EXECUTIVE LEADERSHIP ROUNDING ON STAFF AND ITS EFFECT ON PATIENT SATISFACTION AND PATIENT OUTCOMES

by

Cathleen D. Butenewicz

JOHN SCHMIDT, DNP, Faculty Mentor and Chair

JOANNA FAIRLEY, PhD, Committee Member

ANNE LARA, Ed. D, Committee Member

Patrick Robinson, PhD, Dean, School of Nursing and Health Sciences

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Abstract

It has been recognized in healthcare organizations across the country that there is a significant relation between organizational quality, improved patient outcomes, and the financial success of an organization. Through an evaluation of the current state of rounding at a small community hospital, it was determined that patient and staff rounding lacked consistency and structure, as well as effective leader visibility. Thusly, patient and staff rounding by executive leadership was recognized to be a Quality Improvement (QI) initiative. The objective of this QI initiative was to ascertain the effect of purposeful executive leadership rounding on a medical-surgical unit and its correlation to patient safety as related to the incidence of in-patient falls and the patient's overall satisfaction with their hospital stay over a three-month period. Utilizing a quantitative approach based on verifiable observations and information, data was collected via a third-party vendor, as well as through the organization's in-house Quality department. Baseline data was gathered from the previous year as well as concurrently during the project period. At the completion of the trial period, the data was analyzed for statistical significance and presented as showing no statistical significance between leadership rounding and patient satisfaction yet did yield an overall decrease in the number of in-patient falls during this time. This study gives an early indication that executive leadership rounding is conducive to improved patient outcomes yet warrants further studies to potentially elicit a correlation with patient satisfaction. Future studies will focus on multi-site organizations and broader inclusion of patients and nursing units to capture additional barriers and further expand the outcomes.

Keywords: leadership rounding, patient satisfaction, staff engagement, quality outcomes

Executive Leadership Rounding on Staff:
Its Effect on Patient Satisfaction and Patient Outcomes

Executive leadership rounding, a process where executives are on the unit speaking with staff and patients in a purposeful manner, involves those with authority to implement change and has been advocated as important to the transformation of an organization to a high-reliable organization (HRO). For the intent of this project, rounding is defined as a process of interacting with patients and staff on a planned, regular basis to aid in the anticipation of their fundamental needs (Hutchings, Ward, & Bloodworth, 2013). Best practice suggests that strong leadership with a visible commitment to staff and patients demonstrates a significant correlation to improved patient satisfaction scores and a decrease in safety events within one's organization (Davis, 2013). When done in a purposeful manner, executive leadership rounding can lead the paradigm shift of an organization toward becoming a HRO in which patient experience and safety are recognized as critical components to its continued success within the community as well as having significant returns on investments (ROI). With the Future of Nursing Report asserting that the nursing profession plays a pivotal role in producing safe, quality care and coverage for all patients, it is imperative that nurses' gauge their patients' perception of satisfaction and safety, and to address any deficiencies immediately (Robert Wood Johnson Foundation [RWJF], 2011). One avenue to do this is through executive leadership rounding.

Problem Description

For fiscal year 2015 (FY15), the proposed pilot unit had an overall patient satisfaction score of 64.5%, well below the 80th percentile of 79.3% when benchmarked against like organizations. The first three quarters of FY16 yielded a score of 67.2%, a slight increase from the previous fiscal year, yet remaining below the 80th percentile. Data garnered from FY15 and FY16 in relation to falls illustrated a downward trend from 110 overall within the organization to

98 overall across the two years. On the proposed pilot unit, the number trended slightly down from 22 (20% of all in-patient falls) to 19 (19% of all in-patient falls).

Administrators and leaders of the organization reviewed current rounding practices and quickly identified a lack of structure and consistency. A correlation between the patient satisfaction and in-patient falls was viewed as having a significant impact on organizational quality and outcomes. The QI project reflecting the relevance of executive leadership rounding to the improvement of patient satisfaction and safety outcomes at this community hospital was then initiated.

Available Knowledge

A literature review was conducted using keywords *rounding, patient safety, leadership, patient satisfaction, patient falls, and improved outcomes*. Databases searched included CINAHL, OVID, EBSCOhost, ProQuest, and Sagepub for 2011-2016.

