Nurse Rounding: An Evidenced Based Practice Report

Todd E. Tussing

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NURSE ROUNding: A n EVIDENCED BASED PRACTICE PROJECT

An evidenced based practice project in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice

By

Todd E. Tussing
M. S., Wright State University, 2006

2015

Wright State University
I HEREBY RECOMMEND THAT THE EVIDENCE- BASED PRACTICE PROJECT PREPARED UNDER MY SUPERVISION BY Todd E. TuSSING ENTITLED Nurse Rounding: An Evidenced Based Practice Project BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF Doctor of Nursing Practice.

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ABSTRACT

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Today’s healthcare environment is becoming increasingly competitive for patient volume and revenue dollars. The introduction of Value Based Purchasing by the Center for Medicare and Medicaid Services (CMS) links patient satisfaction and healthcare quality to government reimbursement. Patient satisfaction has been linked to increased market share, thereby, positively impacting revenue for healthcare organization and increasing the competitiveness between healthcare organizations. In addition, patient satisfaction has been linked to increased compliance with prescribed healthcare regimens leading to improved health outcomes.

Nursing leaders of today’s healthcare systems must develop strategies to increase patient satisfaction and improve the revenue streams for their organizations. The effects of nurse rounding have been documented in the literature as improving the overall quality of care. The question raised in this quality improvement project was “On a medical-surgical inpatient unit, does the implementation of a staff nurse led customer service rounding program, as compared to no staff nurse customer service rounding program, increase the Press-Ganey Patient Satisfaction scores as reported by HCAHPS over a three month period?” In order to answer this question, a staff nurse led, customer service
rounding program was implemented that elicited patient feedback to the staff on duty in real time in order to change staff behavior and increase patient satisfaction scores.

Utilization of a process of staff nurse rounding was conducted for patients with in-patient lengths of stay equal to or greater than three days. Specific questions were used to elicit the patient’s perception of care. The summary of rounding findings was shared with on-duty nursing staff to motivate change in behavior and increase patient satisfaction. Rounding and feedback effectiveness were measured via monthly Press-Ganey Patient Satisfaction scores and identification of trends on the Patient Satisfaction Rounding Logs.

The results for the three intervention months revealed an influence on patient satisfaction as the patient satisfaction scores generally improved when compared to a non-intervention month. Several factors were discovered to impact patient satisfaction scores such as number of nurse rounds, number of patients rounded on, completion of post-rounding huddle and number of returned surveys. Additionally, rounding program success was found to be influenced by leadership support and attention and staff workload.
# TABLE OF CONTENTS

LIST OF FIGURES ........................................................................................................... xii

LIST OF TABLES.............................................................................................................. xiii

ACKNOWLEDGEMENT ................................................................................................... xiv

DEDICATION ....................................................................................................................... xv

I. INTRODUCTION AND PURPOSE ............................................................................. 1

  Purpose and Goals ........................................................................................................ 4

  Clinical Question ......................................................................................................... 4

  Summary ....................................................................................................................... 5

II. GUIDING FRAMEWORKS ......................................................................................... 6

  Evidence Based Practice Framework ........................................................................... 6

  Theoretical Framework Related to Patient Satisfaction .............................................. 8

III. REVIEW OF EVIDENCE ......................................................................................... 11

  Patient Satisfaction ..................................................................................................... 11

  Nurse Rounding .......................................................................................................... 12

  Literature Search Strategy .......................................................................................... 14

  Critical Appraisal and Evaluation of the Evidence ..................................................... 14
APPENDIX U ........................................................................................................................................................................

COMPARISON OF Rounding Program Questions TO .................................................................

INTERACTION MODEL OF Client Health Behavior Model Variables

AND HCAHPS Questions .................................................................................................................. 170

APPENDIX V ........................................................................................................................................................................

PATIENT SATISFACTION Rounding Log Analysis Rules ................................. 172

APPENDIX W ........................................................................................................................................................................

POST PROJECT FOCUS GROUP OUTCOMES ................................................................. 174
LIST OF FIGURES

Figure 1: The Evidence-Based Practice Improvement Model ........................................ 7
Figure 2: Interaction Model of Client Behavior ................................................................. 9
Figure 3: Comparison of Nurse Sensitive Dimensions by Month for Unit A .................. 63
Figure 4: Comparison of Nurse Sensitive Dimensions by Month for Unit B ............... 65
LIST OF TABLES

Table 1: Summary of Literature Search.................................................................15
Table 2: Effects of Nurse Rounding on Outcomes.................................................18
Table 3: HCAHPS Overall Scores by Unit............................................................20
Table 4: HCAHPS Scores Breakdown by Nurse Sensitive Questions....................21
Table 5: 2015 Timeline of Proposed Project.........................................................45
Table 6: Interaction Model of Client Health Behavior and Patient Satisfaction Rounding Log Questions.................................................................53
Table 7: HCAHPS Indicators of Psychometric Performance.................................56
Table 8: Interaction Model of Client Health Behavior Variable and HCAHPS Question........................................................................................................57
Table 9: Press-Ganey Patient Satisfaction Percentile Scores for Unit A and Unit B.....61
Table 10: Unit A Patient Satisfaction Rounding Log Summary..............................67
Table 11: Unit B Patient Satisfaction Rounding Log Summary..............................68
Table 12: Unit A and Unit B Post Rounding Huddle Percentage by Month, Year 2015..69
Table 13: Unit A PSRL Responses........................................................................71
Table 14: Unit B PSRL Responses........................................................................72
Table 15: Number and Percent of Positive Comments..........................................76
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DEDICATION

I dedicate this paper, my schooling and my career to my parents, Guy Edward “Ed” Tussing and Lella “Eilene” Watkins Tussing; who have inspired me through their altruism and their dedication to helping others. I thank them for their encouragement and their love that often provided me the courage, strength and wisdom to do the things I had to do.
I. INTRODUCTION AND PURPOSE

Today’s healthcare environment is becoming increasingly competitive for patient volume and revenue dollars. The introduction of Value Based Purchasing (VBP) by the Center for Medicare and Medicaid Services (CMS) links patient satisfaction and healthcare quality to government reimbursement, increasing competitiveness within and between healthcare organizations (Value Based Purchasing, August 1, 2011). Nursing leaders of today’s healthcare systems must develop strategies to increase patient satisfaction and positively impact the revenue stream for their organizations.

The Deficit Reduction Act of 2005 initiated the VBP program as a subset of the CMS Inpatient Quality Reporting program. The Patient Protection and Affordable Care Act (ACA) of 2010 mandated VBP be implemented nationwide (Raso, 2013). The law stipulates, as of 2013, financial reimbursement to healthcare organizations will be based on the publicly reported ratings on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and other quality indicators.

Hospitals must meet thresholds based on achievement or improvement to receive incentive payment. There is a phased in reduction in hospital base Diagnosis Related Group (DRG) payments to fund the incentive pool: 1% for FY 2013 increasing by quarter increments annually up to 2% by 2017 (A. VanBuren, personal communication July 27, 2015).
Each fiscal year the federal government has added or modified the list of quality indicators that are included in the VBP Program. There are currently four domains that comprise the overall VBP score for fiscal year 2016 (five for fiscal year 2017). Each domain score is based on the organization’s performance on individual measures within that domain. The domains include: Outcomes (40%), Patient Experience (25%), Efficiency (25%), and Clinical Process of Care (10%). The Patient Experience section of the VBP program considers the organization’s performance within the following dimensions: communication with nurses, communication with doctors, responsiveness of hospital staff, pain management, communication about medications, hospital cleanliness and quietness, discharge information, and an overall rating of the hospital.

The host organization for this project is estimated to have $1.5 million dollars at risk through the VBP Program for fiscal year 2015, with an increase of 0.25% for fiscal year 2016 and 2017 (A. VanBuren, personal communication, May 19, 2015). The organization’s total performance score for fiscal year 2015 was 37%, which resulted in a net loss estimated at $76,000 of the $1.5 million dollars at risk. Strong performance on the VBP indicators, including patient satisfaction as reported via HCAHPS, will provide a larger payment from CMS.

Commercial payers, similar to government payers, are using the same rewards/loss structure within their contracts with healthcare organizations for the purpose of increasing the quality of care and decreasing cost. An example is the Anthem Blue Cross/Blue Shield Scorecard, which is used by the host organization. Anthem Blue Cross/Blue Shield developed a rewards program that factors in several metrics including quality and patient satisfaction. Patient satisfaction comprises 5% of the total evaluative
criteria per year with a potential gain of 0.5% from a contractual bonus incentive for both the medical center and the physician practices involved. To gain the 0.5%, the host organization must report their patient satisfaction percent as measured by the patient satisfaction survey questions which includes the HCAHPS. Successful scores on the HCAHPS report could gain the medical center $1,000,000 and an additional $250,000 for the physician practices, thus increasing the need to improve patient satisfaction with care (M. Bethel, personal communication, October 18, 2012).

A high patient satisfaction rate for inpatient care has been linked to decreased readmission rates (Boulding, et al., 2011). Beginning 2013, healthcare organization began to be penalized up to 1% of the Medicare revenue for readmissions within 30 days of discharge for patients with diagnoses of acute myocardial infarction, heart failure, and pneumonia as part of the Medicare Readmissions Reduction Program (Raso, 2013). Decreasing the 30 day readmission rate avoids the 1% penalty to an organizations bottom line. Higher patient satisfaction scores are associated with lower readmission rates; therefore, healthcare organizations with higher patient satisfaction are likely to receive more monies from CMS reimbursement (Studer, Robinson, & Cook, 2010) and private payers. Those organizations with lower patient satisfaction scores will likely find themselves in a position where they must pay back monies to the federal government, ultimately negatively impacting their bottom line.

As a response to these changes, healthcare organizations have focused for over a decade on improving the patient experience and increasing patient satisfaction scores and have shown some measureable success. Several important components of high patient satisfaction have been identified in the literature. These components include: a change in
the organizational culture to a more patient-centered approach rather than a disease model approach, a shift in organizational cultural towards staff development initiatives focused on understanding the values and needs of individual patients, and nursing staff committed to delivering high quality care (Morrissey, 2001; Shoemaker, 2011). The nursing staff, as crucial stakeholders who are at the front line of care, need to be at the center of any initiatives to increase patient satisfaction.

**Purpose and Goals**

Higher patient satisfaction scores on the HCAHPS report are correlated to high quality care as well as securing higher reimbursements from both government and commercial payer sources (Studer, Robinson, & Cook, 2010). Initiatives to increase patient satisfaction scores must include bedside nurses and must be incorporated into each nursing unit’s culture for long lasting effects. The literature supports nurse rounding as one method to improve patient satisfaction scores.

The purpose of this quality improvement project was to implement a nurse led customer service rounding project that included a post-rounding summary to active duty nursing staff. The overall goal of the project was to increase patient perception of satisfaction of care as measured by the Press-Ganey Patient Satisfaction Survey scores and provide benefits for the host hospital by increasing patient satisfaction and revenue.

**Clinical Question**

Development of a focused clinical question is essential to finding the evidence to incorporate into practice and effect the appropriate clinical or administrative change. Evidenced-based practice literature supports the use of the PICOT format for the development of clinical questions. PICOT is an acronym in which each letter represents
an aspect of the clinical question; P represents “patient”; I, “intervention” or “issue” of interest; C represents “comparison” intervention or group; O designates the “outcome” desired; and T refers to the “time frame” involved (Melnyk & Fineout-Overholt, 2011).

The PICOT question proposed for this evidenced-based project was:

On a medical-surgical inpatient unit (P), how does the implementation of a staff nurse led customer service rounding program (I), as compared to no staff nurse customer service rounding program (C), increase the Press-Ganey Patient Satisfaction scores as reported by HCAHPS (O) over a three month period (T)?

Summary

Healthcare organizations are feeling the pressure from both governmental and commercial payers to increase quality of care and decrease costs. Contractual agreements between payers and healthcare organizations now include financial incentives linked with quality metrics. Patient satisfaction is one of the metrics that is tied to financial incentives and nursing leaders are responsible to raise patient satisfaction scores. The host organization for this project has identified patient satisfaction as a significant focus area for improvement in order to increase the financial reimbursement as millions of dollars are at risk through the Medicare program. The proposed method of increasing patient satisfaction scores was to implement a staff nurse led, customer service rounding program that incorporated feedback directly to the nursing staff to increase scores and to increase financial incentives from payers. The following section of the proposal discusses the evidence that supports the patient satisfaction rounding program as well as the implementation and evaluative plans and the outcomes for the quality improvement project.
II. GUIDING FRAMEWORKS

Evidence derived from the scientific literature can help to improve health, patient outcomes, financial outcomes, and improve safety. Examining clinical questions in the scientific literature can identify interventions to solve clinical problems based on scientific merit. The challenge is to use this information to enhance practice (Melnyk & Fineout-Overholt, 2011). The evidenced-based practice framework that guided the project is presented below. In addition, the selected theoretical model was used to explain the intervention and its relationship to patient outcomes is discussed.

Evidence Based Practice Framework

The model used for development and implementation of this project is the Evidence- Based Practice Improvement Model (EBPI) developed by Levin, et al., (2010) (see Figure 1).

The EBPI model delineates the steps for the identification of a clinical or administrative problem leading to the formulation of a clinical question to be researched. The EBPI model was conceived from an identified need for a framework that enveloped both the methods of evidenced-based practice and performance improvement. Levin, et al. researched the literature for models and developed the EBPI combining the Mylnek and Fineout-Overholt EBP framework (Melnyk & Fineout-Overholt, 2004) and the Plan, Do, Study, Act model of performance improvement from Deming (Langley, et al., 1996). The first five steps comprise the EBP process of describing the problem; developing a
PICOT question; search, appraise and synthesize the evidence from the literature; and development of a goal statement to solve the clinical problem based on the science.

Figure 1. Evidence-Based Practice Improvement Model (Levin, et al., 2010, pg. 122). (Permission obtained from publisher, See Appendix A.)

The EBPI model does not offer evidence leveling criteria to evaluate the strength of the evidence; therefore, for the purpose of this project, the Johns Hopkins Evidenced Based Practice Evidence Rating Scale will be used for leveling (see Appendix B) (Newhouse, Dearholt, Poe, Pugh & White, 2005).

Next, the PDSA model is used to implement the planned change. An implementation plan is developed in terms of a protocol or clinical guideline to be
incorporated into practice (Plan phase), the plan is implemented (Do phase), in conjunction with data collection pre and post implementation of protocol or guideline (Study phase), and changes are made to the implemented protocol/guideline to strengthen the intervention (Act phase). The PDSA portion of the model can be repeated in a continuous loop for continuous quality improvement to reach the outcome desired. Thus, the EBPI model can be utilized on a continuous quality improvement basis in order to further enhance practice by identifying practice, needs and incorporating evidence to fill the need. The final step of the model results in dissemination of the findings (Levin, et al., 2010).

