in the United States. Approximately half of the acute care hospitals in England have introduced some sort of NIIR process similar to NIIR programs in the United States (Duffin, 2013).

NIIR has not been limited to the civilian nursing organizations, but has also been utilized by the military. Madigan Army Medical Center (MAMC), a large 204 bed facility is not required to have joint commission reviews (Weisgram & Raymond 2008), but voluntarily invites surveyors into their facility in order to compare military services to civilian healthcare and to demonstrate the quality of care, as well as their delivery methods of care. MAMC's scores demonstrated high standards of care; however, the center was experiencing a high number of patient falls in their step down telemetry unit. Subsequently, a pilot project was developed, utilizing an evidence-based approach to decreasing falls (Weisgram & Raymond, 2008).

A literature review had been performed, and it was decided that NIIR would be a strategy to decrease falls as well as call light use. NIIR was considered a protective strategy to reduce or prevent patient falls (Morse, 2002). Call light usage and the nature of the call related to the patient needs were categorized for data collection and a daily report was tabulated with the data entered into a database in a 24-hour period. The MAMC NIIR program outcomes monitored patient falls, call light use, their 12-step hourly rounding program, and patient satisfaction (Weisgram & Raymond, 2008). They had a very high nurse compliance rate of 96% in the call light usage, which demonstrated a decrease from 120 to 20 calls in 24 hours. Overall, fewer falls occurred in the first 30 days of the program, and because of the successful results, the NIIR program was expanded to additional units within the facility.

When there are new clinical practice changes, such as in the case of NIIR, there may be barriers to those changes. Shepherd (2013) examined the barriers to new practice

and changes. Shepard examined cynicism and attitudes of often older experienced nurses

against NIIR. Shepherd offered strategies to overcoming barriers for the seasoned nurse

by providing them with evidence-based literature that supports NIIR. Shepherd also

examined the high acuity of patients and the nurse to patient ratio, as it related to

organization of the nurse's workload.

Shepherd (2013) offered an acuity tool that should be utilized when making

patient assignments, which would possibly diminish or prevent barriers to the

implementation of NIIR. Shepherd also pointed out that nurses frequently have

unpredictable, unscheduled interruptions, demanding very immediate attention. Shepherd

asserted that the certified nurse aide role in NIIR is just as important as a registered

nurse's role, and encouraged nursing leaders and nursing administrators to assist in

diminishing or eliminating the barriers that their nurses may experience in order to have a

successful NIIR experience.

Conceptual Model

The evidence based model chosen to guide the DNP program evaluation was the

John Hopkins Nursing Evidence-Based Practice Model and Guidelines (JHNEBP). The

JHNEBP model was developed in a collaborative effort by nursing leaders from both the

John Hopkins University School of Nursing and from the John Hopkins Hospital, with

the goal that the staff nurses would become proficient in evaluating and translating

research findings into actual practice (White & Dudley-Brown, 2012). The JHNEBP

model was chosen to be utilized because of the step by step methodology in its problem

solving guidelines, as well as the focus of incorporating nursing staff into the process of

practice change as key stakeholders. The JHNEBP model utilizes guidelines that include a three phase, or three step, process of PET, which is the process of developing a practice question, seeking out evidence, and then translation of the evidence into practice (White & Dudley-Brown, 2012).

The three steps of PET represent the P, E, and T of the nomenclature. The first step in the process, or the "P," is the identification of a practice question. The JHNEBP model incorporates an identified practice question utilizing the PICO format, which assists the researcher in identifying the population (nursing staff), what type of intervention would be recommended, and any anticipated outcomes. The second phase, or the "E," is the evidence, which includes conducting an evidentiary search, critiquing the evidence for its strengths and validity, as well providing a summation of the evidence discovered. The third phase, or the "T," includes evaluating for the feasibility and appropriateness of translation of the evidence into the practice setting and reporting results of findings to leadership and stakeholders.

The JHNEBP model was developed by nurses and for nurses, with the goal of helping staff nurses (the target population) in evaluating evidence and then translating that evidence into actual practice. The application of JHNEBP model also facilitated developing evidence for the nursing staff to the benefits of NIIR, as well as served as a guide to the nurses in changing their current delivery of care practices. The program evaluation outcome anticipated was to see an improvement in patient satisfaction scores, post implementation of NIIR. Section 3 includes details of the methodological approach and project design incorporating the JHNEBP model.

Section 3: Approach

Project Design

The program evaluation of implementation of NIIR, and the relationship to patient satisfaction scores, was limited to a 33-bed surgical unit. The program evaluation was a summative evaluation for the purpose of determining the effects that implementation of NIIR has had on patient satisfaction scores specifically. NIIR required the nursing staff to make hourly checks on patients specific to their personal needs, pain management, position/comfort, and environment (room temp and making sure items needed are in close proximity, such as the call light or telephone). Documentation of rounding was required on a rounding log (Appendix A). The only exception to the hourly rounding occurs on the night shift, where between 10 p.m. and 6 a.m. rounds were only completed every 2 hours or as needed, allowing the patients to rest. Using NIIR, the nursing staff anticipate the patient's needs proactively. NIIR was implemented September 1, 2013 on the surgical unit with the goal of improving patient satisfaction scores on the unit.

Satisfaction scores of patients admitted to the surgical unit were measured at 3 months prior to implementation of IR, as well as at three months postimplementation of IR. I extracted these data from the reports sent to the hospital from NRC and then averaged the scores based upon the number of patients who responded to the third party surveyor's questions. The DNP evaluator then evaluated the average scores for positive/negative trending and transferred the data into a scorecard, which the DNP evaluator developed, to include the mandated HCAHPS categories requiring a response from surveyed patients. The scorecard provided a visual aid to the stakeholders, allowing

them to see a dashboard view of the effects of NIIR on patient satisfaction scores. The summative evaluation provided feedback to the leadership and the bedside nursing staff with regard to the effects of NIIR specifically on patient satisfaction scores and the need for implementation of NIIR as a clinical practice change.

The agency for Healthcare Research and Quality established the Consumer Assessment of Healthcare Providers and Systems (CAHPS) in conjunction with CMS. Both CMS and CAHPS jointly work together to develop credible surveys for the purpose of assessing both patient perceptions of healthcare and the healthcare organizations overall performance. These were the data that the DNP project evaluator collected to measure the NIIR program's overall effectiveness on patient satisfaction scores.

Patient satisfaction scores are measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The HCAHPS survey is known as the CAHPS Hospital Survey or Hospital CAHPS (HCAHPS, 2013) and is administered by an approved third party surveyor agency such as NRC Picker. NRC picker uses survey methodology by phone, e-mail, or a combination of both, when collecting data from discharged in-patients. NRC picker then reports their findings to the HCAHPS on a quarterly basis. These same data are also reported to the healthcare organizations that have contracted their services and to CMS where reimbursement decisions are made based upon the data collected.

Population and Sampling

The target population for this program evaluation was that of former inpatients on a 33-bed surgical unit in an acute care hospital who have been discharged. For the

purpose of this program evaluation, the nursing staff were defined as registered nurses,

charge nurses, staff nurses, clinical nursing supervisors, licensed vocational nurses,

nurse's aides, patient care techs, as well as unit secretary, and transportation orderlies.

Sample size of discharged surgical patients was based upon the number of patients who

agreed to participate in the survey, as reported to the healthcare organization through the

third party surveyor NRC.

The number of patients surveyed was based only upon those who respond to the

NRC surveyors, through email, phone call, or general mail. At the time of this paper, the

number of patients who were estimated to respond to the NRC survey was based upon the

last three months of reported patient satisfaction scores. The average number of patient

responders is about 22 per month, or 66 per quarter. The projected average number of

patient satisfaction scores, for a quarter, would be 66 patients. The mean score of the

patient survey pre-intentional rounding was compared to the patients surveyed post pre-

implementation rounding.

Data Collection

The data collection consisted of reports generated from NRC Picker, which were

distributed to the hospital administrative staff, and are reported to a publicly accessed

hospital comparison site, known as HospitalCompare.HHS.gov. The Quality Performance

Improvement Department allowed the DNP program evaluator access to the data as

reported to the organization. The data collection utilized was a retrospective view or

secondary data collection (Hodges & Videto, 2011) of patient satisfaction scores for the

previous 3 months, specific to the surgical unit. Inclusion of the prior 3 months

established a baseline point to start the evaluation of patient satisfaction scores pre-

implementation of IR to patient satisfaction scores post implementation of IR. There were

no foreseeable problems with access to the data or to their interpretation, and there were

no patient identifiers. There were no foreseeable costs to the organization for data

collection, or the need for paid staff members, or volunteers, needed in the purpose of the

data collection process.

The DNP program evaluator assessed the patient satisfaction scores, pre-and post-

implementation of NIIR, and converted this information into scorecards. The DNP

program evaluator provided an average of scores, reflecting any positive or negative

trending of scores in the 10 dimensions of care (Appendix B), mandatory for reporting to

CMS. The scorecard then became a visual aid that reflected the picture of comparative

data and the effects that NIIR has had on patient satisfaction scores to the stakeholders of

the healthcare organization. Each category in the dimensions of care (listed below under

instrumentation) are very specific to the patient experience while hospitalized on the

surgical unit. The NIIR program may impact the 10 dimensions of care through:

- Care transitions: IR activity will consist of nurse to nurse handoff reports,
  nurses explaining transfers to patient when patient required to go to other
  departments for procedures.

- Nurse communication: IR activity will consist of hourly checks to patient,
  with nurses utilizing AIDET communication tool (see Definition of Terms
  section).

- Physician communication-mandated question in survey: IR activity supports physician communication through collaborative relationships.