Patient satisfaction and a culture of safety can be best theorized as a collection of interventions rooted in the principles of leadership, teamwork, and behaviors (Weaver, Lubomski, Wilson, Pfoh, Martinez, & Dy, 2013). A recurring theme found in the literature relates to shared knowledge, an interdisciplinary approach, and leadership behaviors in regards to the effect of leadership rounding on patient satisfaction and safety outcomes.

Shared Knowledge

It is essential that all stakeholders understand the purpose of leadership rounding and what is being conveyed, otherwise the effects of this strategy will be without value. Reimer and Herbener (2004) script that the intent of leadership rounding is to demonstrate to the front-line team that senior executives care and are invested in the resolution of all concerns. Studies conducted by Davis (2013) and Greenwald, Nowacki, and Stoller (2015) both showcase the

empowerment of front line team members through mutual respect, relationship building, communication, and trust when executives are rounding in a consistent and engaged manner.

Interdisciplinary Approach

The literature further supports that an interdisciplinary approach to leadership rounding is essential to having a comprehensive program aimed at improving quality in the acute care in-patient setting (Begue, Blanchard, & Semos, 2012). The overall intent is to have an increased sense of teamwork and communication, thereby transforming the organization into one cohesive unit who are then motivated to achieve the same goals across the board (Winter & Tjiong, 2015). This approach ties directly into enhanced patient care and improved patient outcomes as it is central in improving communication regarding concerns, risks, and threats to safety while improving nurse-physician, physician-physician, and physician-patient communication (Begue et al., 2012). Interdisciplinary rounding fosters the development of realistic, individualized care, and discharge planning and remains reliant on all team members to participate.

Leadership Behaviors

Current literature suggests that there is a complex relationship between leadership behavior and quality and safety. Many executives understand what type of leadership style and behaviors are expected of them, including honesty, supportive management style, and inclusivity (Bohan & Laing, 2012). In recognizing and understanding this, leaders can provide the front-line team with clear expectations and accountability as well as empowerment to problem solve, all while being supportive and engaging. On the other hand, some executives and leaders view quality and safety *only* as a patient safety issue and as a singular event. This view may make it difficult for the front-line team and patients to fully understand the vision of the organization as related to quality in relation to this disconnect. Leadership rounding supports the alignment of

the two views by bringing together leaders, front-line staff, and patients to work together in achieving high quality, cost-effective care, patient satisfaction, and improved outcomes in a proactive manner.

In summary, the literature illustrates a complex relationship between leadership rounding and quality and safety. However, none of the identified studies focused exclusively on executive leadership rounding and its effect on patient satisfaction and improving patient outcomes (Davis, 2013; Winter & Tjiong, 2015; Begue et al., 2012). An interdisciplinary approach to improving patient safety and satisfaction has been identified as essential components of a comprehensive program of working toward improving quality in the acute care in-patient setting. Through shared learning and knowledge within the interdisciplinary team, a wider organizational approach to culture change and patient-centered philosophies toward care and management can be more easily obtained.

Rationale

The assumption was that executive leadership rounding would connect the relevance of rounding to improved patient satisfaction and safety outcomes as defined by in-patient falls. To address this, the influence of the model of knowledge transfer theory and Havelock's theory of planned change were used to drive this QI project.

The model of knowledge transfer theory was utilized as a conceptual guide for dissemination and implementation of this patient safety initiative. When implementing evidence based practices (EBP), this theory recognizes the myriad of perspectives from those who conduct or generate knowledge, those who use EBP, and those who serve as boundary spanners to link the knowledge generators to the knowledge users (Titler, 2008). With its focus on partnerships and end-user involvement, the Model of Knowledge Transfer stresses the importance of defining,

understanding, and working in a collaborative environment across all stages. At the core, there remained an understanding that new relations would be forged between all parties to develop a multifaceted audience-driven strategy which then fully framed the QI project.

Havelock's theory of planned change recognizes the need for a change agent to allow a process of organizing one's work and implementing change within the work environment. With its emphasis on planning and the understanding that people and systems may be resistant to change, Havelock's theory suggests that there are cycles of action which are repeated as change advances, and that these changes must be monitored by the change agent for success (White & Dudley-Brown, 2012). As this QI project involved three levels of behavior – individual, group, and organizational – Havelock's Theory of Planned Change provided the guidance and support needed to tolerate and sustain change across the continuum.