**Theoretical Framework Related to Patient Satisfaction**

One goal of this project is to increase patient satisfaction with nursing care and the overall healthcare experience. The “Interaction Model of Client Health Behavior” (IMCHB) (Cox, 1982) framework was chosen to examine the conceptual issues related to this project as it has previously been used to explore the relationship between nurses and their patients. The model incorporates the patient’s dynamic personal and background attributes and how they relate to the nurse-patient relationship (see Figure 2). Cox theorized that patients are capable of making their own independent decisions for healthcare and that their choices are affected by the patient-provider relationship (e.g. nursing). Four key variables influence the nurse-patient interaction: affective support, health information, decisional control and professional/technical competencies (Cox, 2003, p. 694).
Cox (1982) has defined four key factors (elements) that influence patient outcomes through the client-professional interaction. These factors can influence the patient healthcare outcomes, including satisfaction of care. Described within the model is the concept of Information which is the provision of health information to the patient in order to increase the patient’s knowledge of his/her health state and the interventions that can be taken to improve health or eliminate health threats. According to the model, information is the forerunner for making change, through the decisions the patient makes, to bring about positive health behaviors which lead to patient satisfaction as an outcome. Affective support is the consideration of a patient’s emotional state. The patient’s emotional needs must be met in order to enhance health teaching and learning. Assisting the patient to cope with his/her emotions can increase the affiliative bonds between patients and care caregivers, fostering an increased in coping with the health situation and ultimately increasing patient satisfaction. Decisional control is the patients’ ability to make healthcare decisions and is linked to the patient’s perception of the health problem and his/her motivation to attain health. Increasing decisional control, in turn, increases
self-efficacy and the patient’s commitment to resolve the health problem, which ultimately increases patient satisfaction. The professional-technical competencies describe the skills the caregiver (nurse) brings to the relationship to meet the patient’s needs (both technical as well as personal). These skills affect the health of the client and include practical skills such as frequent assessments, dressing changes, medication administration, etc. As the need for the practitioners skills decrease, the patient’s decisional control increases with the ability to control his/her healthcare interventions, increasing patient satisfaction (Cox, 1982; Cox, 2003, p. E 96).

Each of the four key factors relating to client–professional interaction within Cox’s model is directly linked to the concept of health outcomes. Health outcomes include: utilization of health care services, clinical health status indicators, severity of health care problems, adherence to the recommended care regimen, and satisfaction with care (Cox, 2003, p. 694). The outcomes are influenced by the health provider’s responses to the patient’s identified health needs; for example, when a nurse “tailors affective responses, health information, decisional control, and technical competencies to meet the unique needs of the client, positive outcomes are more likely” (Bear & Bowers, 1998, p. 53).

As can be seen in this model, enhancing the relationship between the bedside nurse and patient is paramount to increasing patient satisfaction. The model proposes that incorporating the key variables from the IMCHB model within the nurse rounding project will help to strengthen the nurse-patient relationship, thus, increasing patient satisfaction. The use of nurse rounding is one intervention that can be utilized to enhance the nurse-patient relationship.
III. REVIEW OF EVIDENCE

The aim of the project was to improve patient satisfaction through changing bedside nurse behavior, thereby, increasing reimbursement for the host organization. This improvement in patient satisfaction was posited to be accomplished by incorporating a nurse rounding customer service approach, which gathered and disseminated patient specific comments in real time to the current shift nurses.

The purpose of Part III is to discuss the evidence as it pertains to patient satisfaction and nurse rounding. A brief discussion of the concepts of patient satisfaction and nurse rounding is provided, followed by an in-depth review of current research linking nurse rounding with patient satisfaction.

Patient Satisfaction

Healthcare quality encompasses many aspects including the competency and skill of the care providers (as measured through competency testing), the processes and systems within the healthcare organization that patients encounter (as measured through quality metrics and benchmarking) and the patient’s perceived satisfaction level of care during their interaction with the healthcare organization (measured through patient satisfaction surveys) (Bear & Bowers, 1998; Wagner & Bear, 2008; Bleich, Ozaltin, & Murray, 2009). The IMCHB model (Cox, 1982) has been used as a framework for research studies measuring patient satisfaction (Bear & Bowers; Wagner, et al., 2011). For the purposes of this project, patient satisfaction was defined as, “the user’s perception of the quality of services he receives” (Bear & Bowers, p. 50).
Patient satisfaction is linked to increased patient compliance with the prescribed healthcare regimen leading to better health outcomes and increased market share, thus, positively impacting revenue for healthcare organizations (Abramowitz, et al., 1987; Mahon, 1996; Johansson, et al., 2002; Merkouris, et al., 2004; Gardner, et al., 2005; Kuguoglu, et al., 2006; Akin & Erdogan, 2007). As a concept, patient satisfaction has been in the healthcare literature as a focus of nursing leadership since the late 1950’s. Nurse theorists Abdellah and Levine developed the first patient satisfaction survey instrument in 1957 (Wagner & Bear, 2009). The 1970s brought forth a more formalized survey process to measure patient satisfaction in healthcare environments (Piper, 2010). In the 1980’s, patient satisfaction began to be viewed as an aspect of quality of care and there were landmark publications that highlighted this new way of thinking (Wagner & Bear, 2009). Furthermore, CMC initiated the Hospital Consumer Assessment Health Plans Survey (HCAHPS) in 2002 to measure the satisfaction of their membership regarding the care they received from healthcare organizations. HCAHPS is a 27 item survey developed by the Agency for Healthcare Research and Quality (AHRQ) on request of CMS and was incorporated into the VBP program in 2013 (Piper, 2010). The importance of achieving the highest levels of patient satisfaction has been identified from the patient as well as the healthcare provider perspective and is now being incorporated into the public reporting and payment structures of health plans (including Medicare).

**Nurse Rounding**

Nurse rounding on hospitalized patients has a history that stretches as far back as the 1860s with Florence Nightingale (Neils, 2010). Nurse rounding defined here as “nursing staff visiting each patient on a predetermined schedule” (Sobaski, Fillmore, &
Davidhizar, 2008, p. 332). The effects of nurse rounding has been documented in the literature as improving the overall quality of care, reducing adverse events such as patient falls, and improving both nurse and patient satisfaction with care (Tea, Ellison & Feghali, 2008; Setia & Meade, 2009; Woodward, 2009). Furthermore, nurse rounding affords the healthcare practitioner the opportunity to identify issues/concerns or other dissatisfaction the patient is experiencing and provides a service recovery approach to remedy the dissatisfaction. Immediate service recovery has been linked to increasing overall patient satisfaction post-hospital discharge (Barsamian, Gregoire, Sowa, Lafferty & Stone, 2010).

Nurse rounding in the literature speaks mainly to a tactic titled, “hourly rounding” or “comfort rounds” that encompasses a nurse or nurse aide visiting patients hourly to determine three specific care requirements, commonly referred to as the three P’s or positioning, potty and pain. The first “p” refers to positioning in the bed or chair, the second to the need for assistance with elimination, and the third, assessment of pain/discomfort level. The majority of the literature is focused on the clinical aspects of the patients experience through clinical rounding (i.e. hourly rounding or comfort rounds), in contrast to customer service rounds. For the purposes of this paper, customer service rounding is defined as soliciting “the perception of the patient regarding his/her overall care from the hospital and includes information such as social treatment by staff, information sharing about plans of care, food quality, and environmental conditions” (Tea, Ellison & Feghali, 2008; Setia & Meade, 2009; Woodward, 2009).
Literature Search Strategy

For the purpose of this project, research articles that focused on the effect of nurse rounding on patient satisfaction were reviewed. A literature search was conducted using the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Cochran Library and PubMed. Keywords for each search included combinations of frequently used terms for rounding and patient satisfaction. See Table 1 for key words used in the search along with search results.

Studies were obtained that met the following inclusion criteria: published from 2006 to 2012, utilized patient satisfaction as a dependent variable, utilized nurse rounding as an independent variable, samples utilized were from hospitalized patients and articles written in English. A total of ten studies were identified. The ten studies were examined for relevance and usefulness to the current quality improvement initiative resulting in seven relevant studies. The remaining seven research articles were summarized into evidence evaluation tables, which included a description as well as a critique (see appendix D). A search for systematic reviews, meta-analyses or randomized controlled trials did not reveal any studies that examined nurse rounding and patient satisfaction.

Critical Appraisal and Evaluation of the Evidence

The Johns Hopkins Nursing Evidenced-based Practice Rating Scale (JHNEBP) was utilized to level the evidence from each research article. The JHNEBP rating scale provides two measures of the evidence, strength of the evidence from the strongest measure (e.g. experimental/randomized controlled trails) to weakest (e.g. expert opinion) indicated by Roman Numerals (“I” being the strongest to “V” being the weakest.) and quality of the evidence (from highest quality with few flaws (indicated by an “A”) to
lowest quality with many flaws (indicated by the letter “C”). The JHNEBP scale offers criteria for both strength and quality to help users appraise research studies.

Table 1

*Summary of Literature Search*

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Five of the seven studies utilized a quasi-experimental design; one utilized a qualitative study approach and one, used a case study format. Five of the studies (Gardner, Woollet, Daly & Richardson, 2009; Meade, Bursell & Ketelsen, 2006; Meade, Kennedy & Kaplan, 2010; Saleh, Nusair, Al Zubadi, AlShloul, Saleh, 2011; Sobaski, Abraham, Fillmore, McFall, & Davidhizer, 2008) were classified as evidence strength level IIB according to the Johns Hopkins Evidenced Based Practice Evidence Rating Scales (Newhouse, Dearholt, Poe, Pugh & White, 2005). Woodard (2009) published a study categorized at level VB and Blakely, Kroth and Gregson (2011) completed a case
study classified at level VC. Thus, the evidence for this quality improvement project is moderate at best as the scientific literature lacks randomized controlled trials or experimental designed studies; however, the seven studies did support the proposed intervention for the project and will be discussed in the subsequent section.

**Synthesis of External Evidence**

Several studies selected as pertinent to this quality improvement project examined the effects of hourly rounding (also referred to as comfort rounds) on patient outcomes such as call light use and patient fall rate, with a narrowed measure on patient and nurse satisfaction. Six of the seven studies reported an increase in patient satisfaction with nursing care when hourly rounding was implemented; one study reported no difference between the control and intervention groups when patient satisfaction was measured post implementation of hourly rounding (Gardner, Woollett, Daly & Richardson, 2009). For a comparison of each of the seven studies with regards to outcomes see Table 2.

In 2006, Meade, Bursell and Ketelsen published a hallmark study investigating the effects of nurse rounding on call light use, patient satisfaction and safety. An increase in patient satisfaction was noted; with a significant increase from 70.4 (on a 100 point scale) pre-study to 79.9 post implementation. Similarly, a retrospective, quasi-experimental study completed in 2008 reported patient satisfaction, post implementation of hourly rounding demonstrated a significant increase to greater than 90% (pre-set benchmark) (Sobaski, Fillmore, & Davidhozar, 2008).

Woodard (2009) completed a study that examined the effects of charge nurse rounding as measured by patient certainty of caregiver coming to their assistance once called and measuring call light usage and patient falls. Of the patients in the groups the
charge nurses rounded on, 72% were certain they would receive help if they needed it. The intervention unit demonstrated a drop in patient falls, from ten the first quarter to only 3 the fourth quarter while call light frequency also dropped from 13 the first quarter post implementation to five. A quasi-experimental study conducted on the effects of hourly rounding on an acute stroke unit revealed similar increase in patient satisfaction with an increase of 7.5% reported (Saleh, Nusair, Zubadi, Shloul, & Saleh, 2011).

Patients experience with care in twenty-eight emergency departments was the focus for a large study that examined the effects of staff rounding on patient safety and patient satisfaction. The results demonstrated that patient satisfaction did increase by as much as 2.62 points on four questions specifically measuring patient satisfaction (Meade, Kennedy, & Kaplan, 2010).

In 2011, Blakely, Kroth and Gregson published a case study illustrating that the impact of nurse rounding on inpatients on a medical-surgical unit. The investigators determined that patient satisfaction with care steadily increased during implementation from 3.5 (1 – 4 scale) to 3.6 within one quarter of patient satisfaction measurement, a small but positive result. Staff reported the perception of call light use decreasing with rounding implementation and that the remaining call lights were being used for more “serious needs”.

The majority (six of the seven) of studies demonstrated that patient satisfaction scores do increase when clinical hourly rounding or nurse leader rounding is initiated as patients perceive that their quality of care is greater (Meade, Bursell, & Ketelsen, 2006; Sobaski, Abraham, Fillmore, McFall, & Davidhizer, 2008; Woodard, 2009; Meade, Kennedy, & Kaplan, 2010; Blakely, Kroth, Gregson, 2011; Saleh, Nusair, Subadi, Al
Please see Table 2 for an overview of the results. Each of the studies had limitations, as each was primarily a small, single site study of a narrowed scope. There was a significantly larger study by Meade, Kennedy and Kaplan (2010) involving 28 hospital Emergency Departments for a total of 1,543 staff participants however, the complexity of the study, coupled with the merging of multiple data points, may have contributed as a weakness affecting the generalizability of results as large, multi-site studies can be subject to study protocol degradation.

Table 2

*Effects of Nurse Rounding on Outcomes*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>↑ ↑ ↔ ↑ ↑ ↑ ↑</td>
</tr>
<tr>
<td>Call Light Use</td>
<td>↓ ↓ NE ↓ ↓ NE ↓a</td>
</tr>
<tr>
<td>Reported Falls</td>
<td>↓ NE NE ↓ ↓ NE ↓</td>
</tr>
<tr>
<td>Staff Satisfaction</td>
<td>NE NE ↑ NE ↑ NE NE</td>
</tr>
</tbody>
</table>

Note\(^1\). ↑=improvement, ↓= decrease, ↔=no change, NE=not examined


Overall, each of the studies provides evidence that a rounding program, when implemented, has a positive patient satisfaction effect. Six of the studies were conducted on some form of inpatient nursing unit (e.g. acute stroke, acute surgical, cardiac telemetry or general medical-surgical); the seventh study involved emergency department patients. Five of the studies were conducted in small, single site acute care settings (Saleh, B. S., et al., 2011; Blakely, D., et al., 2011; Gardner, G., et al., 2009; Woodard, J. L., 2009; and
Sobaski, T., et al., 2008) while two were large, multi-sites studies (Meade, C. M. et al., 2010, and Meade, C. M. et al., 2006). In each case, the studies demonstrated improvement of patient satisfaction with the implementation of a rounding program that involved either nursing staff or charge nurses and involved those patients (either inpatients or emergency room patients) seeking care from hospitals.

Internal Evidence within the Organization

Patient Satisfaction Scores

Two medical-surgical units (referred to as Unit A and Unit B) in the host organization were examined for level of patient satisfaction and current nurse rounding methods. Each nursing department in the hospital receives monthly reports of patient satisfaction as measured by the Press-Ganey Patient Satisfaction Survey; which is mailed to all discharged patients. The scores are broken down into various dimensions along with an “overall” score. The individual unit reports were examined for responses to four nurse sensitive subscales (HCAHPS Communication about Medications, HCAHPS Nurse Communication, HCAHPS Pain Management, and HCAHPS Responsiveness) along with the score for the “Overall” response on the questionnaire.

Previous patients from Units A and B have expressed their moderate satisfaction with the nursing care on each of the units as evidenced by information on HCAHPS Overall Scores by Unit (see Table 3) and HCAHPS Scores Breakdown by Nurse Sensitive Questions (see Table 4). The organization has set a target of meeting the 75th percentile for each component of the patient satisfaction survey (J. Halley, personal communication, February 7, 2014). This target has been set based on comparison with benchmarks to other academic medical centers in the United States.
The Director of Nursing responsible for the Medical-Surgical nursing division cited that the current HCAHPS Overall Scores (as measured through the Press-Ganey Patient Satisfaction Survey) for both units is below the target set by the organization, and there is much room for improvement with the patient satisfaction survey scores (including HCAHPS) to help the organization meet its target as reported to CMS and Anthem. Nursing leadership (nurse managers and director of nursing) for the two units have given their approval for this project as there is a demonstrated need for improvement of the patient satisfaction scores.