- Responsiveness of hospital staff: IR activity of hourly patient checks supports responding to patients proactively versus reactionary.

- Pain management: IR hourly checks include assessing patient's pain, treatment as needed.

- Communication about medicines: IR hourly checks include medication instructions when administered or when new medication introduced.

- Discharge information: IR activity includes nursing communication and education related to discharge instructions.

- Cleanliness of hospital environment: IR activity evaluates patient room through hourly checks, nurse will evaluate environment hourly.

- Quietness of hospital environments: IR activities are limited during night shift to decrease noise levels, allowing for patient rest.

- Overall rating of hospital-IR activity, may be indicator of hospital experience in rating of hospital.

- Willingness to recommend hospital: IR activity through hourly checks, may affect patient's willingness to recommend hospital (see process map in Appendix C).

Instrumentation

The instrumentation utilized was the HCAHPS survey. Patient satisfaction scores previously collected on the surgical floor were assessed from HCAHPS data. The

program evaluation of NIIR was based on the resulting satisfaction scores that reflect the

surveyed patients' answers to the following questions, specific to their inpatient

experience, only on the surgical unit, covering the 10 dimensions of care, such as:

1. Care transitions: This question involved how the patient perceives the

   transitional care from either admission to the hospital, through the emergency

   room, and then subsequently to the surgical floor, or to other procedural areas.

2. Cleanliness/quietness-the patient was asked to rate the cleanliness of the

   quietness of the surgical unit.

3. Communication about medications-the patient was asked to rate how the nurse

   communicated information about the medications, that they received while in

   the hospital.

4. Communication with nurses-the patient was asked to rate the communication

   provided by the nurses during their hospitalization on the surgical unit.

5. Communication with doctors – the patient was asked to rate the

   communication provided by the physicians during a hospitalization on the

   surgical unit (required question).

6. Discharge information – the patient was asked to rate the discharge

   information provided to them upon discharge by the nurse from the surgical

   unit.

7. Overall rating of the hospital-the patient was asked to rate the overall hospital

   experience.

8. Pain management-the patient was asked to rate the pain management, they received from the nursing staff while in the surgical unit.

9. Responsiveness of hospital staff-the patient was asked to rate the responsiveness of the nursing staff upon the surgical unit.

10. Would recommend hospital – the patient was asked to rate if they would recommend the hospital to others.

Each of the above questions were posed by the NRC surveyor, utilizing a Likert scale to rate each survey question. The scale is based on a rating of 1- 4: 1 = *never*, 2 = *sometimes*, 3 = *usually*, and 4 = *always*.

There were also several questions on the survey that require only a yes or no response, such as "during this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital," and several questions that require the patients surveyed to respond based upon a rated scale of 0 to 10, such as when the patient was asked to rate the hospital during their stay on a scale of 0 to 10. A zero would indicate that the patient has chosen the facility as the worst hospital possible, and a score of 10 would reflect that the patient has indicated that the patient has chosen the hospital as the best hospital possible. Within the 0 to 10 scale, the patient had the option to also rate the hospital in degrees of preferences, such as 1-9, again from the worst to the very best (HCAHPS, 2013).

The data collected by NRC were also reported to the CEO and CNO of the healthcare organization, as well as to the director of process improvement, and to risk management. The data collected by NRC also were given to the DNP program evaluator

for evaluation of the results. The scores were evaluated for changes in patient satisfaction scores. The scores were compared to patient satisfaction scores three months prior to NIIR implementation, and to scores three months post NIIR implementation. The evidence was then translated into scorecards for the purpose of discussion with leadership, which may lead to a nursing process practice change, and implementation of NIIR as a new standard of nursing care.

Protection of Human Subjects

The DNP program evaluation did not contain any patient identifiers, and there was no manipulation by the researcher of the data. The data were collected by an approved third party surveyor vendor, known as NRC. NRC reported the data collected from patients with no identifiers such as patient names, to the hospital that was surveyed, and to the multi-regulatory governmental agencies that oversee hospitals performance to determine pay-for-performance reimbursements. Data collected by a third party surveyor do not allow for persuasion, coercion, or any other means of swaying, or altering, the survey results in order to show favoritism to the healthcare organization. The healthcare organization, does not contact the patients in any way for the purpose of surveying and/or data collection, in order to maintain integrity of the healthcare organization, and in order to receive accurate feedback. The DNP student did not contact any patients for the purposes of surveying. The DNP student did not use any patient identifiers in any way, nor did the DNP student remove any paperwork from the organization that may contain patient identifiers, and did not use any patient identifiers in the program evaluation.

Program Evaluation Plan

The purpose of the program evaluation of NIIR was to give feedback to the healthcare organization based upon the outcomes discovered, post implementation of NIIR, and the resulting effects on patient satisfaction scores. Currently, the surgical floor does not have a written policy for IR as a new nursing clinical practice change. The summative program evaluation plan was used to provide information to the leadership of the healthcare organization as to whether there is a need for policy implementation based upon the discovered outcomes of NIIR as a new nursing program.

The DNP program evaluator performed an evaluation of the patient satisfaction scores three months pre-and post- implementation of IR, and then developed scorecards that reflected results of the data collected as it related to nursing actions and nursing care received. The DNP program evaluator graphed the patient satisfaction scores into the 10 dimensions of care, reflecting either a positive or negative score, based upon the number of patients who responded to the survey.

It was the goal of the DNP program evaluator to utilize the summative evaluation as a tool for feedback and discussion among the leadership of the healthcare organization that are in positions to make policy changes that would affect the way nursing care is delivered. The question that was answered, based upon patient satisfaction scores, was whether the program of NIIR, as a new nursing process, increased patient satisfaction scores. The program evaluation may also lead to unforeseeable consequences (Kettner, Moroney & Martin., 2013), such as in the current delivery of nursing care, that may

subsequently need to be changed, or refined, based upon unknown factors that may be revealed as a result of the summative program evaluation.

Summary

This DNP project was a program evaluation of whether NIIR, as a new nursing process trialed on a 33 bed surgical unit, impacted patient satisfaction scores. Nursing engagement is critical in developing goals and objectives related to NIIR. Staff engagement can increase a greater sense of ownership, and a greater sense of commitment to the practice change success.

Hodges and Videto (2011) asserted that a project will have a greater chance of implementation, acceptance, and long-term sustainability, when the target population is engaged in the process development. NIIR may increase patient satisfaction scores and improve the delivery of quality of care through increasing patient safety, as well as improving the patient's perception of their overall hospital experience. Stakeholders of healthcare organizations are invested in the nursing profession and are interested in the results of the clinical practice change when there is a potential benefit to the overall organization. Healthcare organizations may utilize NIIR as a tool of retention of nursing staff by appealing to the idea of a nurse's workload being decreased through reduction of call light usage, and allowing nurses to gain control of their plan of care through proactive nursing (Generals & Tipton, 2008).

Sherrod et al. (2012) suggested that expansion of the evidence-based literature related to IR is needed, and that future studies should include other bundles of patient care processes, such as fall prevention, prevention of catheter associated urinary tract

infections, and the impact that intentional rounding could have on these areas of quality outcomes. Pay-for-performance models and benchmarking, are expanding to a variety of patient care areas (i.e., emergency departments, operating rooms, critical care units).

Today's healthcare consumers are increasingly concerned regarding the quality of care that is being delivered to them. Newspapers, and television shows are informing patients of potential safety issues and harm, which may occur to them or their family members during a hospitalization or medical procedure. The educated consumer is another added pressure that is causing healthcare organizations to deliver high quality care to patient populations who are living longer and who require more highly technical, complex care.

Multi-regulatory agencies are developing pay-for-performance initiatives tied to the quality of care that healthcare organizations are delivering. Patient satisfaction scores are one of the more recent initiatives that are correlated to pay-for-performance. Healthcare organizations, are utilizing third party surveyors, which are vendors approved by the HCAHPS. Based upon the healthcare organization's patient satisfaction scores, monetary reimbursements may be reduced or denied. NIIR may become a standard of care that could increase patient satisfaction with the overall hospital experience, as well as reduce preventable hospital acquired diseases, or unnecessary adverse patient care outcomes. The program evaluation of the effects of NIIR on patient satisfaction scores may be invaluable to the healthcare organization and may result in a policy of NIIR as a new nursing clinical practice change.

Section 4: Findings, Discussion, and Implications

The DNP program evaluation was performed to evaluate the effects of NIIR upon patient satisfaction scores   on a 33 bed surgical unit. The implementation took place on September 1, 2013. Patient satisfaction scores were evaluated retrospectively for three months prior to implementation of NIIR, for the months of June, July, and August 2013. Patient satisfaction scores were also evaluated post implementation of NIIR, for the months of September, October, November, and December 2013. September 2013 satisfaction scores were included, allotting for the month of September as a transitional month for phasing into implementation, followed by the months of October, November and December 2013 post implementation of NIIR.

Summary of Findings

The patient satisfaction scores were evaluated in the 10 categories of care, which are mandated to be reported to CMS. The 10 areas of care evaluated are as follows:

1. Nurse communication,

2. Physician communication,

3. Responsiveness of hospital staff,

4. Pain management,

5. Communication about medications,

6. Discharge information,

7. Cleanliness and quietness of the hospital environment,

8. Care transition

9. Overall rating of hospital,

10. Willingness to recommend hospital.

The project evaluation question was, "Will implementation of intentional rounding for patients on a surgical unit by nursing staff improve patient satisfaction scores?" To address this question, patient satisfaction survey responses were examined during the 7-month period of June 2013 through December 2013. Satisfaction score data were obtained for each of the 10 care dimensions and a total satisfaction score was calculated by summing and averaging the care dimension scores. The data are presented according to mean values by month and a calculated mean score for the 3-month preimplementation period (June-August) and postimplementation period (October-December).