Specific Aim

Richardson, Watson, and Wong (2007) noted that leadership is identified as a critical factor in the successful implementation of patient safety initiatives. The purpose of this project was to explore the relationship between executive leadership rounding and its correlation to overall patient satisfaction and patient outcomes on a 24-bed medical surgical unit during a 3-month period. These two domains were examined utilizing pre-and post-data via statistical analysis with the intent to implement a practice change initiative within the organization to further assist with improvement.

Methods

This descriptive correlational project used a longitudinal data collection survey as well as a data repository for self-reported patient events. Descriptive surveys were used to collect

nominal data related to patient satisfaction, and a data repository was used to collect nominal data reflective of patient safety outcomes.

Interventions

Patient Participants

Inclusion criteria consisted of being 18-years or older at time of admission, a length of stay greater than 1 night, having a non-psychiatric diagnosis, and to be living at time of discharge. Exclusion criteria consisted of prisoners, patients with foreign home addresses, and patients discharged to hospice care. Of the 629 patients admitted to the medical/surgical unit during the project period, 221 patients were randomly selected to complete the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHP) survey. The HCAHP survey assesses overall satisfaction with their recent hospital stay. Of those 221 participants, 12 surveys were undeliverable and only 42 chose to participate for a response rate of 20.1% (See Figure 1).

Nurse Participants

There were a total of 38 nurses assigned to the pilot unit, but only 17 participated due to the actual time of day for the intervention. Of those nurses, 14 (82%) were female and 3 (18%) were male. On education level, the participants reported ADN (n = 7; 41%), BSN (n = 8; 47%), and MSN (n = 2; 12%). For certification, 4 (24%) are nationally board certified in medical-surgical nursing and 6 (35%) are chemotherapy certified. Of those, two participants hold both certifications.

Executive Leadership Participants

At the start of the QI project, eight executives were identified to participate in the QI project. Of those eight, four had clinical backgrounds. Two were board-certified physicians and

two were board certified registered nurses holding a master degree or higher. The remaining four executives were non-clinical with backgrounds in human resources, legal, professional development, and business & finance. During the third week of the intervention phase, one executive retired.

Context. The planned initiative expanded upon the current practice of unstructured, inconsistent rounding. During an 8-week timeframe, the executive leadership team was tasked to round on the identified unit once a day utilizing a Monday through Friday calendar. During this time, executives discussed with staff any barriers they were facing in doing their jobs safely. They also spent time with front-line team members fostering relationships and trust between the two. Of the eight executives participating, three of the executives also rounded on patients whom were identified by the front-line team as having concerns related to their stay.

To stay on task, each executive was provided a detailed calendar of when they were scheduled to round. The time of the day was left to the executive's discretion with the understanding that if they could not round on their scheduled day, they were responsible for finding a replacement. During the eight-week timeframe, executives were encouraged to reach out to either the project lead or nurse manager of the unit for support during rounding. Five of the eight utilized this approach, while the others rounded solo. Overall, there was 80% compliance with executive rounding.

Several safety concerns were revealed during executive rounding; including a lack of response between physician and nurse, aggressive patient behaviors, and limited front-line staff during high volume days. For this initiative, only patient satisfaction and in-patient falls were evaluated for significance.

Measures

Data was collected reflective of patient satisfaction scores and the number of in-patient falls during the intervention period utilizing a post-discharge survey and the in-house reporting system for safety outcomes. For patient satisfaction, a quantitative approach to inquiry was employed through a survey method provided by the National Research Corporation (NRC). NRC is an integration of cross continuum metrics and analytics providing insight for effective process improvements, quality measurements, and other factors which influence population health management (National Research Corporation, 2014). To ensure its validity, random sampling is done on all eligible discharges monthly with an aggregate being done quarterly. To maintain statistical precision (identified target for HCAPHS = 0.8), hospitals must obtain at least 300 completed surveys over a 12-month period to be considered highly reliable (NRC, 2014). For this study, the number of surveys completed reflected this requirement was met. The survey was conducted via a random selection process and administered between two and fourteen days' post-discharge. Collected data was then aggregated at both the organizational level and the unit level, and shared monthly with all stakeholders. The following HCAHP question was used as the measurement to garner the necessary data during the prescribed timeframe: "Using any number from 0 to 10, where 0 is the worst hospital possible, and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?"