Table 3

<table>
<thead>
<tr>
<th>HCAHPS Overall Score</th>
<th>End of Fiscal Year 2012</th>
<th>End of Fiscal Year 2013</th>
<th>End of Fiscal Year 2014</th>
<th>End of Fiscal Year 2015</th>
<th>Fiscal Year 16 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit A</td>
<td>56.7%</td>
<td>65.9%</td>
<td>63.3%</td>
<td>61.3%</td>
<td>79.4%</td>
</tr>
<tr>
<td>Unit B</td>
<td>65.0%</td>
<td>65.7%</td>
<td>62.2%</td>
<td>63.7%</td>
<td>79.4%</td>
</tr>
</tbody>
</table>

Table 3 provides the current patient satisfaction scores for each of the units for fiscal years ending 2012 thru 2015 with 2015 scores well below the target score. Table 3 shows that, on a ten point scale, only 56.7% of patient survey’s rated the overall experience as either a nine or a ten on Unit A for the fiscal year 2012 and 65.9%, 63.3% and 61.3% for fiscal years 2013, 2014 and 2015 respectively, compared to a target of 79.4%. The Unit B survey revealed a similar issue: 65.0% of respondents rated the overall experience a nine or ten on a ten point scale for fiscal year 2012 and 65.7%; 62.2%, and 63.7% for fiscal years 2013, 2014, and 2015 respectively (also compared to a goal of 79.4%). These figures are below the 75th percentile target set for each
component of the patient satisfaction survey (J. Halley, personal communication, February 7, 2014).

Table 4 provides a breakdown of the satisfaction scores further into the nurse sensitive indicators. Currently, both units are meeting none of the components at the 75th percentile target. Ultimately, each unit must improve their individual breakout and HCAHPS Overall Score (as reported through the Press-Ganey Patient Satisfaction Survey) to help the organization meet its target for patient satisfaction as reported to CMS and Anthem.

Table 4

**HCAHPS Scores Breakdown by Nurse Sensitive Questions**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit A FY12</th>
<th>Unit A FY13</th>
<th>Unit A FY14</th>
<th>Unit A FY15</th>
<th>Unit B FY12</th>
<th>Unit B FY13</th>
<th>Unit B FY14</th>
<th>Unit B FY15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication of Medications</td>
<td>55.0%</td>
<td>53.6%</td>
<td>61.4%</td>
<td>54.2%</td>
<td>58.2%</td>
<td>54.2%</td>
<td>59.0%</td>
<td>56.1%</td>
</tr>
<tr>
<td>Nurse Communication</td>
<td>68.8%</td>
<td>71.1%</td>
<td>75.7%</td>
<td>68.6%</td>
<td>71.7%</td>
<td>77.8%</td>
<td>73.6%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>58.2%</td>
<td>60.8%</td>
<td>59.7%</td>
<td>55.3%</td>
<td>64.0%</td>
<td>54.0%</td>
<td>52.2%</td>
<td>55.7%</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>43.9%</td>
<td>49.1%</td>
<td>51.6%</td>
<td>46.1%</td>
<td>47.9%</td>
<td>51.4%</td>
<td>53.3%</td>
<td>45.6%</td>
</tr>
</tbody>
</table>

**Nursing Unit Level Assessment**

In preparation for the rounding project, an organizational assessment was conducted with both nursing units to determine readiness for the project as well as potential barriers. A SWOT analysis was utilized to identify the strengths, weaknesses, opportunities and threats of the hospital and the two units proposed for this project (Pickton & Wright, 1998; Bringing SWOT, 2005; Marquis & Huston, 2012). SWOT analysis is often used for program development and strategic planning. Credited to
Albert Humphrey from Stanford University from the late 1960’s and early 1970’s, the model provides a framework for analyzing internal and external factors that impact an organization. SWOT has been used in a variety of settings including manufacturing and healthcare. One popular feature of the model is its simplicity and ease of use, as the acronym SWOT is, essentially, the tool applied to the organization and its environment. The SWOT analysis was completed by interviewing the nursing leadership on the two nursing units and recording their responses to each of the categories of SWOT proposed to them in question format. A summary of the responses follow.

**Strengths.** An assessment of the organizational strengths of the two nursing units for the rounding program, revealed: (1) a motivated organization willing to compete publically in the VBP program; (2) motivated nursing leadership who utilize a shared governance model to effect change in practice on the nursing units; (3) strong and consistent unit level communication between leadership and front line staff, and (4) motivated charge nurses who are responsible for shift level patient care. The organization is developing processes and systems to comply with and participate in the VBP program through CMS; thus, they are eager for strategies to improve patient satisfaction. Nursing and customer service leaders within the organization are current with recent healthcare literature on tactics to increase patients satisfaction and have implemented: nursing leadership rounding on inpatients, post discharge phone calls, and the use of “purposeful rounding” for patient needs such as pain/discomfort elimination, repositioning in bed, and toileting. The organization has developed clearly defined stretch goals that are part of the strategic plan for patient satisfaction (Host Site, 2011; Host Site, 2013).
The leadership teams of both nursing units expressed a strong willingness to implement the project to increase patient satisfaction scores additionally; they shared that the overall culture of the units would be supportive of the project. The proposed program was discussed with the Chief Nurse Executive of the medical center; who gave approval citing the organizations strategic goals and more importantly, the need based on the organizations current patient satisfaction scores as reported via Press Ganey. Additionally, the director of nursing provided her support for the rounding program as the two nursing units identified for the project have not met their individual patient satisfaction goals.

The site hospital is designated a Magnet® Hospital by the American Nurses Credentialing Center and embraces a transformational leadership style that encompasses a democratic approach through a shared governance model on each nursing unit. Nursing leaders are encouraged to empower their staff members for decision making that impacts nursing practice and utilizes a Unit Leadership Council comprising staff nurses and unlicensed patient care assistants. The rounding project will fit with the shared governance model as it will be led by staff nurses and involve decision making at the point of patient care that would impact patients perception of care and ultimately, patient satisfaction scores. (Marquis & Huston, 2012).

An important strength identified during the assessment is the amount and quality of communication between layers of the organization. At the nursing unit level, communication comes in many forms, including: email, huddles, bedside reports, charge nurse reports, posted fliers, staff meetings, charge nurse meetings and leadership rounding to name a few.
Each unit has a charge nurse for each shift of the day, 24 hours a day, and seven days a week. Nursing leadership’s expectations are that each charge nurse rounds on the patients on their units to determine customer services issues. For the purpose of this project, the current charge nurse rounding time was utilized to keep salary and other expenses for the project neutral. Charge nurses are non-management employees; essentially, staff nurses who rotate between patient care assignments and charge nurse duty. As members of the general staff, they are viewed as “peers” by their colleagues on the unit, which will assist to lend credibility of the rounding results by the staff.

Weaknesses. An assessment of the weaknesses of the organization and the two nursing units identified six concerns: (1) current charge nurse customer service rounding is lacking as a unit routine; (2) numerous patient care initiatives compete for resources; (3) feedback on individual performance involving caregiver to nurse interaction does not always happen in real time; (4) numerous communications to staff impede message delivery; (5) current budgets does not allow for additional expenditures for special projects; and (6) bedside staff lack understanding of the relationship between their actions and patient perception of care.

An expectation of senior hospital leaders is for nurse leaders (e.g. charge nurses) to round on the patients on their respective units for customer service. This is not occurring regularly and lacks a regimen for the charge nurses to follow. Providing the rounding program will assist the nursing unit to establish regular charge nurse rounds with a regimen to be followed by each charge nurse for each round occurrence which should strengthen the rounding experience for greater patient satisfaction.
The host organization is a large academic medical center and has many competing priorities affecting patient care staff which often leads to the failure of new initiatives. One identified reason for such failures is the lack of support and follow through on the part of hospital leadership. Successful initiatives have certain commonalities: visibility of leadership coupled with a consistent level of continual focus on the initiative (Porter-O’Grady & Mallock, 2011).

The large volume of staff coupled with a large number of patient interactions provides a challenge for nursing leaders to give feedback in real time to enhance performance. Often, feedback concerning nurse-patient interaction is only given if a concern is of such a nature that warrants immediate attention. The proposed rounding program will provide real time feedback to the staff, both positive and negative, to improve their bedside interactions and enhance the patient’s perception of care. Additionally, the large volume of information communicated to the staff often dilutes out the various messages resulting in staff ignorance of important information. To avert this potential issue concerning the rounding program, the project lead provided information to the staff regarding the purpose of the rounding program as well as constructed emails updating the nurses on the project progress. During the rounding program, dissemination of the rounding information was given in a brief summary, post rounding, to the on-duty staff in real time by the charge nurse who collected it.

The medical center has established an organizational expectation that all staff productivity levels maintain 100% and for unit level budgets to come in on target. There are no additional monies for special projects; consequently, the rounding program was developed to be incorporated into daily charge nurse rounds, which should be part of the
nursing unit’s daily routine. Utilization of the charge nurses assisted to remain budget neutral during the project. The design of the customer service rounding program made this directive feasible without compromising the outcomes.

Nursing leadership has voiced that staff nurses lack an understanding of how their approach to patient care is linked to patient satisfaction. Often citing incidences in which patients have complained about a perception of rudeness when nurse or other caregiver answer a call light as an example, the nurse managers related many anecdotes of nurse-patient interactions that should have been conducted differently by the nurse to enhance patient satisfaction of care.

**Opportunities.** The organization has been challenged with maintaining the patient satisfaction scores (including HCAHPs scores) to the preset target by senior leadership. Developing tactics to help meet the strategic plan goal for patient satisfaction, including HCAHPS, would be of great benefit to the organization as it would help to garnish additional monies through incentive programs (E.g. Anthem), decrease risk of losing monies from CMS, and place the organization in favorable light with regards to the public reporting of the satisfaction scores.

Additionally, there is a need for bedside staff members to understand how their interactions influence patient’s perceptions of care and ultimately, the patient satisfaction scores. Currently, nursing leadership has identified this need and cites that getting “buy in” from the bedside staff on the importance of their actions and its impact on patient’s perception of care will be crucial in order to increase satisfaction scores. Involvement of staff members with the project either through the actual patient rounding or through the post rounding summary will enable staff members to have a sense of involvement
(fostering the shared governance model of the organization) and modify behaviors to increase patient satisfaction.

**Threats to organization.** The threats identified affect both the organization and the individual nursing units proposed for the project and include: (1) loss of revenue from VBP or similar programs if satisfaction scores do not improve; (2) loss of community reputation; (3) loss of market share; (4) public reporting of non-competitive satisfaction scores and (5) potential downsizing of programs and employees. Loss of revenue is a real threat as the organization participates in the VBP program through CMS as well as similar programs with private insurers (e.g. Anthem) as failure to perform at the benchmarks identified by the individual programs will lead to a decrease in the amount of monies paid to the hospital and in turn will impact the financial bottom line negatively. The monies at risk through the VBP can be as much as $1.5 million for a single fiscal year and with a loss of monies that would otherwise have been reinvested back into the patient experience through either the funding of existing programs or through the acquisition of capital equipment such as radiology scanners, new critical care technology and patient beds. (A. VanBuren, personal communication, September 9, 2013).

Those patients who have perceived experiences that are not to their satisfaction are less likely to return for follow up care and are more likely to share their experiences with others in the community leading to a loss of community reputation and ultimately loss of market share to local competitors. A positive patient perception of care has the inverse affect and can help lead to an increase in market share pulling patients away from competitors (Ries & Trout, 1993). The public reporting of patient satisfaction scores that are non-competitive will impact the overall reputation of the organization in the
Community locally, regionally and nationally. Such unsatisfactory scores would place the organization at a disadvantage for future contract negotiations with third party payers and patients searching for high quality healthcare. The decrease in patients utilizing services at the hospital will lead to a decrease in revenue and place the organization at risk to downsizing of programs and personnel.

**Cost to Benefit Analysis**

A current budgetary goal of the organization is to maintain staff productivity at 100%, coupled with elimination of nonessential use of overtime for all departments. Senior leadership had given the direction for this project to be budget neutral with regards to cost to the organization. To comply with this directive, a customer service rounding program was implemented in conjunction with the current charge nurse rounding already established as a routine on each of the units and did not result in any additional cost. Additionally, training for the program was implemented during charge nurse meetings that are already a scheduled occurrence on the units. The host organization of this project is estimated to have at risk $1.5 million dollars through this program (A. VanBuren, personal communication, September 9, 2013) compared to zero expense of the rounding program, the benefit is clear to support its initiation.

**Synthesis of Internal Evidence**

**Feasibility of Change**

Currently, the hospital is not meeting its strategic goals for patient satisfaction survey scores and is open to the utilization of evidenced-based interventions to help provide improvement. Both nursing staff and leadership were energetic and open to the rounding program. Additionally, adhering to the organizational goal of financial
stewardship (decreasing unnecessary cost) as a directive from senior leadership, this project was implemented on a cost neutral basis utilizing charge nurse rounding time. Consequently, the feasibility of this project becoming a part of the organizations culture was high. In order to plan for the change needed, two additional organizational aspects need to be considered, the timeline of the project and any dedicated resources.

The timeline for the project was about four months from start to finish. This included the training for the charge nurses and three months of actual implementation of the rounding intervention. Resources that were needed for the rounding program was limited to the photocopying of the rounding log used to summarize the patient responses. The timeline and expenses were presented and approved to both the unit level leadership and senior nursing leadership and the project was implemented in May of 2015.

**Recommended Practice Change**

The purpose of this quality improvement project was to increase patient satisfaction scores and, thereby, increase the financial benefit to the host organization. Patient satisfaction was defined as, “the user’s perception of the quality of services he receives” (Bear & Bowers, 1998, p. 50).

The staff nurse’s comprehension of the importance of the nurse-patient relationship and its influence on the overall perception of satisfaction of care by the patient is essential to enhance the nurse-patient relationship. Current evidence from the literature supports nurse rounding as an intervention that improves patient satisfaction (see Table 2). One method of increasing that understanding is to involve the clinical nurse in the role of charge nurse, and perform patient customer service rounding. Patient customer service rounding was defined as the process in which a nurse is physically
present and elicits information from the patient/family regarding their perception of the care rendered thus far.

**Recommendation**

The proposed practice change, based on review of pertinent research and the organizational evidence is to implement a program of charge nurse lead customer service rounding, specifically targeted to patient satisfaction, coupled with the provision of a summary of the rounding results to active duty nursing staff, in real time. Through the timeliness of the feedback, the nursing staff will be able to focus on the aspects of customer service that will provide the most immediate increase in patient satisfaction; including responsiveness, pain control, timeliness of answering call lights, friendliness of staff, and education about care. Additionally, the program allows charge nurses the time to engage patients who have been in the hospital for three days or greater and to assess their satisfaction with the care thus far in their hospital stay and to intervene when patients are not satisfied with their care.

The customer service rounding program fits within two of the host organization’s strategic goals: increasing the health of the population of patients it serves and strengthening its market share ultimately impacting financial revenue. Marketing of services and the overall quality of the organization is important as it lays the foundation of increasing the health of the patients served. It’s important to understand the relationship between satisfactions with care and the use of healthcare services (increasing market share) and its impact on population health.

Healthcare consumers are not unlike other consumers when it comes to making choices for their needs. They prefer to have as many choices as possible and want to
believe they have chosen the right provider for their needs once they’ve made a decision.