Comparisons of Care Dimension Satisfaction Scores During Study Period

The mean satisfaction scores for each of the 10 care dimensions were calculated over the designated 7 month study period from June 2013 to December 2013 (Table 1). Initial implementation of NIIR took place in September, which was considered the transition month. June 2013 through August 2013 were therefore considered the pre-implementation time period and October through December were considered the post-implementation period. Average patient satisfaction scores in each of the 10 care dimensions were graphed over the 7 month period from June to December (see Figure 1). The individual graph representations demonstrate modest increases in patient satisfaction scores, which were evident in all 10 care dimensions.

Table 1

Care Dimension Satisfaction Scores by Month

	Preimplementation						Transition		PostImplementation					
	June 2013		July 2013		Aug 2013		Sep 2013		Oct 2013		Nov 2013		Dec 2013	
HCAHPS Care Dimensions	M	n	M	n	M	n	M	n	M	n	M	n	M	n
Care Transitions	44.7	22	54.8	75	53.5	19	44.1	17	**52.6**	20	46.3	27	**63.8**	23
Cleanliness/ Quietness	58.7	23	56.5	81	40.5	21	**61.1**	18	**65.8**	20	50.0	28	**60.9**	23
Communication About Meds	81.3	8	37.5	34	50.0	9	**63.6**	11	**81.3**	9	**65.4**	13	59.1	11
Communication with Doctors	71.0	23	61.8	81	71.4	21	**68.4**	19	**80.7**	20	**74.1**	27	**75.8**	22
Communication with Nurses	82.6	23	65.3	82	59.7	24	**76.7**	20	**82.5**	20	**75.1**	28	**80.6**	24
Discharge Information	93.2	22	82.6	74	85.7	21	**85.3**	17	**94.4**	19	**88.5**	26	**88.6**	22
Overall Rating of Hospital	77.3	22	47.8	78	47.6	21	**66.7**	18	**73.7**	20	**70.4**	27	**78.3**	23
Pain Management	72.2	18	73.5	60	46.9	16	60.7	14	**84.6**	14	**82.5**	20	67.5	20
Responsiveness of Hospital Staff	65.9	22	59.1	75	50.0	19	62.5	16	**72.2**	18	**64.0**	25	**60.9**	23
Would Recommend	77.3	22	63.6	77	52.4	21	**83.3**	18	**73.7**	20	**84.0**	25	**81.8**	22

Note. *n* = number of pts. responding.

a. Care Transition Satisfaction
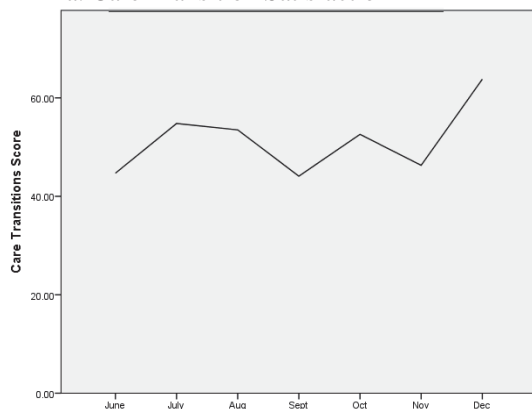
b. Medication Communication Satisfaction
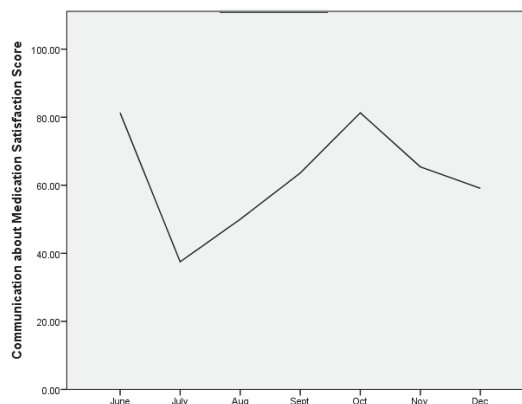
c. Physician Communication Satisfaction
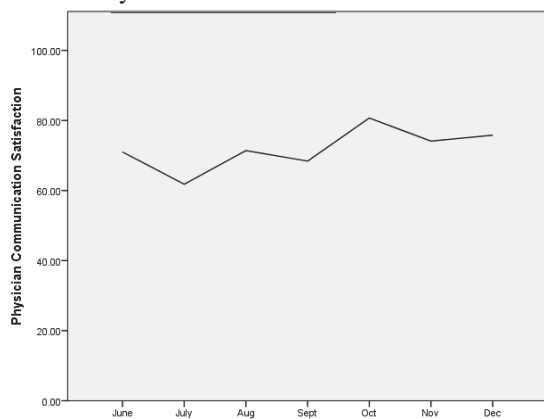
d. Nurse Communication Satisfaction
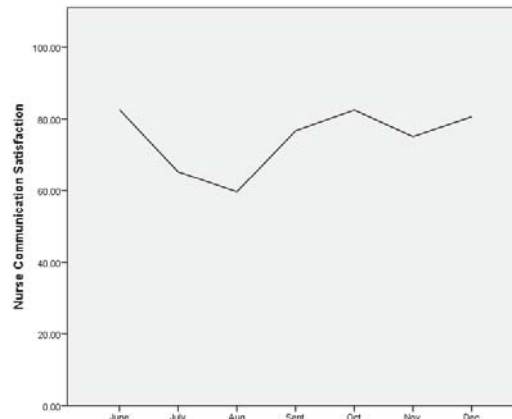
e. Discharge Information Satisfaction

f. Cleanliness and Quietness of Hospital

g. Pain Management Satisfaction

h. Satisfaction of Responsiveness of Staff

i. Willingness to Recommend Hospital

j. Overall Hospital Rating
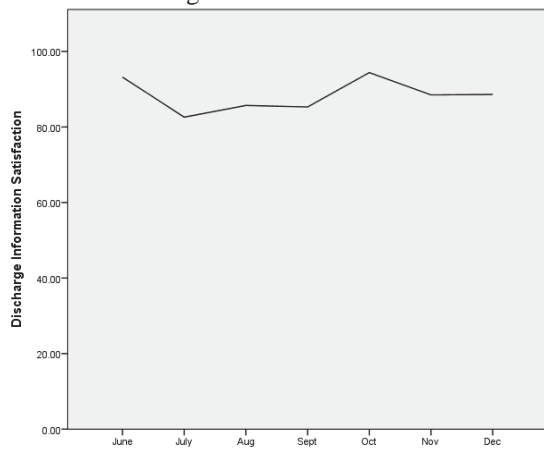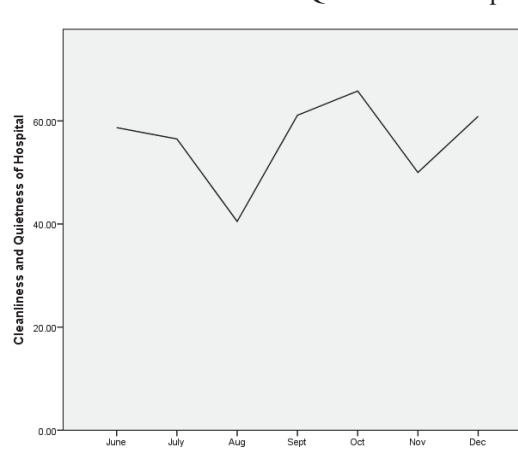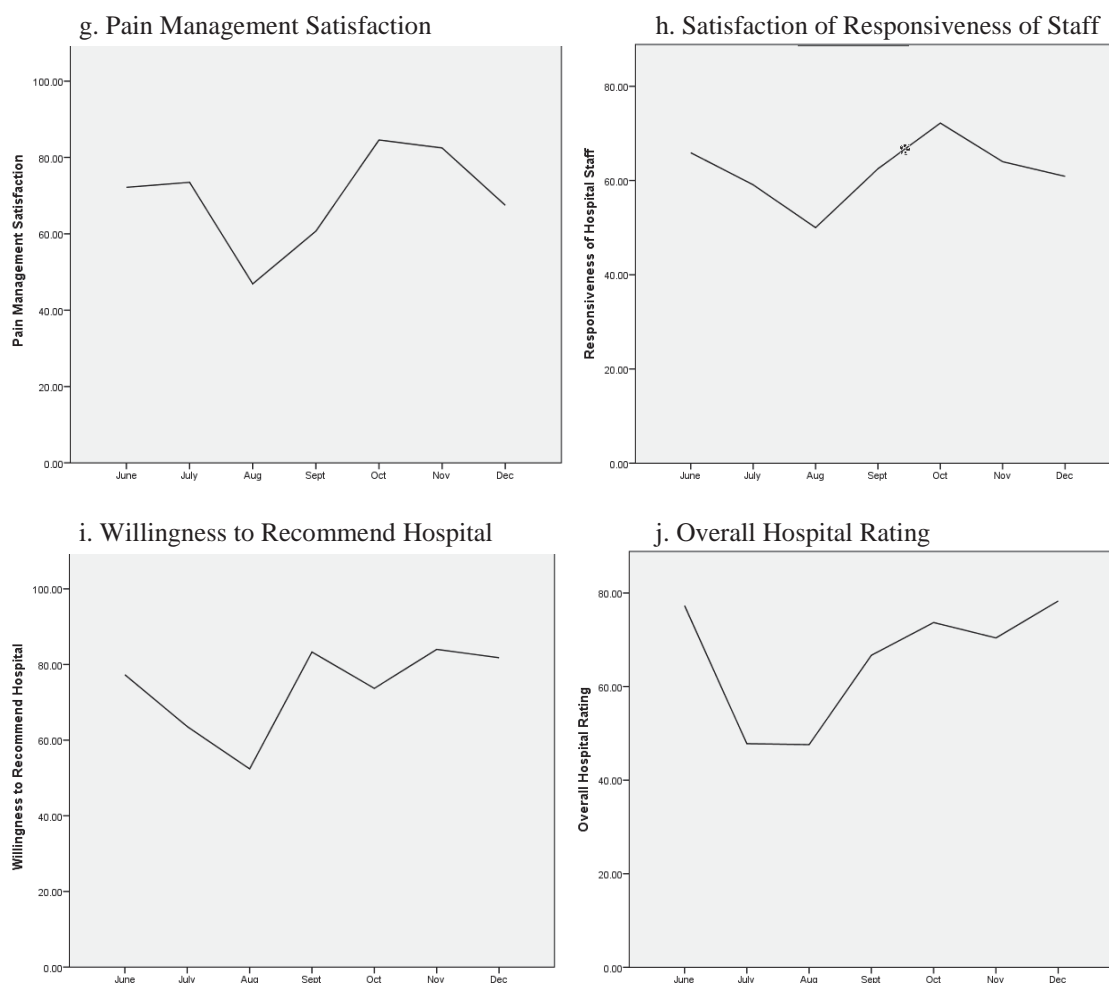
Figure 1. Individual graphs of satisfaction scores by dimension of care and month (June-December). Pre-IR months include June, July, and August; transition month to IR is September; and post-IR months include October, November, December.