To capture the number of in-patient falls, the organizational reporting system, Quantros, was utilized. Quantros maintains a strong focus on patient safety, infection control, quality, and accreditation standards (Quantros, 2015). Information is continuously pulled from discrete fields within the medical record thus eliminating human error associated with data-mining and chart abstraction variability. All data is captured and reviewed by the quality department which then

aggregates and collates the data into monthly reports and then shared with the respective departments.

Data for both variables was collected pre- and post-intervention. Even though data was returned in both quarterly and year-to-date aggregates, only quarterly data was reviewed and analyzed due to the timeframe of the intervention. Year-to-date data was for informational purposes only.

Analysis

Demographics and study variables were tabulated using descriptive statistics, summary scores, and graph displays. Analysis was based on the Chi-square test to explore if the relationship of the nominal variables (patient satisfaction scores and number of patient falls) correlated to the intervention of executive leadership rounding.

Results

The clinical question was "For patients on a medical/surgical unit, what is the effect of executive leadership rounding on patient safety as related to the incidence of in-patient falls and the patient's overall satisfaction with their hospital stay over a 3-month period?"

The numbers of patient falls recorded across the organization were 7 in 2016 and 3 in 2016, for a total of 10 falls during the identified time of the intervention. On the pilot unit, during 2015 there were 2 falls, and in 2016 there were no falls for a total of 2 falls. As seen in Figure 2, the observable trend is that the number of falls went down from 2016 to 2015, both organizationally and on the pilot unit. With only four data points to analyze, statistical analysis was unable to be performed as it lacked the required five data points. Therefore, using descriptive analysis, these findings suggest a possible influence of the intervention. Based on benchmarks stationed against like-size organizations and non-magnet facilities, this finding met

the expectations of the National Database Nursing Quality Indicators (NDNQI) as indicated by data finalized for CY16 Q3 (See Table 1).

A Chi-square test of Independence for patient satisfaction was done as there was the required relationship between two nominal variables obtained with the patient satisfaction raw scores. For analysis, the variables of condition (pre-intervention and post-intervention) and quarterly (September and October with November and December) were compared to see if there was a relationship between the two. The scores represent the hospital's raw scores among other hospitals similar in size. The results indicated that there was not a statistically significant relationship (X^2 = 1.094, df = 1, p = 0.105) and the trend indicated that the hospital's patient satisfaction scores declined in post intervention (See Table 2).

Ethical Considerations

The project consisted of reviews of discharge survey results obtained via a third-party vendor along with reviews of patient falls entered into the organization's data repository thereby eliminating the use of human subjects. This assumption was validated by the confirmation of the Institutional Review Board of Capella University that this project did not meet the federal regulations defined for human subject research and therefore did not require IRB review and oversight.

Discussion

Summary

This project evaluated whether there was a relationship between executive leadership rounding and improved patient satisfaction scores and patient outcomes. Even though no statistical significance was found between the intervention and the two domains, there was an observable improvement in patient safety outcomes. Demographic data reflected variability in

those executives with a clinical background and those who did not. Due to the limited duration of the intervention, no relational study was conducted between the education level of the participants and with safety outcomes and patient satisfaction scores. Though unable to statistically analyze the number of patient falls, there was an observable trend downward which is clinically significant in relation to patient safety.

Limitations

Limitations of the QI initiative included perception, understanding, length of study, non-individualized data points, and executive leadership participation. Patient perception of their hospital stay at time survey was delivered along with the lack of control of who completed it, and patient demographics (age, diagnosis, length of stay) may have impacted the study findings as well. Other variables worth mentioning include the acuity of the pilot unit during the intervention period, unit staffing, and whether front line staff and executive leadership had a clear understanding of the QI initiative's purpose.

Most notable limitations include the fact that the discharge survey results were not inclusive of just those patients and staff during the Monday through Friday rounding intervention. Results received included all patients on the pilot unit across all days and all shifts. Therefore, all data was aggregated and not individualized to those involved in the intervention. In regards to the calculation of in-patient falls on the pilot unit, a statistical analysis was not possible as there was no control group (no empirical comparison) which could also be a limitation. With an 80% compliance rate of executives completing the intervention along with a short time interval for completion, the limitations of the QI initiative reflect the need for further education, expanded studies, and a more robust time-frame.