From a provider standpoint, it is not only important for these consumers to be satisfied with the quality of care they receive, but to garnish their loyalty towards the healthcare provider and to establish a long-term relationship. Once a patient has made their decision for their healthcare services, uncertainty sets in as they contemplate that the other options may have been better. Shortly after arrival in the hospital, it is imperative to make contact with the patient to ascertain the patient is satisfied and to help resolve the anxiety and reaffirm the patient choice in healthcare provider. The customer service rounding program supported this concept as the rounding process was completed on patients who have been in the hospital for three days or longer. Feedback from the patient post initial interaction helps to provide information for improvement within the healthcare organization to improve the quality of patient services and is incorporated into the rounding program through post rounding summary review.

Satisfaction alone is not sufficient to keep patients within the healthcare system. Studies have shown that even with high satisfaction, patients will utilize the services of competitors. The goal of the healthcare providers should be to establish patient loyalty for continued use of services. Berkowitz (2012) describes customer loyalty as encompassing seven levels of “customer psychological movement” which is synonymous with the relationship of patients to healthcare providers. The seven levels begin with awareness as the initial phase to loyalty, the end, the desired phase. The first three levels include: “awareness” of healthcare provider, “interest” in the provider and its services, and “evaluation” of the services offered to the consumers identified needs. A “trial” to test the organization’s services is initiated by the patient by engaging the provider for
services and once contact has been made, then a perception of “satisfaction” leads to
“repeat purchase” and ultimately, “loyalty”. The rounding program is designed to
interact during the “satisfaction” phase of this model and would provide staff nurses and
nursing leaders the opportunity to increase the patient’s perception of the quality of care
leading to a “repeat purchase” and in time, to patient loyalty to the hospital. Patients who
are loyal tend to become “apostles” for the hospital by telling their stories and
encouraging others to utilize the services of the hospital which would increase market
share and revenue streams (Berkowitz, 2010, p. 237).

Improving the health of those the hospital serves is part of the organization’s
mission and strategic plan. Healthcare organizations utilize communication between the
caregiver and the patient to increase the health of those they serve. Such teaching
includes information about treatment plans, health preventative information and is given
by discharge to increase and maintain health. Patients receive such teaching and
instruction from their care teams throughout hospitalization and need to be able to
understand the information given to them as well as having input into their plan of care.
Secondly, satisfaction with in-patient care has been linked to a decrease in re-admission
rates as patients understand their discharge instructions and adhere to treatment plans
(Abramowitz, et al., 1987; Johansson, et al., 2002; Boulding, et al., 2011; Dilworth, et al.,
2012; Study links HCAHPS, 2013). Adherence to treatment plans and identification of
health risk through in-patient health teaching increases the health state of the patient and
thus, increases the health of the population served by the organization.
Conclusion

The need for a competitive edge in today’s healthcare market is a main goal of all healthcare organizations. The host organization of this project is no exception. That competitive edge includes having a strong social reputation for high quality care which includes patient satisfaction. The requirement of public reporting of quality data as well as that data being tied to financial incentives, including patient satisfaction scores, adds to the importance of strong performance. Failure to secure a competitive performance with the public reportable metrics will place the hospital at a significant disadvantage for future third party payer contracts, a lucrative source of income for the healthcare organizations.

A review of the healthcare literature on the effects of nurse rounding and patient satisfaction reveals a positive influence. It’s important that staff nurses understand how the role of the nurse/patient interaction influences patient satisfaction and its impact on the hospital overall. Patient satisfaction has a link to patient adherence to treatment plans and a decrease in readmissions to hospitals. Additionally, patient satisfaction can lead to an increase market share for the healthcare provider as satisfied patients will return for their healthcare needs as well as encourage others to utilize the provider as well. Involving clinical staff in a customer service rounding process will provide the experience necessary to develop such an understanding of the importance of the nurse/patient interaction to patient satisfaction with the goal of increasing it.

The following sections of this project report will review the plan utilized for implementation of the rounding project. In addition, the evaluative metrics utilized to measure its effectiveness and the outcomes will be discussed.
IV. IMPLEMENTATION METHODS

The literature regarding the link between patient satisfaction and nurse rounding found that patient satisfaction scores increased when hourly rounding was initiated and patients perceived that their quality of care was greater (Saleh, et al., 2011; Blakleyet al., 2011; Woodard, 2009; Meade, et al., 2008; Sobaski, et al., 2008; & Meade, et al., 2006) . The organizational SWOT assessment of the host organization indicated a favorable environment for changing the nursing unit level approach to assessment of customer satisfaction along with potential barriers that may be overcome with careful planning. The project developed was to initiate a charge nurse rounding program with a customer service focus to increase patient satisfaction scores.

Population of Interest

The population of interest was defined as those in-patients with hospital stays of three days who were over the age of eighteen, male or female, non-inmate, and who presented with a functioning level of consciousness. In addition, those patients selected for rounding were able to make medical decisions as determined by nursing and medical assessments.

Patients who were hospitalized for three days or greater were chosen for the rounding program. The criteria of “three days or greater” was chosen as this is usually the time frame in which diagnostic results should be reported, allowing the patient’s care team to have a greater understanding of the patient’s problem and provide the patient with a plan of care. In addition, this is the population who receives the post discharge
Patient Satisfaction Survey’s from Press-Ganey. Furthermore, this population mirrors the patients in the general literature that speaks to patient satisfaction.

**Project Setting**

The host organization for the rounding project is a Joint Commission certified tertiary, acute care hospital. The host organization is located in a large urban setting next to one of the largest universities in the United States and is affiliated with the College of Medicine. The medical center is comprised of four business units (main hospital, 500 beds; cancer hospital, 150 beds; psychiatric hospital, 60 beds; and a community based hospital, 120 beds) that maintain their own leadership structure including: a chief executive officer, chief financial officer and chief nursing officer. Each business unit maintains a separate budget, operational, and strategic plan. Patient care quality metrics are also established by each business unit with all quality and patient satisfaction plans and goals reporting up through the Health System to a system level chief executive officer and chief nurse executive. Currently, the medical center serves the local population of the surrounding counties in a mid-western state, but receives most of its patients as tertiary referrals for advanced medical care associated with the College of Medicine. The two medical-surgical units utilized for this project are located within the main hospital business unit.

The nursing units are titled: Unit A and Unit B. The first unit, Unit A, is a 39 bed general medical-surgical unit housed in an eleven story medical building that is part of the main hospital. The second unit, Unit B, is a 27 bed medical-surgical unit that is housed in an 11 story building adjacent to the building that Unit A is located in, and is also part of the main hospital. Both buildings are on the main campus of the main
hospital and are part of the academic medical center (AMC) and receive support services from other departments within the medical center itself (e.g., physician coverage, nutritional support, respiratory care support, housekeeping, etc.). The patient care rooms are off a central corridor on each nursing unit and comprise of private and semi-private rooms.

Unit A has a total of 75 staff members including registered nurses and unlicensed assistive personnel (such as nurse aides and unit clerical assistants) and Unit B has 65 staff members (including unlicensed assistive personnel). Each unit has a nurse manager and an assistant manager who are responsible for the daily patient care and human resource operations. Additionally, each unit utilizes a registered nurse in the role of charge nurse for shift level decision making involving nursing care, twenty-four hours per day, seven days per week. Both Units A and B share a clinical nurse specialist who is responsible for the clinical quality of care and education of nursing staff (K. Renz, personal communication, November 24, 2014).

The model of care utilized is a blend of primary care and team nursing. Nursing care is provided by registered nurses (RN), patient care associates (PCA), and student nurse associates (SNA); while unit clerical associates (UCA) provide clerical support for the unit. Each registered nurse is assigned a grouping of patients called an “assignment” of approximately five to six patients and is responsible for nursing assessments, developing plans of care, treatments, medication administration, and discharge planning. PCAs and SNAs are assigned six to eight patients each and are responsible for the basic activities of daily care such as bathing, oral care, phlebotomy, linen changes, ambulation, etc. UCAs are assigned to the nursing station and have the primary responsibility to greet
As visitors approach the nursing station as well as answer the desk phones and call light control panel. Assignments are made based on pairing of patient need with staff skill. A shift to shift report is completed at the shift start between the caregivers using a bedside report model (K. Renz, personal communication, November 24, 2014). The patients admitted to both units are comprised of adults, age seventeen and older, who have a medical or surgical diagnosis such as Crohn’s disease, pneumonia, chronic obstructive pulmonary disease, cellulitis, chronic pain or abdominal surgery among others. The majority of the patients are Medicare recipients as the average age is over 65 years. This setting is comparable to the general literature that speaks to patient satisfaction.

Each of the nursing units receives patients from one of two sources, admissions from outside the hospital or Transfers In from other units within the hospital (i.e. intensive care, progressive care, etc.). The numbers of admissions and “transfers in” for these two units are 2,446 for Unit A and 1,775 for Unit B for the fiscal year 2015. Daily, number of admissions equate to approximate eight admits/Transfers In for Unit A and six for Unit B. The total number of days a patient remains in the hospital is calculated by the midnight census and is called “patient days” and reflects those patient who are newly admitted/Transferred In as wells as those patients who are staying on a continual basis. The annual patient days for these two units are 12,071 for Unit A (average daily census of 33) and 8,249 for Unit B (average daily census of 23) (R. Salmen, personal communication, August 5, 2014). During the selected three month period of the projects implementation, it was estimated that the number of patients meeting the criteria for the project would be approximately 80% of the average daily census on each unit. (S. Taylor,
personal communication, August 5, 2014) The average daily census for Unit A is 33 patients with approximately 26.4 of those patients meeting the criteria additionally; Unit B average daily census is 23 of which 18 patients would meet the inclusion criteria.

**Project Sponsor/Key Stakeholders**

The project sponsor for the host organization was the Chief Nurse Executive (CNE) for the health system. As the most senior nursing leader in the combined organization, she has responsibility for overall patient care, including quality and patient outcomes. She also fulfills the role as the Chief Experience Officer, who has direct responsibility of patient satisfaction and meeting organizational goals relating to Press-Ganey Survey (which include HCAHPS targets). Other key stakeholders include: patients, patient families/significant others, staff nurses and other direct care givers, the nurse manager of the unit, director of nursing for the unit, chief nursing officer of the main hospital, clinical nurse specialist for the unit, customer service staff, and the nursing quality staff.

The customer service rounding program’s ultimate goal was to increase patient satisfaction so that each of the stakeholders would realize a benefit. According to the literature, the organizational stakeholders (nursing leaders, nurses, physicians, administrators, customer services staff, etc.) will experience more satisfied patients with an increased positive health outcomes, decreased readmissions once discharged due to more satisfactory information transfer, and accomplishment of the organization’s patient satisfaction and readmission goals. The stakeholders would likely see an increase in community awareness of the organization’s service reputation with the potential of taking more of the market share from local competitors. Internal stakeholders would also
experience a sense of pride in the hospitals reputation to provide high quality care, one that they would send their own family to. (Boulding, et al., 2011; Gupta, et al., 2014).

External stakeholders (patients, families, significant others) were expected to experience a greater sense of decisional control regarding their healthcare in turn, affecting their sense of security, safety and trust while in the hospital. Recently, published studies support a tactic of increasing patient satisfaction to increase adherence to treatment plans and increasing health status, ultimately decreasing readmissions and loss of productivity in society (loss of work, school, play, etc.) (Boulding, et al., 2011; Dilworth, Higgins & Parker, 2012).

Ethical/Legal Considerations

The host organization requires that all projects be reviewed for applicability for Institutional Review Board (IRB) approval and utilizes a policy to determine if IRB approval is warranted, the policy document is titled, “Guide for Determining Quality Improvement vs. Research”. As this project will not involve a comparison group and will not generate new knowledge, it is not considered research; however, as this is an academic based project from outside the AMC, the organization does require an expedited review by the IRB to maintain patient/staff and data security. The rounding project was determined to be of quality improvement in nature and the appropriate application was submitted to the host organization for review and approval by the Chief Quality and Patient Safety Officer as well as the IRB. Per hospital policy the “Data Quality Release Form” was completed and approved by the Chief Quality Officer of the host organization (See Appendix E). Internal Review Board (IRB) approvals were sought and obtained from both the host organization (See Appendix F) and Wright State
University, site of the doctoral program of the project lead (See Appendix G). The Nurse Scientist of the AMC assisted the project lead with IRB application construction and post approval by IRB, signed the Agency Permission for Conducting Doctoral Project form required by Wright State University (See Appendix H). Permission for project implementation had been obtained from several layers of nursing leadership within the host organization including: Chief Nursing Officer of host business unit (see Appendix I), director of medical-surgical nursing (see Appendix J), and the nurse managers of the two identified medical-surgical units (See Appendix K).

**Ethical Obligations**

The purpose of the rounding project was to ensure that patients perceive that they are getting the highest quality of care possible and to identify and rectify the obstacles to that perception. The principle of beneficence, defined as the act of “doing good” as opposed to “doing harm” is the guiding principle for this project (Johnson, 2003).

Healthcare organizations are not perfect and stories of poor outcomes encountered by the general public populate the common literature. The proposed rounding project will help to identify any concerns the patients and families have about the care rendered thus far and provide an opportunity for the nursing staff to take action for correction to ensure that the organization delivers high quality care and thus “do good”.

Ethical concerns that may have been encountered during the project were negligible. Should a participant have encountered a concern, a policy was available to guide the staff (see Appendix L). Access to the medical center policy was available by addressing such concerns to the nursing leadership (nurse manager, assistant nurse managers, etc.) on the assigned nursing units as well as the project lead and could also
have been brought forward via access to a confidential reporting line provided on the AMC’s intranet website which was available to all staff members. Patients who encounter ethical concerns are encouraged to contact the Guest Services office via a posted phone number.

One ethical concern stemming from this project was the perception of jeopardy for disciplinary action or loss of employment by staff for those nurses identified by patients citing poor customer service or practice issues. Staff members for both of the identified units were given an explanation of the project along with its goals and intended outcomes. One topic that was presented was a statement of the process to be followed by the charge nurse should a serious concern/issue be identified during the customer service rounding process. The current practice for serious issues identified on the units is that the charge nurses notify the nurse manager or designee, who then assesses the situation and determines a plan of action. Such action can include the disciplinary process (known culturally as the “corrective action process”). The fact that this is a quality improvement project to elicit patient satisfaction brings forth a reasonable chance that poor performance by a staff member will be identified. Due to the seriousness of the nature of the work on the unit, exemption from corrective action was not feasible for the staff members. Historically, the host organization does not provide exemption from corrective action based on the implementation of quality initiatives (E. Chipps, personal communication, August 5, 2014). Additionally, failure to follow through with serious issues/concerns could place the patient and/or the host organization in greater jeopardy legally, financially, and socially. This may have led to a fear to take part in future quality
initiatives or research by those staff members involved, a risk that the host organization has maintained for quite some time.

**Project Barriers and Vulnerabilities**

All projects offer potential barriers and vulnerabilities with implementation. The potential barriers to the implementation of this project are identified below along with the probable solution to the barrier.

- Failure of all charge nurses to receive the training during charge nurse meetings. Solution: Those charge nurses who are not in attendance during the training, were provided individual training by the project lead during a scheduled time in which they are designated a charge nurse.

- Lack of rounding consistency from nurse to nurse (i.e. not following same process from rounding nurse to rounding nurse). Solution: This was addressed through the training of the rounding team using the protocol outlined.

- Lack of buy-in from unit level nursing leadership. Solution: The leadership of the units was kept informed of the programs progress and reviewed the rounding summaries to help understand the value of the program.