Comparison of Pre and Post Implementation Care Dimension Satisfaction Scores

Pre-NIIR implementation data and post-NIIR implementation data were summed and averaged according to each of the 10 care dimensions (Table 2). Thus, pre-NIIR implementation data consisted of data points from June through August 2013 and post-implementation data consisted of data points from October through December.

Table 2

Pre Implementation and Post Implementation Scores by Care Dimension

HCAHPS Care Dimensions	Pre-IR M	Post-IR M	% Increase
Care Transitions	51	54.2	6.27
Cleanliness / Quietness	39.9	58.9	47.62
Communication About Meds	56.2	68.6	22.06
Communication with Doctors	68	77	13.24
Communication with Nurses	69.2	79.4	14.74
Discharge Information	87	90.5	4.02
Overall Rating of Hospital	58	74.1	27.76
Pain Management	64.2	78.2	21.81
Responsiveness of Hospital Staff	58.3	65.7	12.69
Would Recommend	64.4	79.8	23.91

Note. *n* size=number of pts. responding.

Figure 2 offers graphic visualizations of the overall pre- and post-IR implementation satisfaction scores. The graph demonstrates the general increase in satisfaction in each of the 10 care dimensions.

Figure 2. Pre-implementation and post-implementation satisfaction scores by care dimension.

Examining the data from Table 2 and the graph in Figure 2, satisfaction score increases were strong within care dimensions of nurse communication (14.74% increase), physician communication (13.24% increase), responsiveness of hospital staff (12.69% increase), pain management (21.81% increase), communication about medication (22.06% increase), cleanliness and quietness of the hospital environment (47.62% increase), overall rating of the hospital (27.76% increase), and willingness to recommend

the hospital (23.91% increase). The data on the dimensions of care transitions (6.27% increase) and discharge information (4.02% increase) demonstrated a lesser degree of improvement graphically. The largest differences, shown on the graphic visualization, appear to be within the care dimensions of cleanliness and quietness of the environment (47.62% increase), overall rating of the hospital (27.76% increase), would recommend the hospital. (23.91% increase), communication about medication (22.06% increase), and pain management (21.81% increase).

Comparisons of Mean Overall Satisfaction Scores: Pre and Post IR Implementation

Satisfaction scores for each of the care dimensions were then summed and averaged across the 10 dimensions. Scores for the month in which IR was implemented (September) were not included as part of the post-IR implementation month, but rather were excluded from the analysis as a transition month. Average pre-IR implementation scores from the 3 months prior to implementation (June, July, and August) were compared to the average post-IR implementation scores from the 3 months after implementation (October, November, December). Descriptive statistics of the mean (M) and standard deviation (SD) demonstrated a mean pre-IR implementation overall satisfaction score of 61.62 (SD 12.45), compared to a post-IR implementation mean score of 72.64 (SD 10.86). A graph of the Pre and Post IR implementation satisfaction scores illustrated an increase in mean satisfaction patient scores (Figure 3).

Figure 3. Pre versus post-IR implementation overall satisfaction scores.

Discussion of Findings in the Context of Literature and Frameworks

The findings of this program evaluation support previous research indicating the

benefits of implementation of NIIR as a process of purposeful, directed communication

and evaluation, of patient needs proactively, helps the nurse to anticipate the patient's

needs through hourly checks instead of waiting for the patient to alert the staff to their

needs (Berg et.al.2011; Haack, 2009). Ford (2010) asserted that this directed

communication and proactive patient evaluation serves to improve quality of care and

may also contribute to improved patient satisfaction.

This program evaluation supported the assertion offered by Ford (2010),

demonstrating improvement in all 10 care dimensions post-implementation. Prior

research also has supported increased patient satisfaction related to implementation of

NIIR (Blakely et al., 2011; Johnston & Macleod, 2012; Leighty, 2006; Meade et al.,

2006; Orr et al., 2006). The increased patient satisfaction related to NIIR has been

suggested to develop through the increased consistency and continuity of the patient care

delivered within an NIIR model (Leighty, 2006), that provides a decrease in patient falls,

medication errors, and other negative patient outcomes, while improving the patient

perceptions of a positive hospital experience (Meade et al., 2006). In addition, research

has shown that when focused IR is done, that patient's experience greater pain

management, and safety (Haack, 2009) by nurse initiated questions regarding the

patient's comfort, and need for analgesic relief. Similarly, Abraham et al. (2008) reported

patient perceptions of greater communication.

      Although the data collected in this program evaluation did not include patient

outcomes, patient rated satisfaction scores related to communication (communication

about medication and communication with doctors and nursing staff), pain management,

and overall rating of experience at the hospital, supported increased satisfaction related to

these aspects of care, similar to reports by Meade et al. (2006), Haach (2009), and

Abraham et al. (2008). In this evaluation, however, improvements in satisfaction scores

were evident in all 10 dimensions of care, with particularly noticeable improvements in

the areas of nurse communication, physician communication, responsiveness of hospital

staff, pain management, communication about medication, cleanliness and quietness of

the hospital environment, overall rating of the hospital, and willingness to recommend the

hospital.

      In particular, the dimension of cleanliness and quietness of the hospital

environment demonstrated a percentage increase of over 47%, an element not noted in

previous research, but one that may indicate the effect of NIIR on nurse efficiency and

reduced call-button use. A quieter, cleaner environment may be indicative of nursing

staff that are afforded more time through efficiency and consistency of practice. The

results of implementation of NIIR among nursing units represents not only a shift toward

more proactive nursing care to support improved patient care and satisfaction (Harrision,

2012), but perhaps also a shift toward more efficient, progressive, consistent, organized,

and less hectic nursing practice.

Implications

Implications on Practice

NIIR may change the current way that nursing care is delivered from

"reactionary" care to proactive care. Reactionary nursing care is care that is driven by

"incidents" that may occur throughout a patients hospital stay, and that may be

preventable, if NIIR was a model of care, utilized in the delivery of care. For example, a

patient who frequently uses the call light, may not have a timely response from nursing

staff, and may decide to attempt ambulation by themselves in order to meet their personal

needs, such as using the bathroom, even though they need assistance to do so. This may

result in a fall, (which is a preventable adverse outcome), resulting in injury to the

patient, as well as an increased cost, and liability to the healthcare organization. Proactive

nursing care, as modeled in NIIR, requires the nursing staff to check the patient on an

hourly basis, in order to anticipate the patients' needs, thereby reducing or preventing

patient related adverse outcomes. NIIR supports the goals of the IOM as previously

stated, which supports successful care, centered on meeting the patient needs, keeping the

patient informed, encouraging patient participation, and returning to the patient, control

in their health care choices (IOM, 2010). NIIR as a new model of nursing care, not only meets the needs of patients proactively, but also may increase the patient's overall hospital experience, resulting in an increase in patient satisfaction scores.

Implications for Future Research

This study may serve as a foundational framework for other nursing researchers to build upon to examine the benefits of incorporating NIIR into practice. While the evidence to support NIIR is growing, there needs to be much more rigorous and larger scale evidence-based studies to examine NIIR as a new clinical practice change model. Future studies, may want to incorporate comparing the model of NIIR to other models of nursing care. A similar study conducted over a longer time period and possibly incorporating patient outcomes would also be beneficial to understand the long term benefits of NIIR. Future studies should also include the perceptions of the staff, the patient, and the patient's families for their perceptions and /or feedback, along with factors that influenced or hindered the implementation of NIIR as a clinical practice change where NIIR has been implemented (Forde-Johnston, 2014).

Implications on Social Change

The implications for social change, utilizing the concepts of NIIR, have the potential to be extensive. NIIR may serve as a catalyst in changing the model of nursing care delivery, from reactionary nursing, to proactive nursing. The idea, that NIIR can serve as a driver, in improving patient care outcomes, by preventing adverse outcomes, is beneficial to the patients, their families, and to the overall healthcare organizations in the acute care setting. NIIR may improve patient satisfaction scores, which are correlated to

pay-for-performance models of reimbursement as well as improving communication

between the nursing staff, the patients, and families that they care for.