Nursing Implications

In a study by Reimer and Herbener (2014) where leadership rounding was one part of a triangular strategy, it was noted that the overall trend for patient falls decreased from one fiscal year to the next. In the same study, patient satisfaction scores via Press Ganey demonstrated an upward trend. Nurses play a pivotal role in producing safe, quality care for all patients in the healthcare system (RWJF, 2011). As noted by Hutchings et al. (2013), regular interactions with patients and staff aid in the anticipation of their elementary needs. Current research confirms that leadership rounding (including those at the executive level) can have a direct impact on patient outcomes.

Recommendations for Future Research

Further investigations into the relevance of executive leadership rounding toward patient satisfaction and patient safety outcomes will need to be conducted to capture statistically significant outcomes. In order to do so, executive leadership rounding would need to expand to include the various nursing shifts on the unit as well including the weekend shifts. Had the timeframe been longer with more pronounced rounding on both staff and patients, along with control groups, the outcomes may have been quite different.

Conclusion

Through various rounding strategies, it has been acknowledged that with a standardized structure and process, staff and patient expectations are reinforced and supported. Continued vigilance is compulsory to strengthen and validate the processes and strategies which are implemented. Current research illustrates that a rounding program with engaged leaders can significantly reduce in-patient falls in the acute-care adult setting while also improving overall patient satisfaction scores. Buy-in from all stakeholders is essential to any process improvement

initiative and when there is leadership and staff involvement with the development of the process, a sense of ownership abounds. As this QI project did not produce the results as expected, it could be noted that perhaps executive leadership rounding is not as relevant to improved patient satisfaction scores as presumed, and further inquiry is required to either support or refute that ideal from a statistical standpoint.

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Tables and Figures

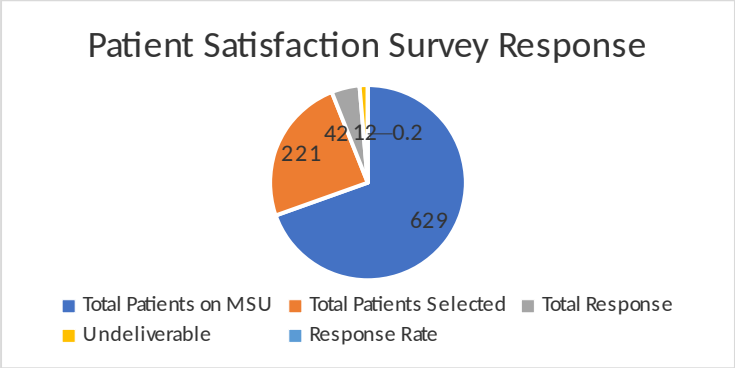

Figure 1. Patient Satisfaction Survey Response

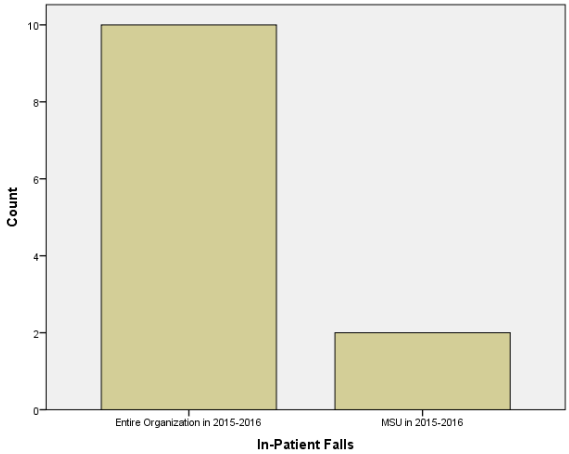

Figure 2. In-Patient Falls

Table 1

Total Patient Falls per 1000 Patient Days

	2016 Q3	Average
Unit	1.69	2.38
Mean	3.26	3.39
Standard Deviation	1.92	2.14

Table 2

Chi-Square with Condition and Quarter

Condition	September and November	October and December
Pre-Intervention HCAHPS Rank	80	76
Post-Intervention HCAHPS Rank	42	57