- Failure to provide the immediate feedback to nursing staff post rounding. Solution: The rounding protocol provided aide in adherence to the rounding process and all of its components. This includes giving timely feedback to staff.

- Failure to properly identify the day three or greater patients. Solution: Adherence to the rounding protocol assisted to ensure that patients day three or greater are visited by the rounding nurse.
- Failure to round on identified patients during assigned rounding time. Solution: the project lead contacted each charge nurse daily via phone as a reminder to complete the rounding intervention and post huddle.

- Failure for active duty staff to participate in the sharing of the rounding information post rounds. Solution: The rounding nurse pulled all staff who was not engaged in active patient care to the nursing station to receive the summary.

**Project Vulnerability**

The rounding project has four potential areas of vulnerability with regards to the project process itself: (1) consistency with the group orientation of the charge nurses to the rounding project, which includes their role and responsibilities, (2) consistency with the practice orientation round of the rounding process with the charge nurses by the project lead, (3) the charge nurses daily performing the rounding independently during project implementation, and (4) the rounding process to be consistently followed by the charge nurses including the incorporation of the post rounding summary (huddle).

Project implementation can be a daunting task for any experienced leader and the complexity of the project can increase based on the number of individuals involved and steps within the actual project process itself. The implementation of treatment protocols and measurement of outcomes are no different and without proper design and monitoring can lose their internal validity by drifting away from the project design. To decrease the threats to validity of the project process, a check list was developed for each of the four identified vulnerable steps. The “Orientation Curriculum checklist” was developed as a means to decrease variability with the material presented between orientations and was utilized by the project lead during the meeting with the charge nurses to orient them to
the project (see Appendix M). During the 1:1 or 1:2 rounding education (practice patient rounding with the project lead) a checklist was used to provide consistency of the training between the charge nurses (see Appendix N). Once the charge nurses began the rounding process on their respective shifts, the Patient Satisfaction Rounding Log served as a checklist to aid in adherence to each step of the project process (see Appendix O). The fourth identified vulnerability was the actual rounding process itself with potential failing to complete forms in part or whole by the charge nurses. To foster the adherence to the project, the project lead called each charge nurse a minimum of three times per week and completed Project Lead Checklist (see Appendix P). All checklists are maintained by the project lead in a locked office and will be destroyed after the project is complete.

**Action Plan**

The Evidenced-Based Practice Improvement Model (Levin, R. F., et al., 2010) was utilized to guide the action plan for the rounding project (see Figure 1). The problem of patient satisfaction was identified and assessed via communications with nursing leadership and a PICOT question was formulated to guide the literature review. Evidence was obtained by searching the scientific literature and that evidences was leveled for its applicability and strength to help answer the PICOT question. Evidence supported the use of nurse rounding to impact patient satisfaction, which prompted the design of the charge nurse lead customer service rounding with post huddle.

Within Levin’s model (2010), the Deming performance model of Plan, Do, Study, Act (PDSA) is used to aid the implementation of the evidence into practice. The PDSA portion of the model was used to guide the project lead. The rounding project was defined and approved for use on the nursing units in the “plan” stage and implemented on
both nursing units during the “do” stage. The overall purpose of this project was to influence the bedside behavior of the nursing staff to increase patient satisfaction. Collecting patient satisfaction information and sharing it with the staff in real time was expected to impact the behavior staff are displaying towards their patients. Summarizing and reviewing the patient comments, both positive and negative, provide the staff with a barometer with which to change their own behavior. During the “study” stage the results of the rounding intervention were reviewed leading to the proposal for continuance of the rounding intervention post project completion for the “act” stage.

Timeline

The project implementation and evaluation timeline was estimated to be six months, see Table 5 for details. The timeline was realistic as the project was completed as scheduled.

Table 5
2015 Timeline of Proposed Project

<table>
<thead>
<tr>
<th>Month</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>Identify and orient/train charge nurses.</td>
</tr>
<tr>
<td></td>
<td>Orientation of staff to the project.</td>
</tr>
<tr>
<td>June</td>
<td>Staff begin rounding</td>
</tr>
<tr>
<td>July</td>
<td>Staff rounding</td>
</tr>
<tr>
<td>August</td>
<td>Staff rounding and gather data.</td>
</tr>
<tr>
<td>September</td>
<td>Gather data.</td>
</tr>
<tr>
<td>October</td>
<td>Gather data and summarize findings.</td>
</tr>
</tbody>
</table>

Project Team

Members of the rounding project team included three groups: the project lead, the nursing leadership on the individual units (nurse managers and assistant nurse managers), and the charge nurses for each nursing unit. The project lead was responsible for development and implementation of the rounding project and was available to help guide
and answer any questions/concerns the charge nurses may have had. The project lead was also responsible for providing the orientation and training for the charge nurses involved as well as the collection of the Press Ganey Patient Satisfaction Survey results during the project implementation.

The nursing leadership groups included both the nurse managers and assistant nurse managers for each unit and who were responsible for supporting the project lead with the customer service rounding implementation. Each of the nursing units has charge nurses for each shift, twenty-four hours per day, seven days per week. The charge nurses are chosen by the nurse managers from the registered nurses on the unit based on their attributes of resourcefulness, team orientation and knowledge of the patient population served, years of nursing service and dependability. The charge nurses assigned for a particular shift round on the patients on their respective units to determine patient care issues and concerns. For the purpose of this quality improvement project, the criterion for the individuals performing the customer service rounding was the identified charge nurses on each of the units on the day shift (K. Renz, personal communication, August 5, 2014).

**Project Implementation**

Once approval had been received from the Institutional Review Boards, the project lead initiated the implementation plan to orient the charge nurses to the rounding project. During the development of the rounding project, the project lead consulted with the nurse managers and assistant nurse managers of both nursing units for their input into the project design and implementation. Nursing unit leadership proposed the project lead attend a series of charge nurse meetings for both of the nursing units in order to make
introductions and provide education of the project. The nursing unit leadership also identified the location for the Patient Satisfaction Rounding Log to be kept for the charge nurses access. Each nurse manager identified the names of the charge nurses that would require the orientation to the rounding program and provided those names to the project lead. Eight charge nurse names were submitted for the project orientation by the Unit A leadership team, and nine charge names were submitted by the Unit B leadership. Thus, a total of 21 individuals were identified for the project orientation and rounding process orientation.

**Orientation Phase**

The charge nurses for the units identified received an orientation and training for the rounding project for a total of two to three hours (one hour for orientation and one or two hours for training). Nursing unit leadership (nurse managers and assistant nurse managers) received the same education and rounding training provided to the charge nurses.

The incorporation of a checklist to be used during the project implementation at identified vulnerable steps of the project process aids in decreasing threats to internal validity (Resnick, et al., 2005; Chlan, Guttormson, & Savik, 2011). Two checklists for the orientation process were developed by the project lead to help guide the content taught to each charge nurse, as well as the nurse managers. One was developed to aid in keeping the orientation of the charge nurses to the project process as uniform and consistent with each project orientation session as possible. In addition, the importance of each charge nurse completing the rounding intervention consistently and completely between each customer service rounding session and between each charge nurse was also
considered important to project validity. To address the issue, a checklist was implemented during the orientation of the charge nurses to the customer service rounding process with the project lead. Last, the data collection tool used by the charge nurses during the rounding (described below in the section relating to outcomes measurement) was developed and introduced to the staff during orientation.

The project implementation began with the orientation of the charge nurses to the project and its purpose. Each member of the team, including the nurse managers, was provided an orientation and training. The orientation curriculum consisted of the following topics (see Appendix Q for a detailed script):

- Overall purpose/goal of the project.
- Operational definitions: Patient Satisfaction and Nurse Rounding.
- Measurement of project via Press-Ganey Patient Satisfaction Survey Tool. (see Appendix E).
- Coaching
- Rounding program explained in detail.
- Staff summary post rounding.

The staff meetings for the two units were held on May 19th, 20th and 27th of 2015 in Unit A’s break room. Conference call option was available to help foster attendance. A total of 12 charge nurses attended the three staff meeting times. The staff meeting agenda included an introduction of the project lead; historical perspective as to why patient satisfaction and nurse rounding was chosen for the project; overview of the project using the Nursing Rounding Project Orientation Curriculum document. Copies of the Nursing Rounding Project Orientation Curriculum were provided to each participant.
Attendance of each staff meeting was obtained by having the participants sign the Nurse Rounding Project Orientation Curriculum document. The Nurse Rounding Project Orientation Curriculum checklist was used as a conversation guide to help ensure that all aspects of the project were shared with each participant to maintain fidelity during the orientation process with the charge nurses (Resnick, et al., 2005; Chlan, et al., 2011).

The remaining six charge nurses, two nurse managers, and two assistant nurse managers were provided the project orientation using the Nursing Rounding Project Orientation Curriculum document in small sessions conducted by the project lead. Five of these sessions were conducted: May 28th for one participant; May 29th for two participants; June 1 for two participants; June 15th for three participants and June 22nd for one participant. As with the staff meeting sessions described above, the content was the same and the Nurse Rounding Project Orientation Curriculum checklist document was utilized to capture attendants name and help to maintain fidelity for the orientation content.

Once a charge nurse (or one of the nurse managers or assistant nurse managers) completed the Nurse Rounding Project Orientation Curriculum session with the project lead, he/she was then provided a structured rounding experience with the project lead. The Nurse Rounding Project Rounding Orientation Checklist was utilized as a tool to provide internal fidelity between participants structured rounding experience. Each participant signed the Nurse Rounding Project Rounding Orientation checklist with each structured experience. The project lead visited each of the two nursing units ten times from June 1st to June 22nd and enlisted the charge nurses (or nurse manager, assistant nurse manager) to conduct the “practice” round. The Process Guidelines for Staff (see
Appendix R) was utilized as a guide for the practice round and each rounding session involved a small number of charge nurses to decrease the number of staff in the patient environment and enhance privacy for the patients. Three sessions had one nurse rounding with the project lead, six sessions has two nurses and one session had three nurses participate in the practice round with the project lead. Once a charge nurse, nurse manager or assistant manager had completed the practice round, they were considered to be able to perform the patient satisfaction rounding independent beginning with their next available work shift.

**Rounding Phase**

Post orientation, the rounding program commenced beginning in June 2015 and continue through the end of August 2015. During the rounding intervention, the charge nurses engaged the patient/visitors/family members present at the bedside in a conversation guided by the pre-determined set of questions on the rounding log with the purpose of eliciting the patient’s perceptions of their care. Patient responses were recorded on the rounding log and shared with the active duty nursing staff post rounding, called the “huddle”. Additionally, the nurse managers were required to handle any serious patient complaints. Such complaints would include: rude staff member, missing/theft of items, alleged abuse and any other matter that the rounding nurse deems necessary to forward to nursing leadership. All rounding logs were submitted to the nurse manager/assistant nurse manager for review and documentation of any patient follow-up.

The charge nurse rounding targeted patients who were day three or greater of their hospital stay as this is the time frame in which patient begin to experience questions and concerns regarding the course of their hospitalization. Those patients who were
discharged before day three (who do not receive the charge nurse rounding) potentially benefitted from the intervention as the customer service feedback provided to the nursing staff should guide them in all patients interactions and not just with those with hospitalizations of three days or more. Following patient discharge, the Press-Ganey Patient Satisfaction surveys were mailed to all patients by the Press-Ganey Corporation with the exception of those patients under 18 years of age or those who are incarcerated or deceased. The survey is automatically mailed by the Press-Ganey company to the home address listed in the hospital registration system at the time of the patient’s admission to the hospital. The patient address data is sent to Press-Ganey four days post discharge from the hospital for a target of being received by the patient within seven days of discharge (J. Halley, personal communication, August 7, 2014).

The project lead began a diary of project activities with the initiation with the first charge nurse meeting on May 19th. This diary was kept electronically and was used to document observations made during project activities by the lead during the life of the project. Additionally, during the project implementation, the nurse leaders of the two units requested a daily phone call to the charge nurses of each unit to remind them to perform the patient satisfaction rounds on their shift and to follow those calls with a text message to each manager informing them the calls were made.
Anticipated Outcomes

The primary outcome from this project was an expected increase in patient satisfaction as measured by the Press-Ganey Patient Satisfaction Survey scores. Two metrics were utilized for this EBP project: completion of the Patient Satisfaction Rounding Log and the monthly reporting of the nursing unit level Press-Ganey Patient Satisfaction scores. Outcomes were measured by changes in the monthly unit scores on the Press-Ganey Patient Satisfaction Survey tool mailed to all discharged patients. In addition, changing trends in positive and negative comments by patients during rounding was monitored via the rounding log. Lastly, staff impressions of the program were solicited via focus groups to aid in the development of proposals for future enhancement of the rounding program.

Outcomes Measurement Tools

Three tools were developed to be utilized for the implementation and evaluation of the customer service rounding project: The Patient Satisfaction Rounding Log (PSRL) (completed by the charge nurses when they completed the customer service rounding intervention); an excel spreadsheet for compiling outcomes data gathered by the project lead during the projects implementation (see Appendix S), and the project Lead Checklist completed by the project lead during the implementation of the project.

The PRSL was developed to guide data collection during the rounding process. The PSRLs were completed by the charge nurses during customer service rounding and the documents were collected by the project lead after the nurse managers had reviewed them. Raw data were kept secure in a locked office until review for summation. The PSRL is printed on a single sheet of paper in a grid format. Four questions specific to the
four areas of customer service impacting patient satisfaction, as identified on Cox’s (2003) IMCHB model, were included on the PSRL. Please see Table 6 below.

Table 6

Interaction Model of Client Health Behavior and Patient Satisfaction Rounding Log Questions.

<table>
<thead>
<tr>
<th>Interaction Model of Client Health Behavior Variable</th>
<th>PSRL Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>• Are you getting the information you need about your care to make the needed decisions?</td>
</tr>
<tr>
<td>Affective Support</td>
<td>• Are the nurses treating you well?</td>
</tr>
<tr>
<td></td>
<td>• Are you getting the information you need about your care to make the needed decisions?</td>
</tr>
<tr>
<td></td>
<td>• Is discomfort/pain being managed to your expectation?</td>
</tr>
<tr>
<td>Decisional Control</td>
<td>• Is your call light being answered timely?</td>
</tr>
<tr>
<td></td>
<td>• Are you getting the information you need about your care to make the needed decisions?</td>
</tr>
<tr>
<td>Professional/Technical Competencies</td>
<td>• Is discomfort/pain being managed to your expectation?</td>
</tr>
<tr>
<td></td>
<td>• Are you getting the information you need about your care to make the needed decisions?</td>
</tr>
</tbody>
</table>

The four rounding questions to be asked during the customer service rounds were listed across the “X” axis at the top of the grid and include a column for “Comments”. The “Y” axis included rows for individual patient responses and is labeled “Patient 1”, “Patient 2”, etc. As the charge nurses completed the customer service rounding, he/she summarized the patients’ responses into the proper boxes. Additionally, as failure to provide the real-time patient feedback via post rounding huddle was expected to impede the incorporation of customer service information to the staff and enhance performance, the PSRL had a section that required the charge nurse to indicate if the post rounding
huddle has been completed and, if not, to provide a reason as to why. The last portion of the tool included a section for the nurse manager of the unit to make comments post his/her review of the PSRL.