Project Strengths and Limitations

Strengths

The study relied on existing patient satisfaction survey data over a 7 month period

during which the NIIR was implemented. Data were examined in the 3 months prior to

implementation and the 3 months after implementation (the month of implementation

was viewed a transition month). The strengths of the study included the use of the 10

dimension subcategories of the satisfaction survey results, which highlighted the specific

areas of patient satisfaction most affected by the implementation of IR on this hospital

unit, rather than only a more general patient satisfaction score comparison according to

pre- and post-implementation. Another strength of the study was the use of graphic

representation of the patient satisfaction scores over the 7 month period to provide a

visual indication of trends toward improvement of satisfaction scores.

Limitations

The study results were limited by the fact that the data do not accurately represent

a truly paired sample given patient population differences across the 7 month period.

Because the study examined patient satisfaction scores based on the performance of the

same nursing staff in the same hospital unit, differences in individual patient experiences

introduced the possibility for nonequivalent patient groups, specifically in terms of

demographic characteristics of the patient populations and the unique experiences of

participants in the unit. As a result, data were not followed across the study period by

individual patient, but rather, were compared using monthly reported satisfaction scores for the unit to demonstrate changes in the earned satisfaction scores from patients in a given implementation of the NIIR strategy. This analysis strategy, although necessary given the changing patient populations, limited the data to the monthly mean scores, rather than the actual survey scores of each individual patient taking the survey. Thus, the small sample size limited the results. Future similar research could include a larger time period of both pre and post-implementation, such as 12 months pre- and 12 months post-implementation.

The patient satisfaction scores fell universally across all 10 care dimensions from the month of June to the months of July and August, with satisfaction scores recorded in July and August (prior to IR implementation in September) demonstrating the lowest patient satisfaction scores across the board. This study was limited in scope to the differences in pre and post-IR implementation and therefore did not investigate reasons for the severe drop in satisfaction scores from June to July 2013, within the pre-implementation data set. An investigation and unit practices and operations strategies could be conducted to examine the root cause for this satisfaction decrease across all care dimensions.

Analysis of Self

As Scholar

The process of developing a DNP project has helped me to feel confident in my skills as a researcher and scholar. Throughout my DNP journey, I have been able achieve, not only my professional goal of completing a doctoral degree, but also overcoming

personal adversity secondary to a brain injury incurred in the 1980s. I never thought that I would ever obtain registered nurse licensure, much less a doctoral degree of nursing practice. My role as a DNP scholar and nursing leader has also increased my level of knowledge in the development of new approaches to clinical practices which occur within the delivery of nursing care based upon evidence.

Throughout the process of this DNP scholarly journey, I have grown as a writer, as a researcher, and as an educator to my fellow nurses. I have come to realize that many nurses involved in clinical care of patients, may not be familiar with the process of research, and are not well versed, in the research that is tied to their daily clinical practice. Brown et al. (2010) suggested that many nurses will seek information from other colleagues, before they go to journals and other scholarly works as a source of knowledge versus actual credible evidence, and I have found this true in my own lived experience. I feel confident in being a mentor and example to the nurses I am surrounded by and to those with whom I may come in contact in the future.

Doody and Doody (2012) supported transformational leadership, and I believe that much of the success, or accomplishments that I have obtained, is because I believe that I practice idealized influence. Idealized influence occurs, when the leadership has become role models that the staff wants to emulate, and because of a relationship where the leadership has established trust, there becomes a confidence in the leadership, resulting in employees that are more apt to be open to new changes.

I have learned to develop my scholarly voice, and my scholarly writing with every revision that I have written. I have also learned to become a better researcher by

remaining objective and unbiased, no matter what the data may show, my work will not be in vain, nor will I see it as a failure. Having outcomes that are less than expected, does not nullify my work as being less than valid, but it can open the door for other scholars to build upon.

As Practitioner

I am still a practicing nurse in an acute care hospital, and an educator of other nurses, both in the acute care hospital setting, and for a well-known online university. As practitioner, and educator, I have grown through the process of learning the scientific Underpinnings (AACN, 2006) for the development and analysis of NIIR.

As Project Developer

My role as a nursing leader is to help develop an organizational change that promotes patient safety, and that results in the improvement in quality of healthcare delivery (AACN, 2006). As project evaluator, this DNP project has caused me to grow in the overall process of how to develop a research project, how to evaluate it, and how to disseminate the findings of the project. Prior to the DNP project, I was not very confident in research, and I experienced great anxiety over approaching research. But as I worked through the project, first with the DNP premise, followed by the DNP proposal, and then followed by my research and findings, I am now feeling very confident, and secure in approaching and developing any type of research project necessary.

Project and Future Development

NIIR can be developed into a standardized procedure, not only as a means to improve the patient's overall hospital experience and the organization's patient

satisfaction scores, but also as a standard for improving patient safety, decreasing adverse outcomes, and improving the overall quality of care that is being delivered an acute care settings. NIIR may also change the manner in which nurses deliver care, from reactionary nursing to proactive nursing. Proactive nursing care, delivers the control back to the nurses in the management of their patient care as well as the new management of their overall nursing practice. This DNP project, may serve as a foundation, or a springboard, that may open doors for collaborating with a variety of professionals within healthcare industry, who would like to see improved delivery of nursing care, reduction in adverse patient outcomes, as well as the safety of the patients in each of their prospective facilities.

Summary and Conclusions

Acute care hospitals across the United States are facing increased scrutiny, in the delivering of quality health care to the patient/consumer. Multi-regulatory governmental agencies, are mandating benchmarking, and proof from healthcare organizations, that all hospitals have plans in place, that are aimed at reducing and/or preventing adverse patient outcomes. Pay-for-performance models of healthcare, are serving as drivers for financial reimbursement, or financial declinations to acute care hospitals, dependent upon the   overall performance in the delivery of care. Patient satisfaction scores are one of the newer pay-for-performance mandates and the patient's hospital experience is often directly tied to the nurse, and the patient's perception of the nursing care delivered, during their hospitalization as a critical indicator of the hospital experience. NIIR may serve as a driver to assist healthcare organizations, and prevention of adverse patient

outcomes, through delivering of improved proactive nursing care, which results in positive patient satisfaction scores, and increased reimbursements to the healthcare organizations.

Section 5: Scholarly Product Project Dissemination

Impact of Nurse-initiated Intentional Rounding on Patient Satisfaction Scores

Manuscript

Tina Eslinger Vaughn MSN RN, DNPc

Patricia Schweickert PMC FNP-C, DNP

Amy Swango-Wilson Ph.D., MSN, RN

Faisal Aboul-Enein D.Ph., MSN, MPH, RN, FNP-BC, ACHE, USPHS

Abstract

Purpose- Evaluating the impact of nurse-initiated intentional rounding (NIIR) on patient satisfaction scores on a surgical unit.

Methods- Patient satisfaction survey responses were examined during a 7 month period Satisfaction score data was obtained for each of the 10 care dimensions and a total satisfaction score was calculated by summing and averaging the care dimension scores. The data is presented according to mean values by month, and a calculated mean score for the three month pre-implementation period and three month post-implementation period.

Findings -Mean satisfaction scores revealed an increase in overall satisfaction scores post implementation. The highest percent increase in satisfaction scores, to dimensions of cleanliness/quietness (47.5% increase), overall hospital rating (27.8% increase), would recommend hospital (23.9% increase), communications concerning medication (22.1% increase), and pain management (21.8% increase).

Conclusions- NIIR has a positive effect on patient satisfaction scores, supporting previous research indicating the benefits of implementation of NIIR as a process of purposeful, directed communication and evaluation of patient needs proactively.

Key Words-*intentional rounding, hourly rounding, patient satisfaction, HCAHPS, value-based purchasing*

Nurse-initiated Intentional Rounding and Patient Satisfaction Scores on a Surgical Unit

Nurse-initiated intentional rounding (NIIR) anticipates the needs of patients through nurses performing hourly checks, or intentional hourly rounding, on their patients. Every hour, the nurse will assess the patient for pain, personal needs, safety issues, medication needs, and overall comfort. Hospitals today are facing significant challenges with declining reimbursements and the rising financial costs in the delivery of healthcare. Multi-regulatory agencies such as the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), and the Agency for Healthcare Quality (AHRQ) are mandating hospitals to meet standards of reimbursement models, which are based upon the performance of nursing staff in the delivery of patient care (Brown, Donaldson, Burns-Bolton, & Aydin, 2010). These reimbursement models are also referred to as Pay-for Performance initiatives, which are considered to be a check and balance type of system, requiring healthcare organizations to meet quality benchmarks.

The performance of a hospital's overall organization and the Pay-for-Performance initiatives, serve as drivers to improve the quality of patient care by providing financial incentives to healthcare organizations specific to patient safety and patient satisfaction (Sura & Shah, 2010). If healthcare organizations do not meet quality benchmark standards, or at the least, show that there is an improvement in an area related to a quality of care benchmark (such as in patient satisfaction scores), hospitals will then be given a reduction in financial reimbursement for care delivered, or be denied financial reimbursement all together. Both CMS and TJC have endorsed Pay-for Performance

initiatives in order to (a) facilitate reduction of hospital acquired infections (HAI), skin breakdowns and ventilator acquired pneumonias (VAP), catheter associated urinary tract infections (CAUTI), and (b) increase patient safety, increase patient satisfaction, and an overall improvement in the quality of care delivered.

Hospital leadership across the nation are seeking a variety of measures to improve the quality of care delivered, in an era of declining revenues, and an increasingly expanding pay-for-performance initiatives, correlated to patient quality outcomes, and more specifically to patient satisfaction. Nurse-initiated intentional rounding (NIIR) is one such measure that follows the recommended guidelines of the Institute of Medicines (IOM,2010) supporting successful care, which is centered around meeting the patient needs, keeping the patient informed, encouraging patient participation, and returning to the patient control in their health care choices.