The second tool developed was an excel spreadsheet to record the monthly Press-Ganey Patient Satisfaction scores. Each nursing department in the hospital receives a monthly report of patient satisfaction as measured by the Press-Ganey Patient Satisfaction Survey mailed to all discharged patients. The scores are broken down into dimensions that correspond to questions on the actual patient survey form. The project lead had access to the individual unit reports and extracted the scores for the four dimensions along with the score for the “Overall” response on the questionnaire. The July of 2015 was the first month of data collection from the Press-Ganey Patient Satisfaction Reports distributed to hospital leadership and continued through August of 2015. Press-Ganey posts the scores on the intranet site during the second week, one month after the month of the survey distribution to discharge patients, causing a five week lag time from the month in review to the posting of scores.

The third tool developed for the customer service rounding project was the Project Lead Checklist which was used by the project lead to monitor the progress of the project. Each question on the tool was chosen to help provide information as to completion of important aspects of the project. This tool was kept by the project lead and was of assistance during discussion of the project progress with the nurse managers. Additionally, post implementation, an additional step was requested and added to this checklist in the form of daily phone calls to the charge nurses as a reminder to complete
the patient satisfaction rounding on their shifts followed by a text message from the project lead to the nurse managers stating that such calls had been made.

In addition to the three tools developed for the project, the impact of the intervention on patient satisfaction was measured by reviewing the Press-Ganey Patient Satisfaction Survey results. These survey results are reported monthly to hospital leadership as an electronic report titled, Press-Ganey Patient Satisfaction Overview. The Press-Ganey Patient Satisfaction Overview was accessed via the internal intranet site of the host organization and was gathered for the months of June, July and August of 2015.

**Press-Ganey Patient Satisfaction Survey.** The Press-Ganey Patient Satisfaction Survey (PGPSS) (see Appendix T for copy of the survey) is comprised of two components: (1) questions developed by the Press-Ganey Corporation and (2) questions developed by the federal government. Those questions developed by the federal government are known as HCAHPS. HCAHPS stands for Hospital Consumer Assessment of Healthcare Providers and Systems. The total number of questions for the PGPSS is 71, of which 32 are HCAHPS questions.

The PGPSS questions have a reliability range of 0.78 to 0.95 for each of the dimensions in the survey, with 0.7 or greater indicating “good” reliability (Supporting Statement, retrieved November 14, 2011). Construct validity for the domains of the survey was determined to be 0.75 with a score of 0.4 considered to be adequate. (Supporting Statement, retrieved November 14, 2011). See Table 7 for HCAHPS Indicators of Psychometric Performance.
Table 7  
HCAHPS Indicators of Psychometric Performance

<table>
<thead>
<tr>
<th>Domain –level Composite</th>
<th>Hospital-level Reliability</th>
<th>Hospital-level correlation with willingness to recommend.</th>
<th>Hospital-level correlation with overall rating.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with doctors</td>
<td>0.76</td>
<td>0.54</td>
<td>0.59</td>
</tr>
<tr>
<td>Communication with nurses</td>
<td>0.89</td>
<td>0.76</td>
<td>0.81</td>
</tr>
<tr>
<td>Responsiveness of hospital staff</td>
<td>0.81</td>
<td>0.70</td>
<td>0.75</td>
</tr>
<tr>
<td>Cleanliness and quiet of environment</td>
<td>0.77</td>
<td>0.68</td>
<td>0.75</td>
</tr>
<tr>
<td>Pain control</td>
<td>0.62</td>
<td>0.72</td>
<td>0.76</td>
</tr>
<tr>
<td>Communication about meds</td>
<td>0.68</td>
<td>0.73</td>
<td>0.65</td>
</tr>
<tr>
<td>Discharge information</td>
<td>0.75</td>
<td>0.53</td>
<td>0.57</td>
</tr>
</tbody>
</table>

Note. From [www.cms.gov/Medicare/Quality...Patient.../HospitalHCAHPS.html](http://www.cms.gov/Medicare/Quality...Patient.../HospitalHCAHPS.html)

The HCAHPS questions were developed and tested by the federal government and are used to elicit overall patient satisfaction with their healthcare for the Center or Medicare Services (CMS). CMS partnered with the Agency for Healthcare Research and Quality (AHRQ) to develop and test the survey. AHRQ tested the survey through a three state pilot studies involving 130 hospitals and 19, 683 discharges (Supporting Statement, 2012). Of the 32 questions, four questions are demographic in nature (i.e. highest grade level accomplished, race and ethnicity and language spoken) and six questions require a “yes/no” response. The remaining questions utilize a Likert scale with multiple answers to choose from.

For the purpose of this project, a conceptual link was identified between the HCAHPS questions of the survey (as patient satisfaction outcome measures) and the corresponding IMCHB model variables to illuminate the relationship between
caregiver/patient interaction and patient outcomes. Each HCAHPS survey question corresponds to one of the four key Client-Professional Interaction factors on the IMCHB, (see Table 8). Additionally, the questions chosen for the PSRL have a direct relationship to the HCAHPS questions on the PGPSS (see Appendix U).

Table 8:
*Interaction Model of Client Health Behavior Variable and HCAHPS Questions.*

<table>
<thead>
<tr>
<th>Interaction Model of Client Health Behavior Variable</th>
<th>HCAHPS Question</th>
</tr>
</thead>
</table>
| Information                                         | • How well the nurse kept you informed.  
• Explanations about what would happen during tests or treatments.  
• Instructions given about how to care for yourself at home. |
| Affective Support                                    | • Friendliness/courtesy of the nurses.  
• Amount of attention paid to your special or personal needs.  
• Staff attitude towards your visitors.  
• Degree to which staff addressed your emotional needs.  
• Response to concerns/complaints made during your stay. |
| Decisional Control                                   | • Extent to which you felt ready to be discharged.  
• Staff effort to include you in decisions about your treatment. |
| Professional/Technical Competencies                  | • How well your pain was controlled.  
• Skill of the nurses. |

**Press-Ganey Patient Satisfaction Overview report.** The Press-Ganey Patient Satisfaction Overview report to hospital leadership contains a summary of the results for the Press-Ganey Patient Satisfaction Survey, of which four of the dimensions were extracted as metrics for the customer service project. Those four dimensions included: HCAHPS nurse communications comprising five questions; HCAHPS communication about medications comprising two questions; HCAHPS pain management comprising
three questions; and HCAHPS responsiveness comprising two questions. Each of the questions is believed to be a nurse sensitive indicator of the overall satisfaction a patient had with nursing care while hospitalized (Studer, Robinson, & Cook, 2010). The Patient Satisfaction Overview reports are compiled and tabulated through the Patient Experience Department of the host organization in conjunction with the Press-Ganey Corporation. The unit level detailed report is prepared and sent to a designated website for each leader and can be accessed via the intranet of the host organization. Each report includes the unit level data for HCAHOPS Overall score, as well as percentiles for the nurse sensitive questions. Additionally, the report includes data regarding questions pertaining to the admission process for the hospital, quality of meals, tests/treatments and a survey response count for the month.

**Data Collection Procedure**

To determine the effect of the customer service rounding on the patient satisfaction scores, the data for each nursing unit that was pulled came from one source, The Press-Ganey Patient Satisfaction Survey results and contained the following scores: the HCAHPS Overall score, HCAHPS Communication about Medications, HCAHPS Nurse Communication, HCAHPS Pain Management, and HCAHPS Responsiveness. This data was accessed via the internal intranet site of the host organization and was gathered for the months of June, July and August of 2015. The PSRLs were collected by the project lead after the nurse managers had reviewed them and were kept secure in a locked office until review for summation.
Conclusion

The proposed practice recommendation was to initiate a charge nurse rounding program with a customer service focus on two medical-surgical units in a mid-western academic medical center. The patient population proposed for this quality improvement project was those admitted to the units and be over the age of eighteen, both male and female, non-inmate, who presented with a functioning level of consciousness and who were able to make medical decisions as determined by nursing and medical assessments. The Press-Ganey Patient Satisfaction Survey results are utilized as a metric to measure the effectiveness of the rounding intervention. In addition, qualitative data collected from both patients and administrators were examined for general frequency of positive, neutral or negative statements.
V. PROJECT OUTCOMES

The PICOT question developed for this evidenced-based, quality improvement project was “On a medical-surgical unit (P), does the implementation of a staff nurse led customer service rounding program (I), compared to no staff nurse customer service rounding program (C), increase the Press-Ganey Patient Satisfaction scores as reported by HCAHPS (O) over a three month period (T)?” The Press-Ganey Patient Satisfaction Survey (PGPSS) scores were examined to determine the effect of the nurse rounding intervention on patient satisfaction scores to answer the PICOT question. Additional evaluative methods were incorporated into the project to examine the effectiveness of the intervention including, the PSRLs review and use of post project focus groups.

Satisfaction Score Outcomes

Following the project timeline, the Press-Ganey Patient Satisfaction Overview report was accessed for nursing unit level data. The data for the four HCAHPS questions and the HCAHPS Overall Score were obtained for each nursing unit by accessing the organizations intra-net and transcribed monthly into a spreadsheet and stored for statistical comparison beginning in July of 2015 and ending in October 2015. During data extraction, it was noted that the month of April had only seven returned patient satisfaction surveys for Unit B. To maintain a comparable comparison, the month of February was chosen as the non-intervention month for Unit B as it had 17 returned surveys, a number more closely related to the intervention months. The goal of patient satisfaction customer service rounding was to increase patient satisfaction as reported
through the PGPSS report. Per discussion with the unit administration, an increase of five points for each dimension was considered to be a clinically significant target of the rounding program.

The data presented in Table 9 are percentiles calculated by the Press-Ganey Corporation. A descriptive analysis was conducted to help identify any clinically significant impact of the rounding intervention on the patient satisfaction scores as received by Press-Ganey.

Table 9
Press-Ganey Patient Satisfaction Percentile Scores for Unit A and Unit B

<table>
<thead>
<tr>
<th>Question from PGPSR</th>
<th>Unit A April</th>
<th>Unit A June</th>
<th>Unit A July</th>
<th>Unit A August</th>
<th>Unit B February</th>
<th>Unit B June</th>
<th>Unit B July</th>
<th>Unit B August</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication of medications</td>
<td>n = 21</td>
<td>n = 24</td>
<td>n = 24</td>
<td>n = 27</td>
<td>n = 17</td>
<td>n = 19</td>
<td>n = 10</td>
<td>n = 16</td>
</tr>
<tr>
<td>Nurse Communication</td>
<td>47.6</td>
<td>63.3</td>
<td>75</td>
<td>44.1</td>
<td>55.6</td>
<td>73.1</td>
<td>50</td>
<td>73.7</td>
</tr>
<tr>
<td>Pain Management</td>
<td>81</td>
<td>81.4</td>
<td>86.1</td>
<td>72.5</td>
<td>72.5</td>
<td>78.9</td>
<td>50</td>
<td>78.7</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>76.9</td>
<td>71.4</td>
<td>61.9</td>
<td>45.8</td>
<td>61.1</td>
<td>76.9</td>
<td>56.3</td>
<td>68.8</td>
</tr>
<tr>
<td>Overall</td>
<td>48.5</td>
<td>66.7</td>
<td>54.3</td>
<td>50</td>
<td>47.8</td>
<td>42.3</td>
<td>57.1</td>
<td>73.7</td>
</tr>
</tbody>
</table>

**Unit A.** Review of the data for Unit A revealed a consistent pattern of the number of returned survey responses from month to month with 21 surveys returned in April 2015 and 24, 24, 27 respectively for June, July and August of 2015. The means for the four nurse sensitive HCAHPS scores were examined. Comparing the intervention months to the non-intervention month, an increase in patient satisfaction was noted for each of the dimensions except for pain management and the overall score (see figure 3).
• For the dimension, “communication about medications” the June and July PGPSS percentile results showed an increase of 15.7 points and 27.4 points respectively; while August scores decreased by 3.5 points.

• Nurse Communication had a less dramatic increase as the April score was 81, June scores increased by 0.4 points to 81.4, July increased by 5.1 points to 86.1, and August decreased by 8.5 points to 72.5.

• Pain management’s April percentile was 76.9 and showed a decrease of 5.4 points to 71.4 for June, a decrease of 15 points in July to 61.9, and a further decrease in August to 45.8 for a total loss of 31.1 points.

• Responsiveness’s April score was 48.5 with an increase of 18.2 points to 66.7 for June; scores continued above the April baseline by 5.8 points with a July score of 54.3, and an August score of 50, which was an increase of 1.5 above the baseline April score.

• The overall score includes all aspects of the patient experience from admission, to environment, diagnostic testing experience, food, cleanliness of environment, and discharge preparations among others and is not solely influence by nursing practice. The Overall scores for Unit A decreased from 71.4 in April to 70.8 in June; rebounded to 78.3 in July and dropped in August to 69.2.
**Unit B.** Unit B Press-Ganey Patient Satisfaction Survey returns for the intervention months were 19 for June, 10 for July and 16 for August. The comparison month previously chosen, April, had a lower return rate with of only 7 surveys returned raising concern that the lower number of surveys would weaken the comparison of the non-intervention month scores (7 surveys returned in April and 19, 10, 16 respectively for June, July and August). Therefore, February 2015 was chosen as the comparison month as the return rate was similar to the intervention months at 17. The means for the four nurse sensitive items in the Questions section were examined. Comparing the intervention months to the non-intervention month, an increase in patient satisfaction was noted for three of the nurse sensitive items for the months of June and August with decreased in the month of July (see Figure 4).

- Communication about Medications score for February was 55.6, June increased by 17.5 points to 73.1. July revealed a decrease from June dropping to 50, a loss
of 5.6 points compared to the February score of 55.6. August score increased back to 73.7, 18.1 points above the February score.

- Nurse Communication score demonstrated a similar pattern with the February score at 72.5, and the intervention months at 78.9, 50, 78.7 respectively for June, July and August.

- Pain Management score increased by greater than 5 points for July and August, however, scored dropped in July by 4.8 compared to February (February score of 61.1 compared to June 76.9, July 56.3 and August 78.7).

- Responsiveness scores increased greater than 5 points for two of the three intervention months (February 47.8 compared to June, 42.3; July, 57.1 and August 73.7) with June demonstrating a decrease of 5.5 points compared to February.

- The Overall score increased, for June by 24.5 points to a percentile of 83.3; June, and July increased by 1.2 points to 60, while August increased 3.7 points to 62.5. (See figure 4.)
Figure 4. Comparison of Nurse Sensitive Dimensions by Month for Unit B
Note: CMED- communication about medications, NSCM- nurse communication, PMGM- pain management, RESP- responsiveness, OVAL- overall score.

Patient Satisfaction Rounding Log Outcomes

Examination of the PSRL was conducted for the number of times the rounding program was completed per shift (called rounding occurrences), and the number of patients visited per rounding occurrence (called patient encounters) along with the satisfaction scores and the number of post rounding huddles (see Tables 10 and 11). It was noted that for the number of logs fell short of expectations of the rounding program. The rounding program was designed for customer service rounds to be performed daily and thus, 30 or more PSRLs was expected for each of the intervention months. Unit A had 12 completed PSRLs for June, 14 for July, and 3 for August. Unit B has 20 completed PSRLs for June, 12 for July, and 5 for August. During the first two months of the rounding intervention the numbers of logs were higher than the last month of the project, in which the number decreased noticeably.
Unit A had 12 rounding occurrences with 43 patient encounters in June; 14 rounding occurrences involving 68 patient encounters in July; and three rounding occurrences and 15 patient encounters for August. In addition, after each rounding occurrence, the charge nurses were to conduct a post-rounding huddle to provide the patient feedback to the staff on duty. Post huddle completion rates for Unit A were: June = 11, July = 13 and August = 0.

Unit B had 20 rounding occurrences with 66 patient encounters for June; 12 rounding occurrences and 51 patient encounters for July; and 5 rounding occurrences with 18 patient encounters for August. Unit B’s post huddle completion rates were: June = 13, July = 7, and August = 3.

For Unit A, an increase in the patient satisfaction scores were noted during the first two intervention months in which the number rounding of occurrences and subsequently, the number of patient encounters were noted to be higher. The last month of the intervention, August, the number of rounding occurrences and patient encounters dropped and, subsequently, the patient satisfaction scores dropped. Unit B experienced a drop in patient satisfaction scores during the second month of the intervention (July) and a rebound in the scores for August. It was noted that the number of returned surveys from patients the month of July was significantly lower when compared to the other two months of the intervention time frame and may have had a significant impact on satisfaction scores for July.
<table>
<thead>
<tr>
<th>Week (Per Saturday date.)</th>
<th>Number of Patient Satisfaction Rounding Log Sheets Submitted</th>
<th>Patient Rounding Encounters Recorded</th>
<th>Post Huddles Documented as “Yes”</th>
<th>Post Huddles Documented as “No”</th>
<th>Post Huddles NOT Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 6</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20</td>
<td>4</td>
<td>17</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27</td>
<td>3</td>
<td>11</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>June Total</td>
<td><strong>12</strong></td>
<td><strong>43</strong></td>
<td><strong>11</strong></td>
<td><strong>1</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>July 4</td>
<td>4</td>
<td>19</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>14</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>18</td>
<td>4</td>
<td>20</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>July Total</td>
<td><strong>14</strong></td>
<td><strong>68</strong></td>
<td><strong>13</strong></td>
<td><strong>0</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td>August</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<tr>
<td>29</td>
<td>2</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>August Total</td>
<td><strong>3</strong></td>
<td><strong>15</strong></td>
<td><strong>0</strong></td>
<td><strong>2</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>
Completing the post rounding huddle is important as it provides real-time feedback to the staff to affect behavior change leading to higher perceived patient satisfaction with care. Unit A charge nurses completed the post huddle 92% of the time for the month of June, 93% for July and 0 times for August. Unit B charge nurses completed the post rounding huddle 65% of the time for June, 58% for July and 60% for August (albeit, August had only 5 occurrences of patient satisfaction rounding documented) (see Table 12).
Table 12
*Unit A and Unit B Post Rounding Huddle Percentage by Month, year 2015*

<table>
<thead>
<tr>
<th>Unit</th>
<th>Month</th>
<th>Number of Patient Satisfaction Rounds</th>
<th>Number of Times Post Huddles Documented as Y.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>June</td>
<td>12</td>
<td>11</td>
<td>92</td>
</tr>
<tr>
<td>A</td>
<td>July</td>
<td>14</td>
<td>13</td>
<td>93</td>
</tr>
<tr>
<td>A</td>
<td>August</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>June</td>
<td>20</td>
<td>13</td>
<td>65</td>
</tr>
<tr>
<td>B</td>
<td>July</td>
<td>12</td>
<td>7</td>
<td>58</td>
</tr>
<tr>
<td>B</td>
<td>August</td>
<td>5</td>
<td>3</td>
<td>60</td>
</tr>
</tbody>
</table>

**PSRL Comments**

The PSRLs comments were reviewed and categorized into three themes of patient responses: positive, neutral and negative. A set of rules were developed to guide the evaluation of each comment into the correct description (see Appendix V). For both nursing units, the majority of the recorded comments were positive. The second largest category was the neutral comments. The least in quantity, were the negative comments (see Tables 13 and 14). Review of each of the rounding questions revealed that “are the nurses treating you well?”; “is your call light being answered timely”; and “are you getting the information you need about your care to make decisions” had a similar number spread between the positive, neutral and negative comments.

Comments categorized as positive exceeded a monthly total of 70% for both units. Examples of comments categorized as positive include: “Yes, everyone is doing well”, “…excellent care”, “good bunch”, “pleasant”, with the majority responding as “yes”. The highest percentage of comments was noted for three of the four rounding questions:
• Are the nurses treating you well?
• Is your call light being answered timely?
• Are you getting the information you need about your care to make decisions?

The comments categorized as neutral were predominately check marks (√) or “N/A” (not applicable) written on the PSRL by the charge nurses. The next frequently seen neutral comment involved a statement by the patient that indicated satisfaction (i.e. a “yes” was written by the charge nurse) followed by a statement indicating dissatisfaction (i.e. “sometimes had to wait”; “depends on RN”, “everyone has been nice except one…”, “most of the time”, etc.). Most of the neutral comments involved the question relating to pain/discomfort was noted.

The negative comments were the lowest percentage of all the comments on the PSRLs and their frequency ranged from 0% (occurred 8 times between the two nursing units) to 17% (14 occurrences had percentages less than 10) (See Tables 13 and 14). Examples of comments categorized as negative included: “could have improved”; “feels like not getting pain meds enough”; “no, I have to wait forever”, “I need more than Tylenol for a headache”, etc. A pattern was noted in relation to pain management as this question had the majority of the negative responses.
Table 13
Unit A PSRL Responses

<table>
<thead>
<tr>
<th>June Domain</th>
<th>Positive</th>
<th>%</th>
<th>Neutral</th>
<th>%</th>
<th>Negative</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the nurses treating you well?</td>
<td>50</td>
<td>93</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Is your call light being answered timely?</td>
<td>50</td>
<td>93</td>
<td>4</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Is discomfort/pain being managed to your</td>
<td>43</td>
<td>80</td>
<td>7</td>
<td>13</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>expectations?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you getting the information you need</td>
<td>51</td>
<td>94</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>about your care to make decisions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>194</strong></td>
<td><strong>90</strong></td>
<td><strong>15</strong></td>
<td><strong>7</strong></td>
<td><strong>7</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>July Domain</th>
<th>Positive</th>
<th>%</th>
<th>Neutral</th>
<th>%</th>
<th>Negative</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the nurses treating you well?</td>
<td>54</td>
<td>95</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Is your call light being answered timely?</td>
<td>52</td>
<td>91</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Is discomfort/pain being managed to your</td>
<td>48</td>
<td>84</td>
<td>8</td>
<td>14</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>expectations?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you getting the information you need</td>
<td>54</td>
<td>95</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>about your care to make decisions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>208</strong></td>
<td><strong>91</strong></td>
<td><strong>18</strong></td>
<td><strong>8</strong></td>
<td><strong>2</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>August Domain</th>
<th>Positive</th>
<th>%</th>
<th>Neutral</th>
<th>%</th>
<th>Negative</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the nurses treating you well?</td>
<td>15</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Is your call light being answered timely?</td>
<td>15</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Is discomfort/pain being managed to your</td>
<td>12</td>
<td>80</td>
<td>2</td>
<td>13</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>expectations?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you getting the information you need</td>
<td>15</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>about your care to make decisions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>57</strong></td>
<td><strong>95</strong></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>
Table 14
*Unit B PSRL Responses*

<table>
<thead>
<tr>
<th></th>
<th>Positive</th>
<th>%</th>
<th>Neutral</th>
<th>%</th>
<th>Negative</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>June Domains</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the nurses treating you well?</td>
<td>52</td>
<td>79</td>
<td>13</td>
<td>20</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Is your call light being answered timely?</td>
<td>46</td>
<td>70</td>
<td>17</td>
<td>26</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Is discomfort/pain being managed to your expectations?</td>
<td>42</td>
<td>64</td>
<td>20</td>
<td>30</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Are you getting the information you need about your care to make decisions?</td>
<td>48</td>
<td>73</td>
<td>15</td>
<td>23</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>188</td>
<td>82</td>
<td>65</td>
<td>11</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td><strong>July Domains</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the nurses treating you well?</td>
<td>48</td>
<td>94</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Is your call light being answered timely?</td>
<td>42</td>
<td>82</td>
<td>6</td>
<td>12</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Is discomfort/pain being managed to your expectations?</td>
<td>35</td>
<td>69</td>
<td>11</td>
<td>22</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Are you getting the information you need about your care to make decisions?</td>
<td>43</td>
<td>84</td>
<td>5</td>
<td>10</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>168</td>
<td>83</td>
<td>23</td>
<td>13</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td><strong>August Domains</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the nurses treating you well?</td>
<td>16</td>
<td>89</td>
<td>2</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Is your call light being answered timely?</td>
<td>17</td>
<td>94</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Is discomfort/pain being managed to your expectations?</td>
<td>10</td>
<td>56</td>
<td>5</td>
<td>28</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Are you getting the information you need about your care to make decisions?</td>
<td>17</td>
<td>94</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>60</td>
<td>90</td>
<td>9</td>
<td>7</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

**Post Project Focus Group Outcomes**

Following the customer service rounding project conclusion, two focus groups were organized to elicit feedback from the nurse managers and charge nurses regarding the project and its implementation. The first focus group attendee were the nursing leaders (nurse managers and assistant nurse managers) on the two nursing units involved and was conducted on September 16, 2015. Four questions were used to elicit their experiences with the project and included:

- What went well?
- What could have been better?
What may have influenced the project outcomes?

What were lessons learned?

Each question was addressed one at a time and responses were recorded by the project lead on a large sheet of paper visible for each participant to review during the discussion. The second focus group was conducted on October 9, 2015; attendees included the charge nurses from both the nursing units involved. Four charge nurses attended the session. Each of the four questions was asked in the same manner as with the nurse managers’ focus group and recorded for the participants to observe during the discussion. (See Appendix W for specific responses.)

When asked, “What went well?” the focus groups identified one common theme: that was nice to hear that the nurses are doing a good job (e.g. “…nice to hear patients say good things”). A second common comment stated by both groups was the mentioning of staff names by patients who they wished to be acknowledged for a “job well done”. Most of the comments by the nursing leaders of were complimentary of the customer service rounding process itself, including the training of the staff nurses to prepare for the rounding. Additionally, the nurse managers identified that the tool was “clear to understand” and appreciated the training of the charge nurses by the project lead on patient rounding.

The majority of the responses to the question, “What could have been better?” related to the time needed to perform the customer service rounds. Charge nurses stated that the nurse managers had to “pick up” when they identified that they didn’t have time for the rounding. Supporting this observation, the nurse managers identified that staffing and “time” was a factor in the ability to perform the rounds and that the charge nurses felt
stressed with their patient assignments; additionally, they stated that the daily phone call reminders to complete the patient satisfaction rounds, added to that stress.

Staffing and workload were reported as two potential influences on the project when the focus groups were asked to identify “What may have influenced the project?” An overwhelming majority of both focus group attendees agreed with this observation citing these reasons as to why the customer service rounding wasn’t performed. The nurse manager group added that vacancy of staff positions added to the workload of the charge nurses contributing to a lack of time to perform the rounding. Additionally, charge nurses are now assigned a patient assignment (an organizational change from 2014) that can entail up to a full patient load. Coupled with the responsibilities of patient placement and unit staffing regulation, this left the charge nurses feeling stressed to accomplish all of their duties to both patients and organization; often, leaving them to abandon the rounding project. Nurse Managers also identified that their own time was limited to support the rounding project as they had other higher priorities to attend to (e.g. annual evaluations and vacations).

The nurse managers stated that finding a private place to perform the post rounding huddle was a challenge as staff members did not care for the break room to be used as it is perceived as a respite from the units activities and they didn’t want to be disturbed while on their break. They stated that performing the huddles in the nursing station were a challenge due to other activities occurring at the same time and non-nursing caregivers present in the station. The solution they initiated was to pull together smaller groups in the corridors, away from patient rooms, to provide the patient feedback in hushed tones.
Nurse Managers believed, as did charge nurses, that patient satisfaction is impacted by how patients discomfort/pain is being managed by the physician groups. Charge nurses stated that they avoided rounding on rooms of patients who were known to be dissatisfied with their pain medication regimen as they felt “there’s nothing more that can be done” to appease them. Additionally, nurse managers stated that patient satisfaction is physician dependent, citing that they have observed high satisfaction with those physicians who were more customer service friendly and provided the pain medication requested by patients and lower scores by those physicians who viewed as less customer service friendly or who did not provide pain medication to the specification of the patient.

The patient coordinator role was identified as a possible influence on the outcomes of the project. During the project, nursing unit A initiated an innovative care model in which one nurse was pulled from the regular staffing assignment and assigned to be a coordinator for patient care on the unit. Responsibilities include: rounding with physicians, providing patient teaching specific to patient needs/disease state, discharge preparation, overcoming barriers to patient needs from within the medical center (i.e. assisting to schedule the needed diagnostics, contacting and following up with consultants, etc.). One duty of the care coordinator is to round on the patient every day and to review their daily plan of care and to list two to three goals for the day on the patients white board at the bedside. The nurse managers cited that this may have increased the positive responses to “Are you getting all the information you need about your care to make decisions?” Comparing Unit A to Unit B, in terms of positive, neutral, and negative responses, there does appear to be an increase in the number of positive
comments on the PSRL to “Are you getting all the information you need about your care to make decisions?” as nursing unit A’s percentage of positive comments for the three months were each over 94% (see Table 15).

Table 15
Number and Percent of Positive Comments to “Are You Getting all the Information You Need about Your Care to Make Decisions?” by the Month

<table>
<thead>
<tr>
<th>Nursing Unit</th>
<th>June 2015</th>
<th>July 2015</th>
<th>August 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Nursing Unit A</td>
<td>51</td>
<td>94</td>
<td>54</td>
</tr>
<tr>
<td>Nursing Unit B</td>
<td>48</td>
<td>73</td>
<td>43</td>
</tr>
</tbody>
</table>

When asked, “What were lessons learned from the rounding project?” overwhelmingly, both nurse managers and charge nurse linked the positive patient comments during the rounding to overall performance and noted that this was a positive aspect of the rounding project with one nurse manager stating, “We are doing a good job!” Charge nurses related that getting the compliments from the patients was exhilarating and helped to provide balance to a stressful day. Charge nurses also cited that they believed the patient population on the unit impacted the rounding project as those patient with psychiatric disorders or who presented with drug seeking behavior were difficult to “please” and that they tended to avoid those patients if they were recognized prior to initiating the patient satisfaction rounds as “those patients who are not happy with pain management usually complained about other things such as room cleanliness and there’s nothing I can do for them.”
Summary

Data collection for the customer service rounding project concluded in October 2015 and included the PGPSS scores (including the nurse sensitive dimensions and HCAHPS Overall score), Patient Satisfaction Rounding Logs, and the focus groups feedback. PGPSS scores increased during the rounding interventions months providing an answer to the clinical question. However, review of the data revealed several areas for further discussion including: factors that influenced the survey data and care process issues that influenced the customer service rounding; each of which will be discussed in the next section.
VI. DISCUSSION

Satisfaction Scores

The patient satisfaction scores were shown to increase when the customer service rounding by charge nurses occurred on a regular basis and, therefore, support the clinical recommendation under investigation. Comparison of the results from this project to the seven studies reviewed from the literature revealed that nurse customer service rounding has a facilitating impact on patient satisfaction. The patient populations of both, Units A and B were medical-surgical in nature, which is similar to six of the studies reviewed (Blakley, et al., 2011; Gardner, et al., 2009; Meade, et al., 2006; Meade, et al., 2010; Saleh, et al., 2011; Sobaski, et al., 2008; Woodard, 2009). Thus, in terms of the PICOT question, use of a customer service nurse rounding program on an adult medical-surgical nursing unit is shown to improve patient satisfaction.