Background

Hospitals today are facing significant challenges with declining reimbursements and the rising costs of healthcare. Reimbursement models are based upon the hospitals performance in the delivery of care including patient safety and patient satisfaction (Brown, Donaldson, Burnes-Bolton, & Aydin, 2010). Healthcare organizations are competing for patients, while they are expected to deliver quality of care that is measurable, as well as meets the pay-for-performance initiatives. Value-based purchasing, is the Centers for Medicare and Medicaid Services (CMS) initiative, that rewards acute care healthcare organizations with incentive payments based on the quality of care they deliver to Medicare patients. Public reporting and financial incentives for

improved performances, serve as a driver to improve clinical quality, patient centeredness and efficiency.

One of the more recent pay-for-performance initiatives facing healthcare organizations is that of patient satisfaction. Healthcare organizations are examining models of nursing that will increase patient satisfaction scores, while delivering quality of care and increasing patient safety. NIIR is one model of care, which may be considered to improve patient satisfaction scores. NIIR is a descriptive, systematic process that is directed towards the overall care of the patient in an acute care setting, with the goal of improving quality of care, increasing the efficiency of the staff, and increasing the overall safety and satisfaction of patients (Upenieke, Akhavan, & Kotlerman, 2008).

Patients develop perceptions of a healthcare organization from the first time they enter into the healthcare system, during their time of stay, and up to the time of discharge. These perceptions are often determinants of the overall care received. Intentional rounding (IR) was developed by the Studer group (Studer, 2005) as a way, or a technique, to organize one's current workflow, with an additional goal of increasing customer service, resulting in customer satisfaction. There are some patient's perception of satisfaction or dissatisfaction with care that appear to be directly related to a nurse's responsiveness to the patient, and whether the nurse offers any comforting measures (Castledine, Grainger, & Close, 2005). There also appears to be certain commonalities with the process across all healthcare settings (Deitrick, Baker, Paxton, Flores & Swavely, 2012). For example, during IR, the nurse begins by introducing themselves to the patient and explains the process of what IR consists of. During each visit by the nurse

to the patient on the hour, the nurse will assess the patient's comfort, personal needs, such as, toileting, repositioning, pain, and the environment of the room (too cold or hot). At the conclusion of each visit, the nurse is to address the patient asking one last time, if there are any unmet needs.

The role of the bedside nurse is a critical indicator in how the patient views their hospital experience, and translates to reimbursement monies for healthcare organizations. Ford (2010) asserted that the patients value their nurse to patient relationship, including the amount of time a nurse is at the patient's bedside, and that NIIR is a strategic tool to improve patient satisfaction scores. The idea is that NIIR is more than just a checklist (Mason, 2012) when NIIR is utilized by nursing staff, there is a reduction in patients using their call lights because the patient's needs are being anticipated, and patient outcomes are improved through proactive intentional care. Mason (2012) suggested that the nurse recognizes patient care issues earlier than other practitioners, because of the time spent rounding on the patient, and that NIIR should be the foundation of all patient care delivered.

Evidence shows that proactive patient care by nurses, leads to better care by anticipating the patient needs. The patient's hospital experience will often depend upon the nursing staff and the care they delivered (Meade, Bursell, & Ketelsen, 2006). Meade et al. (2006) conducted a six week nationwide study in a quasi-experimental, non-equivalent group design, where baseline data were taken during the first two weeks. Data were collected and analyzed from 27 nursing units, in 14 different hospitals where nursing staff performed IR, either at one or two hour intervals, following a very specific

protocol. Their findings reflected a statistical reduction in patient's use of call lights, reduction in falls, and an increase in patient satisfaction scores.

The relationship between the staff and the patient, appears central to the outcomes of hourly rounding, and patients have reported a stronger connection with greater communication, and a sense of their needs being met by the nurse that cared for them (Abraham, Fillmore, & Sobaski, 2008). Several studies have shown that when focused NIIR is done, that patient's experience greater pain management, and safety (Haack, 2009) by nurse-initiated questions regarding the patient's comfort, and need for analgesic relief.

Healthcare organizations today are competing for patients, now referred to by many organizations as "customers," instead of patients. Customer service is a critical driver in patient satisfaction scores, and there appears to be a relationship between patient satisfaction scores and NIIR, resulting in financial gain for the organization (Blakely, Kroth & Gregson, 2011). Customer service has driven many healthcare organizations to look for outside help from healthcare to customer service training organizations, such as the Quint Studer Group. Creating service improvement as a practice change introduces the nursing staff to the reasons why customer service, and improving customer service, is so critically important to patient satisfaction scores (Gage, 2013).

The means to improving the delivery of quality care in today's competitive healthcare organizations requires a cultural change in which all members of the healthcare team engage in creative ways to meet the patients' overall needs (Mullan, 2007). Education to the process of NIIR is critical to staff engagement, as well as for

consistency in staff participation in the implementation and the practice of NIIR
(Hutchings, Ward, & Bloodworth, 2013). Because improving customer service is
foundational to improving patient satisfaction scores, the leadership of the healthcare
organization are key stakeholders in leading the changes that are needed when
implementing NIIR as a new practice. All change requires planning, and strategies that
would lead to sustainability from the very onset of planning a change (Parsons, 2011),
and must include early engagement of staff.

Nurses have reported that a critical element to successful implementation of NIIR
is the support and inclusion of the nurses and the leadership, from the onset of the
planning stages of NIIR through the completion of implementation of NIIR (Bourgault et
al, 2008). The healthcare team members should share in a common goal of improving the
quality of care delivered, by sharing the same vision, within a caring environment that
supports an exchange of ideas (Taylor, 2007).

The process of NIIR supports meeting the patient's needs by nurses becoming
proactive, as opposed to reactive, in their approach to patient care when meeting the
patient's needs. Blakely, Kroth, and Gregson (2011) supported this by their research
conducted on a medical surgical inpatient unit, where data were collected through a
variety of means (i.e., observation, surveys, interviews, and patient satisfaction data
obtained from HCAHPS scores that were updated and published quarterly). The end
results supported that IR did increase patient satisfaction scores.

The concepts of NIIR, to some, may be viewed as nothing new, but that NIIR is
just experiencing a revival in hospitals today due to required benchmarking and pay-for-

performance initiatives (Olrich, Kalman, & Nigolian, 2012). NIIR may be experiencing

resurgence in hospitals, as Olrich et al. (2012) suggested, but as a strategic tool to

improve patient satisfaction scores, it remains a relatively new concept. However, NIIR is

being developed within healthcare organizations in all patient care areas due to the

growing need for improved patient satisfaction scores. Most recently, the TJC has

evaluated emergency departments for patient wait times, as well as patient satisfaction.

Baker (2010) conducted a study evaluating the results of patient rounding, as it relates to

patient satisfaction in the emergency department. Baker reported that patients felt less

isolated and did not feel abandoned when nursing staff made contact with them on a

regular basis, even if no real or perceived needs were present.

There is evidence to show that when NIIR is implemented with staff engagement,

the results appear to be very positive for both nursing staff as well as patient outcomes,

on a consistent basis. Orr, Tranum, and Kupperschmidt, (2006) examined NIIR from the

position of being positive for the patient outcomes, and positive for the staff, but that

NIIR needs to be implemented as a standard of care, with utilization of the Studer group

materials as a basis for designing implementation of NIIR. Their work described a

trialing of hourly rounding on a medical surgical unit, which included scripting,

overcoming barriers to implementation, facilitators, and outcomes. The study findings

revealed the use of patient rounding at one hour increments as a care model, which

resulted in a decrease in call light use, and an increase in patient satisfaction (Orr et al.,

2006).

Purpose Statement and Project Objectives

The purpose of this project was to determine whether the implementation of NIIR by nursing staff on a 33 bed surgical unit has a positive effect on improving patient satisfaction scores. NIIR has been shown in some literature to increase patient satisfaction, through decreasing the number of patient falls, the number of medication errors, reduction in negative patient care outcomes, and improving the patient's perception of their hospital experience (Meade, Bursell & Ketelsen 2006). The Institute of medicine (IOM) has suggested that all healthcare organizations have a plan in place, to improve the health care of all patients (IOM, 2010). NIIR may be a step to establish a methodology of assessing patients' needs routinely, resulting in improving their satisfaction and improving the healthcare organizations patient satisfaction scores specifically. The objective of this project was to evaluate the effects of NIIR as a new nursing practice process, and to determine whether NIIR has a positive effect on improving patient satisfaction scores.

Method

NIIR was implemented September 1, 2013 on the surgical unit with the goal of improving patient satisfaction scores on the unit. The data collection utilized was a retrospective view or secondary data collection (Hodges & Videto, 2011) of patient satisfaction scores for the previous three months, specific to the surgical unit. This established a baseline point to start the evaluation of patient satisfaction scores pre-implementation of NIIR to patient satisfaction scores post implementation of NIIR. Data was extracted from reports to the hospital from a third party surveyor known as NRC Picker (NRC), which also reports this data to a publicly accessed hospital comparison

site, known as Hospital Compare.HHS.gov. The scores were averaged, based upon the

number of patients that responded to the surveyor's questions, it should be noted that the

questions asked of the patients, followed CMS mandated HCAHPS categories of the 10

dimensions of care listed below.

The instrument used was the HCAHPS survey. Patient satisfaction scores

previously collected on the surgical floor were assessed from HCAHPS data. The

program evaluation of NIIR was evaluated based on the resulting satisfaction scores that

reflect the surveyed patients' answers to the following questions, specific to their

inpatient experience, only on the surgical unit, covering the ten dimensions of care, such

as:

1. Care transitions – This question involved how the patient perceives the

   transitional care from either admission to the hospital, through the emergency

   room, and then subsequently to the surgical floor, or to other procedural areas.

2. Cleanliness/quietness-the patient was asked to rate the cleanliness of the

   quietness of the surgical unit

3. Communication about medications-the patient was asked to rate how the nurse

   communicated information about the medications, that they received while in

   the hospital.

4. Communication with nurses-the patient was asked to rate the communication

   provided by the nurses during their hospitalization on the surgical unit

5. Communication with doctors – the patient was asked to rate the communication provided by the physicians during a hospitalization on the surgical unit (required question)

6. Discharge information – the patient was asked to rate the discharge information provided to them upon discharge by the nurse from the surgical unit.

7. Overall rating of the hospital-the patient was asked to rate the overall hospital experience.

8. Pain management-the patient was asked to rate the pain management, they received from the nursing staff while in the surgical unit.

9. Responsiveness of hospital staff-the patient was asked to rate the responsiveness of the nursing staff upon the surgical unit.

10. Would recommend hospital – the patient was asked to rate if they would recommend the hospital to others.

Each of the above questions were posed by the NRC surveyor, utilizing a Likert scale, to rate each survey question. The scale is based on a rating of   1 -4:

1 = never,

2 = sometimes,

3 = usually,

4 = always.

There were also several questions on the survey that require only a yes or no response, such as "during this hospital stay, did you get information in writing about what

symptoms or health problems to look out for after you left the hospital," and several

questions that require the patients surveyed to respond based upon a rated scale of 0 to

10, such as when the patient was asked to rate the hospital during their stay on a scale of

0 to 10. A zero would indicate that the patient has chosen the facility as the worst hospital

possible, and a score of 10 would reflect that the patient has indicated that the patient has

chosen the hospital as the best hospital possible. Within the 0 to 10 scale, the patient had

the option to also rate the hospital in degrees of preferences, such as 1-9, again from the

worst to the very best (HCAHPS, 2013). The scores were compared to patient

satisfaction scores three months prior to NIIR implementation, and to scores three months

post NIIR implementation.

Results

The mean satisfaction scores for each of the 10 care dimensions were calculated

over the designated 7 month study period from June 2013 to December 2013 (Table 1).

Initial implementation of NIIR took place in September, which was considered the

transition month. June 2013 through August 2013 were therefore considered the pre-

implementation time period and October through December were considered the post-

implementation period. Average patient satisfaction scores in each of the 10 care

dimensions were graphed over the 7 month period from June to December (See table 1).

The individual graph representations demonstrate modest increases in patient satisfaction

scores, which were evident in all 10 care dimensions.

Table 3

Care Dimension Satisfaction Scores by Month

	Pre-Implementation						Transition		Post-Implementation					
	June 2013		July 2013		Aug 2013		Sep 2013		Oct 2013		Nov 2013		Dec 2013	
HCAHPS Care Dimensions	M	n	M	n	M	n	M	n	M	n	M	n	M	n
Care Transitions	44.7	22	54.8	75	53.5	19	44.1	17	**52.6**	20	46.3	27	**63.8**	23
Cleanliness/ Quietness	58.7	23	56.5	81	40.5	21	**61.1**	18	**65.8**	20	50.0	28	**60.9**	23
Communication About Meds	81.3	8	37.5	34	50.0	9	**63.6**	11	**81.3**	9	**65.4**	13	59.1	11
Communication with Doctors	71.0	23	61.8	81	71.4	21	**68.4**	19	**80.7**	20	**74.1**	27	**75.8**	22
Communication with Nurses	82.6	23	65.3	82	59.7	24	**76.7**	20	**82.5**	20	**75.1**	28	**80.6**	24
Discharge Information	93.2	22	82.6	74	85.7	21	**85.3**	17	**94.4**	19	**88.5**	26	**88.6**	22
Overall Rating of Hospital	77.3	22	47.8	78	47.6	21	**66.7**	18	**73.7**	20	**70.4**	27	**78.3**	23
Pain Management	72.2	18	73.5	60	46.9	16	60.7	14	**84.6**	14	**82.5**	20	67.5	20
Responsiveness of Hospital Staff	65.9	22	59.1	75	50.0	19	62.5	16	**72.2**	18	**64.0**	25	**60.9**	23
Would Recommend	77.3	22	63.6	77	52.4	21	**83.3**	18	**73.7**	20	**84.0**	25	**81.8**	22

Note. n size=number of pts. Responding

Pre-NIIR implementation data and post-NIIR implementation data were summed and averaged according to each of the 10 care dimensions (Table 2). Thus, pre-NIIR implementation data consisted of data points from June through August 2013 and post-implementation data consisted of data points from October through December.

Figure 4. Pre-implementation and post-implementation satisfaction scores by care dimension.

Table 4

Pre Implementation and Post Implementation Scores by Care Dimension

HCAHPS Care Dimensions	Pre-IR M	Post-IR M	% Increase
Care Transitions	51	54.2	6.27
Cleanliness / Quietness	39.9	58.9	47.62
Communication About Meds	56.2	68.6	22.06
Communication with Doctors	68	77	13.24
Communication with Nurses	69.2	79.4	14.74
Discharge Information	87	90.5	4.02
Overall Rating of Hospital	58	74.1	27.76
Pain Management	64.2	78.2	21.81
Responsiveness of Hospital Staff	58.3	65.7	12.69
Would Recommend	64.4	79.8	23.91

Note. n size=number of pts. Responding

Figure 2 offers graphic visualizations of the overall pre- and post-IR implementation satisfaction scores. The graph demonstrates the general increase in satisfaction in each of the 10 care dimensions.

Examining the data from Table 2 and the graph in Figure 2, satisfaction score increases were strong within care dimensions of nurse communication (14.74% increase), physician communication (13.24% increase), responsiveness of hospital staff (12.69% increase), pain management (21.81% increase), communication about medication (22.06% increase), cleanliness and quietness of the hospital environment (47.62% increase), overall rating of the hospital (27.76% increase), and willingness to recommend the hospital (23.91% increase). The data on the dimensions of care transitions (6.27% increase) and discharge information (4.02% increase) demonstrated a lesser degree of improvement graphically. The largest differences, shown on the graphic visualization, appear to be within the care dimensions of cleanliness and quietness of the environment

(47.62% increase), overall rating of the hospital (27.76% increase), would recommend the hospital. (23.91% increase), communication about medication (22.06% increase), and pain management (21.81% increase).

Satisfaction scores for each of the care dimensions were then summed and averaged across the 10 dimensions. Scores for the month in which IR was implemented (September) were not included as part of the post-IR implementation month, but rather were excluded from the analysis as a transition month. Average pre-IR implementation scores from the 3 months prior to implementation (June, July, and August) were compared to the average post-IR implementation scores from the 3 months after implementation (October, November, December). Descriptive statistics of the mean (M) and standard deviation (SD) demonstrated a mean pre-IR implementation overall satisfaction score of 61.62 (SD 12.45), compared to a post-IR implementation mean score of 72.64 (SD 10.86). A graph of the Pre and Post IR implementation satisfaction scores illustrated an increase in mean satisfaction patient scores (Figure3).
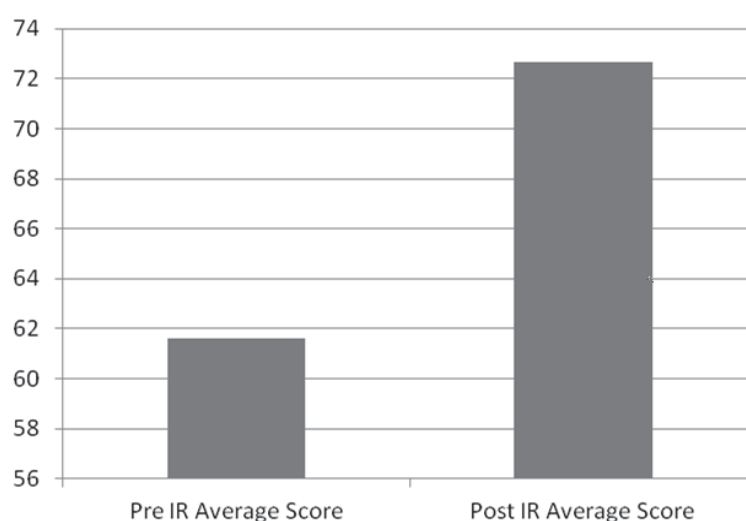

Figure 5. Pre versus post-IR implementation overall satisfaction scores.

Conclusion

This project evaluated the impact of implementation of NIIR, and the relationship to patient satisfaction scores. The findings of this project support previous research indicating the benefits of implementation of NIIR, as a process of purposeful, directed communication and evaluation, of patient needs proactively, helping the nurse to anticipate the patient's needs through hourly checks, instead of waiting for the patient to alert the staff to their needs (Berg et.al.2011; Haack, 2009). Ford (2010) asserted that this directed communication and proactive patient evaluation serves to improve quality of care and may also contribute to improved patient satisfaction. Although the data collected in this program evaluation did not include patient outcomes, patient rated satisfaction scores related to communication (communication about medication and communication with doctors and nursing staff), pain management, and overall rating of experience at the hospital, supported increased satisfaction related to these aspects of care, similar to reports by Meade et al. (2006), Haach (2009), and Abraham et al. (2008). In this evaluation, however, improvements in satisfaction scores were evident in all 10 dimensions of care, with particularly noticeable improvements in the areas of nurse communication, physician communication, responsiveness of hospital staff, pain management, communication about medication, cleanliness and quietness of the hospital environment, overall rating of the hospital, and willingness to recommend the hospital.

In particular, the dimension of cleanliness and quietness of the hospital environment demonstrated a percentage increase of over 47%, an element not noted in previous research, but one that may indicate the effect of NIIR on nurse efficiency and

reduced call-button use. A quieter, cleaner environment may be indicative of nursing

staff that are afforded more time through efficiency and consistency of practice. The

results of implementation of NIIR among nursing units represents not only a shift toward

more proactive nursing care to support improved patient care and satisfaction (Harrision,

2012), but perhaps also a shift toward more efficient, progressive, consistent, organized,

and less hectic nursing practice.

      Acute care hospitals across the United States are facing increased scrutiny, in

the delivering of quality health care to the patient/consumer. Multi-regulatory

governmental agencies, are mandating benchmarking, and proof from healthcare

organizations, that all hospitals have plans in place, that are aimed at reducing and/or

preventing adverse patient outcomes. Pay-for-performance models of healthcare, are

serving as drivers for financial reimbursement, or financial declinations to acute care

hospitals, dependent upon the   overall performance in the delivery of care. Patient

satisfaction scores are one of the newer pay-for-performance mandates and the patient's

hospital experience is often directly tied to the nurse, and the patient's perception of the

nursing care delivered, during their hospitalization as a critical indicator of the hospital

experience. NIIR may serve as a driver to assist healthcare organizations, and prevention

of adverse patient outcomes, through delivery of improved proactive nursing care, which

results in positive patient satisfaction scores, and increased reimbursements to the

healthcare organizations.

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Appendix A: Hourly Rounding Checklist

Hourly Rounding Check List   **Surgical Unit**

Date: _____   RM #_____

Rounding will occur hourly from 06:00am and then from 10:00pm and every two hours

Time of Visit Staff initial	Pain	Potty/Environment	Other need
06			
07			
08			
09			
10			
11			
12			
13			

Nursing staff signatures and initial-please sign legibly

Appendix B: Ten Dimensions of Care HCAPS Categories

Table of Ten Dimensions of Care HCAPS Categories
1- Care transitions
2- Cleanliness/quietness
3- Communication about medications
4- Communication with nurses
5- Communication with doctors
6- Discharge information
7- Overall rating of the hospital
8- Pain management
9 -Responsiveness of hospital staff
10-Would recommend hospital

Each of the above categories is rated by the discharged patient based upon their perception of their hospital experience. Each category is a required dimension of care, mandatory to be reported to CMS and other regulatory agencies, reflecting the patient experience

Appendix C: Intentional Rounding Process Map

Intentional Rounding Process Map

```
Pt enters
into
Surgical
unit

        Staff
        greets pt
        and
        explains.
        Intention
        al
        rounding

                Hourly
                visits
                begin
                upon
                admissio
                n by RN
                and NA.

                        Pt assessed for
                        personal
                        needs, pain,
                        environment
                        and other
                        needs

                                Patient's
                                needs met

                                        no further
                                        needs
                                        identified

                                                Documen
                                                t to
                                                hourly
                                                rounding
                                                log

                                                        Documen
                                                        t to EMR
```
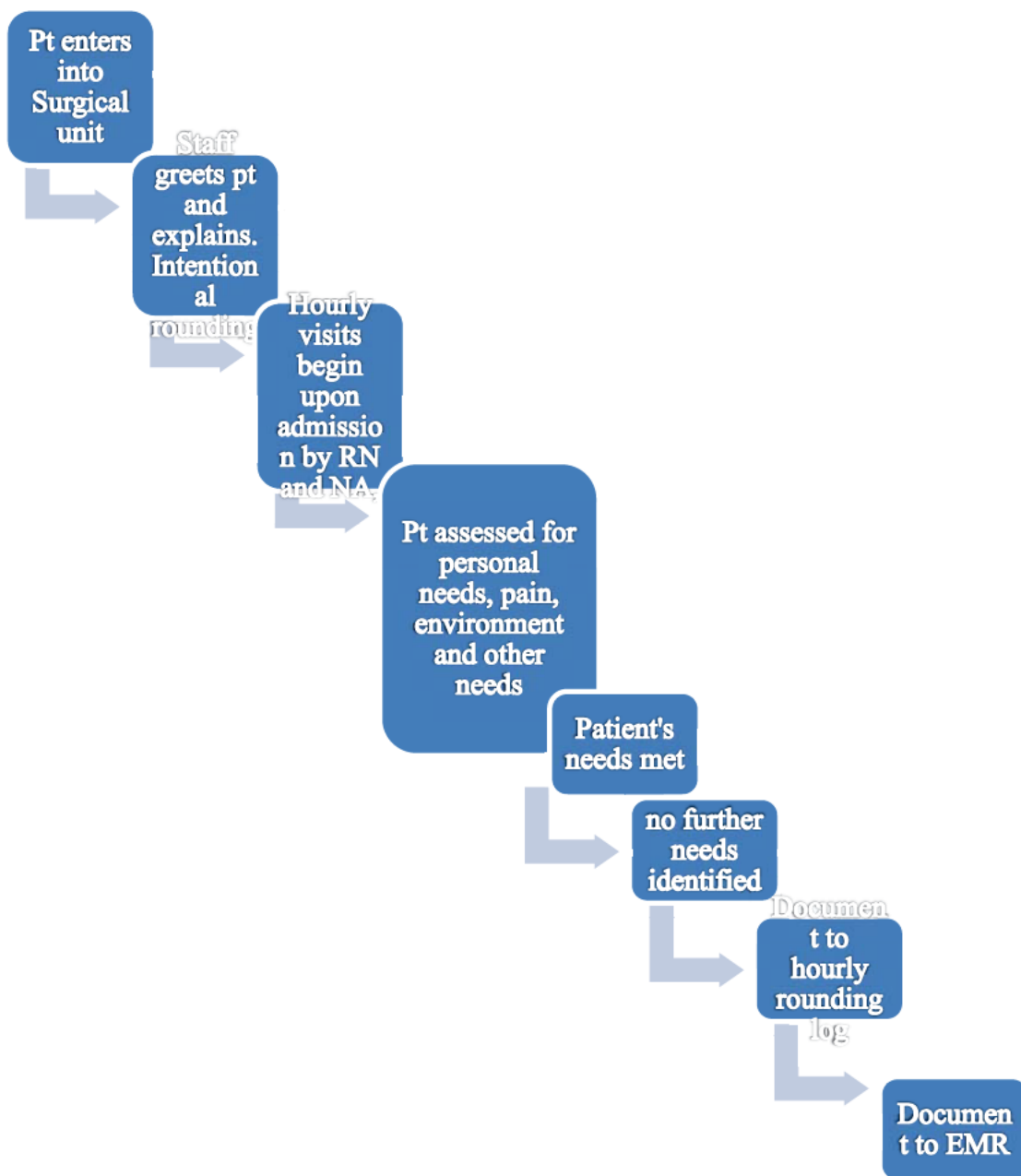
Curriculum Vitae

TINA M. ESLINGER-VAUGHN BSN, MSN, RN-C, DNP Candidate

██████████████

PROFESSIONAL SUMMARY:

Kaplan University

3/2007-present

Professor of Nursing for RN-MSN Program

Shasta Community College - Redding, CA

2002- (Present)

<u>Clinical Nursing Instructor Adjunct</u>

Responsible for clinical instruction of associate degree nursing (ADN) students in the

Clinical skills lab as well as in their hospital clinical rotations. I have instructed in all four

semesters of the ADN program including fundamentals of nursing, critical care, and

leadership and management.

Shasta Regional Medical Center (Formerly Redding Medical Center) - Redding, CA
1987 – Present

<u>Occupational Health</u> (2010-to present)

<u>PAS Unit</u> (2001 to present)

Staff RN - responsible for all phases of patient education and preparation for surgery and

for recovery of patients post anesthesia.

<u>Emergency Department</u> (1987 - 2001)

Staff RN, Charge RN and Clinical Supervisor - responsible for day-to-day operation of

emergency department, policies and procedures, new hire interviews, staff evaluations,

staff education, and materials management.

Redding Medical Home Health Division - Redding, CA

1988 – 2000

<u>Staff RN / Case Manager</u>

Company closed in 2000 due to corporate restructuring.

CURRICULUM VITAE - TINA M. ESLINGER-VAUGHN

*EDUCATION***:**

Walden University

 Doctor of Nursing Practice Candidate

Walden University

Master of Science in Nursing
Graduated 2006

National University - Redding, CA

Baccalaureate of Science in Nursing
Graduated 2003

Shasta Community College - Redding, CA

Associate Degree of Nursing
Graduated 1985

College of the Siskiyou - Weed, CA

LVN Certification and AA Degree
Dean's List
1979 – 1984
Graduated 1980

CERTIFICATIONS:

- Registered Nursing CA License # Y390718

  Registered Nursing Iowa License # 118391

  Registered Nursing Minnesota License # 207245-0

- Basic Life Support (CPR)
-
- Advanced Cardiac Life Support
-
- Pediatric Advanced Life Support

- Sexual Assault Nurse Examiner
-
- Mobile Intensive Care Nurse #153
-
- Certified Medical Surgical RN
-

PROFESSIONAL MEMBERSHIPS:

- National League of Nurses
-
- Emergency Nurse Association
-
- Academy of Medical Surgical Nurses
-
- California Teachers Association

CURRICULUM VITAE - TINA M. ESLINGER-VAUGHN

SCHOLARSHIP:

Developed mandatory influenza policy for Shasta Regional Medical Center

Committee member GEL: Communication Kaplan University

Coordinator and developer of the Sexual Assault Response Team (SART)

Professional Practice Committee Member Shasta Regional Medical Center

Committee member Nursing Quality Shasta Regional Medical Center

Committee member Infection Control Shasta Regional Medical Center

Committee member Environment of Care and Safety Shasta Regional Medical Center

COMMUNITY SERVICE:

Former Community Speaker for SART program

Former member Injury Prevention Coalition Committee

Former Member of City-wide Disaster Planning Committee

Active member Little Country Church