At project onset, the nursing leaders of the two units agreed that an improvement of five points or more for the patient satisfaction scores would be significant. During the intervention months, consistent increases in score were seen for three of the five questions when the customer service rounding intervention was applied. Several factors may have influenced the patient satisfaction scores during this project and need to be considered for evaluation and future application of the rounding program. These factors include: influence by other professions, number of patient satisfaction survey’s returned, number of rounding occurrences or number of times the charge nurse rounded on patients; number of patient encounters, and the number of post huddles held for staff.
HCAHPS Questions Influenced by Other Professions

Two of the dimensions were determined to be influenced by other disciplines and may have impacted the scores: HCAHPS Overall scores and the HCAHPS pain/discomfort scores. The scores for those two dimensions did not appear to be impacted by the rounding intervention and fluctuated during the intervention months. The Overall scores is a composite of the patients’ perception of the entire hospital experience and is not solely focused on the nursing care. Patients experience wait times in the emergency department, edibility of the food, cleanliness of the room, and the friendliness of staff from other departments for example. Each of these patient experiences factor into the patients rating of the Overall score. Additionally, the HCAHPS pain/discomfort score is influenced by physician practice for pain/discomfort management. Nursing’s impact on pain/discomfort management is in conjunction with medical practice as cited by the two focus group attendees and often is not in conjunction with patient expectations.

Survey Return Rate

The number of patient satisfaction surveys returned by the patients on Unit A for the months of the program fell between 21 and 27. Unit B’s patient surveys returned was as low as 10, and as high as 19. The number of patient satisfactions surveys returned can have an impact on the satisfaction scores reported through Press-Ganey. The greater the number of survey’s returned increases the likelihood of a more accurate description of patient perceptions of care. With a lower number of surveys returned, the inverse is true, there’s less accuracy to reflect the patient’s perception. Press-Ganey acknowledges this relationship by stating the following at the bottom of each Patient Satisfaction Overview
report, “confidence in the accuracy of scores and percentiles based on a small number of responses is low” (Press-Ganey Patient Satisfaction Overview, October 9, 2015). Unit B only had 10 surveys returned during the intervention month of July 2015, which may impact the interpretation of intervention on patient satisfaction scores. Maintaining a high return rate for such surveys is challenging and healthcare organizations have limited impact on these rates. They do, however, continue to look for interventions to increase the number of patient surveys returned including a tactic to remind patients to return their survey once received at home.

**Rounding Occurrences**

The number of rounding occurrences may have an impact on the patient’s perception of satisfaction. As stated through the literature review, nurse rounding was suggested to have an impact on patient satisfaction (Blakley, et al., 2011; Gardner, et al., 2009; Meade et al., 2006; Meade, et al., 2010; Saleh, et al., 2011; Sobaski, et al., 2008; Woodard, 2009). Comparing the number of rounding occurrences to the patient satisfaction dimensions reveals a modest increase in the nurse sensitive scores during the months in which the rounding intervention occurrences was higher and a subsequent drop in August during which the rounding intervention occurrences decreased markedly. For example, Unit A’s April 2015’s score for the dimension “communication about meds” (47.6) increased during the intervention months of June, July and August, by a range of 3.5 to 27.4 points. The August score dropped from the June and July scores as did the number of rounding occurrences by the charge nurses on Unit A (from 12 and 14 rounding occurrences for June and July to only 3 in August).
Patient Encounters

The number of patient encounters may have a similar impact on the satisfaction scores. In support of this, the outcomes found that the more patient encounters, the higher patient satisfaction scores, as was demonstrated with the number of rounding occurrences. The seven studies from the literature review examined the effects of nurse rounding on patient satisfaction and demonstrated an increase in satisfaction scores when nurse rounding was implemented; however, they did not provide any information of how the number of patients included in each round impacted patient satisfaction scores.

Comparing patient encounters to patient satisfaction scores, Unit A experienced a drop in satisfaction scores for four of the dimensions during the month of August (the lone exception was responsiveness with a score of 50), which coincided with the decrease in patient encounters for that particular month. A similar pattern was observed with the number of patient encounters and patient satisfaction scores for Unit B. Most notably, for Unit B, an increase in the number of scores in the intervention months of June and August when compared to February scores (only responsiveness for June dropped, by about 5.5 points compared to February). July 2015, however, demonstrated a drop in three of the five scores when compared to February. August patient satisfaction scores for nursing unit B continued to be greater than the comparison month of February (all dimension scores had a greater than three point increase) with only five reported rounding occurrences including 18 patient encounters. Consequently, the suggested relationship between the lower numbers of rounding occurrences/patient encounters to the higher August scores may possibly be attributed to the effect of the rounding program.
on the nursing staff who continued to incorporate the feedback into their daily practice to improve patient satisfaction.

**PRSL Comment Patterns**

The majority of the comments recoded on the PSRL were mostly positive (greater than 70% of the comments) while the next category of comments in size, the neutral ones, comprised of a significant number of check marks (√). Had the charge nurses placed comments rather than the check marks, additional information would have been available that provided insight into the patient’s perception of care for that question. While significantly smaller by category, the negative comments were noted to be related to the question asking about perception of the management of pain/discomfort when compared to the other questions.

**Post-Rounding Feedback**

Providing the post rounding feedback to the staff, in real time, to impact nursing staff performance and influence patient satisfaction scores was a goal of this performance improvement project. Unit A performed most consistently with completion of the post rounding huddle and demonstrated the most consistent improvement with patient satisfaction scores when the nursing rounding program was conducted. When the rounding occurrences decrease and subsequently, the post-rounding huddles, staff is not given the real-time feedback in order to adjust their approach to patient care and thus, scores dropped as noted in the August patient satisfaction scores. Unit B demonstrated a similar pattern, however, the August patient satisfactions remained strong compared to the February scores and compared to the rounding occurrences and patient encounters and may also be attributed to a lasting effect of the rounding project on staff behavior.
from the previous months. Commitment to following the rounding process was cited in the literature reviewed as a barrier to rounding (Meade, et al., 2006).

**Focus Group**

Nurse Managers and charge nurses cited that staffing and time were a concern and impeded the completion of the patient satisfaction rounds. Both groups indicated that not having enough nursing staff increased patient loads and left the charge nurse with little time for customer service rounding. Additionally, the nurse managers stated that their workload impeded their ability to support the customer service rounding as they were focused on annual evaluations and vacations during the last month of the rounding intervention. Workload impeding patient satisfaction rounding was a similar finding in three of the seven studies reviewed for this project (Meade, et al., 2010; Sobaski, et al., 2008; and Woodward, 2009). Positively, focus group information revealed that both the charge nurses and nurse managers found that patient satisfaction rounding to be important as it helped to identify patient issues early and they were appreciative to receive the positive patient comments regarding specific staff members. This finding was also cited in the study involving the 28 emergency departments as 83% of the staff commented that they felt rounding was beneficial to the patients (Meade, et al., 2010).

Pain and discomfort management was cited as a concern by the focus group members stating that patient expectations and physician practice, especially among the frequent readmitted patients, was not always the same and they believed this to have a direct impact on patient satisfaction. Noting such dissatisfaction the charge nurses chose not to round on those patients citing that there wasn’t anything that they could do for the
patient. Avoiding these patients can cause the loss of an opportunity to improve the perception of care, and subsequently, the patient satisfaction scores.

Commitment by leadership to sustain the customer service rounding is essential for continual increased patient satisfaction scores. Consequently, the lack of unit leadership commitment to the rounds was identified in the literature as a barrier to nurse rounding cited in Meade, et al., (2006) during a one year post project review. Senior leaders in healthcare organizations will need to assess customer service rounding to determine compliance and discovery of barriers coupled with action plans to address such impediments.

Summary

Results provide an answer to the clinical question. PGPSS scores showed evidence of increasing during the rounding intervention months when the actual intervention most closely resembled the planned intervention. Review of the data revealed several factors that influenced the customer service rounding and the patient satisfaction scores including: number of rounding occurrences and patient encounters, post rounding huddle completion, use of the clinical coordinator role, and influence on scores from other entities of the hospital. Therefore, implementation of a staff nurse led customer service rounding program, as compared to no staff nurse customer service rounding program, influenced the Press-Ganey Patient Satisfaction scores as reported by HCAHPS. The following section will present a summary of the barriers to customer service rounding, a discussion on remaining questions from the project, and recommendations for future projects on customer service rounding.
VII. CONCLUSION

The implementation of this evidenced-based practice project was guided by the Evidenced-Based Practice Improvement Model developed by Levin, et al., (2010). The model contains components of Act, Plan, Study, Do imbedded within an Evidenced-Based Practice Model comprised of: describing the clinical problem, formulating a clinical question, searching the literature for evidence, synthesizing the evidence, developing a goal for intervention and to implement the intervention.

The clinical question proposed for this evidenced-based project was:

On a medical-surgical inpatient unit (P), does the implementation of a staff nurse led customer service rounding program (I), as compared to no staff nurse customer service rounding program (C), increase the Press-Ganey Patient Satisfaction scores as reported by HCAHPS (O) over a three month period (T)? To answer this question, the nurse rounding project implementation began on May 19th, 2015 with the first charge nurse meeting for orientation to the project and concluded on August 31, 2015. Data collection started with program implementation in June and concluded with the final extraction of the PGPSS results for August in October of 2015. Post analysis of the patient satisfaction data revealed an influence through an increase in patient satisfaction scores during the months of the nurse rounding intervention, thus, answering the PICOT question.

Through the life of the project several key points were discovered as “lessons learned.” These lessons warrant addressing and can be categorized into three subjects: nurses’ role; impact of other professions and survey vulnerabilities.
Nurses’ Role

The nursing profession remains as the front line “face” of healthcare to patients who interact with the healthcare system. Patients look to the nurse for comfort and to help navigate the complexity of hospitals and healthcare. As demonstrated with Cox’s (1982) Interaction Model of Client Behavior the relationship between the nurse and patient can determine the patient’s outcome, and in this particular case, perception of care. IMCB model incorporates four elements of this nurse-patient interaction as being important for the outcomes desired: Information, Affective Support, Decisional Control and Professional/Technical. Each of the rounding questions asked during the rounding program were correlated to one of the four elements from Cox’s model. Furthermore, based on the current scientific literature, nurse rounding does have a positive impact on patient satisfaction with care and it is best practice to focus efforts on nurses understanding of how their actions impact patient perception of care (Saleh, B. S., et al., 2011; Blakley, D. et al., 2011; Gardner, G. et al., 2009; Woodard, J. L., 2009; Meade, C. M. et al., 2010; Sobaski, T. et al., 2008; Meade, C. M. et al., 2006). The patient satisfaction scores extracted for this project demonstrate clinical evidence of a positive trend when nurse rounding was completed as designed and lower patient satisfaction scores when the rounding program was not implemented or only implemented in part.

Similar to the literature, barriers to nurses completing the rounding program were identified in post intervention focus groups. These barriers include staffing and patient assignments as well as competing work priorities. Recent changes in staffing assignments on the two nursing units resulted in the charge nurses being assigned a patient load and coupled with high vacancy rates, often taking a full patient assignment.
The additional patient care load resulted in the charge nurses prioritizing the patient satisfaction rounding program a low priority in their day and, thus, the patient satisfaction rounds did not occur as prescribed. Additionally, nursing leadership for the two units cited competing priorities that kept them from monitoring the patient satisfaction rounds for completion. Four of the seven studies reviewed for this project cited that nurse’s workload was a barrier to completing the rounding (Meade et al., 2010; Saleh et al., 2011; Sobaski et al., 2008; Woodard 2009). Another nurse-related concern was the continual lack of understanding by the nursing staff of how their bedside actions can alter the patient’s perception of care. Many nurses were complimented during the rounds as evidenced by the comments categorized as positive during the PSRL summary review. There were a fair number of nurses who were commented on by patients that were categorized in the negative and required feedback from the nursing leadership on the unit.

Impact of Other Professions

Two of the patient satisfaction dimensions measured was discovered to be heavily influenced by factors outside of nursing. These dimensions were: pain management and the overall score. Pain management was cited as being heavily influenced by physician practice. Additionally, physician practice was not necessarily uniform from one physician to another within the same patient care cluster. Rotation of physician coverage changed the medication administration practice for pain on the nursing units on a weekly to every two week basis further compounding the management of patient satisfaction for the nursing staff. Cited in the focus groups, another factor is that there is a significant majority of returning patients who are not satisfied with their pain management. Those patients are often perceived as being “drug seeking” by the
medical and nursing staff and continue to cite their dissatisfaction of care through the patient satisfaction scores on the unit.

The overall score is a compilation of the perceptions of the patients’ experience of the total hospital stay which can be influenced by any nuance of that stay. Such factors that come into play include: room cleanliness, wait time in the emergency department for the inpatient bed, perceived edibility of the meals, quiet at night, friendliness of registration, transporter and volunteers, physician communication, etc. Assigning the responsibility of patient satisfaction with the pain medication and overall score solely does not allocate the responsibility for those domains in a fair and equitable fashion.

Survey Vulnerabilities

The potential relationship between the numbers of PGPSS’s returned post discharge to the final percentile rankings warrants caution for interpretation. Lower survey returns lead to a decrease in confidence in the percentile rankings. Furthermore, with lower number of surveys returned, there are fewer positive ratings to “dilute” out the negative ratings and thus, it may only take one bad survey to lower your percentile on a dimension which may not accurately reflect the experiences of the majority of patients for the same time frame.

Limitations of the Project

Limitations discovered during the implementation of this project include: time frame of the project; number of nursing units involved; lack of defined space for post rounding huddle; and only one shift of charge nurses provided the rounding intervention. The time frame of the project was approximately four months; one month for training and three months of the rounding intervention. While this timeframe may be sufficient for
the scope of this student led project, a longer period of time for the intervention period would have increased the number of PGPS scores to reveal the impact of the intervention. Utilization of only two units for the rounding program is also a limitation as the rounding intervention and patient satisfaction relationship would have indicated a greater influence with additional nursing units involved. The third limitation identified was the charge nurses’ reports that they struggled with the post rounding huddle as they couldn’t find a place to conduct the huddle that met confidentiality and staff needs. Locating an acceptable space for the post rounding huddle would help to increase the occurrence of the huddle. In addition, only one shift of charge nurses were trained on the rounding procedure and performed the rounds to maintain a reasonable score of project implementation for the project lead. Introducing the rounding program to the night shift for evening rounds would have been beneficial to increase the patient satisfaction scores for both nursing units.

Remaining Questions

Several remaining questions may need to be addressed by researchers. This includes research on the workload of nursing staff on medical-surgical units and interventions that are effective for pain and discomfort management. Workload was cited by charge nurses and unit leadership as a barrier to nurse rounding for both units a finding that is similar to four of the seven studies from the literature. Research is indicated on nursing workload for nurses on medical-surgical units to provide insight as well as recommendations to support nurse rounding. The management of pain and discomfort were cited by charge nurses and nursing leadership to be influenced by physician practice as well as perception of drug-seeking behavior by frequently admitted
patients. Research into the issues of pain and discomfort management would be beneficial for patient care management and ultimately, patient satisfaction.

Nursing administrators may need to consider three questions. What support can be provided to augment staffing to aide with nurse rounding? What research can be applied to review nursing workload? What tactics can they apply to support nurse rounding? As cited by the charge nurses and nursing leaders, staffing was a barrier to conducting the customer service rounds. Nursing administrators need to identify methods of resolving staffing concerns in order to provide support to the charge nurses for the customer service rounds. Examples may include increasing the internal float pool, expedition of process to replace vacant positions and review of attendance policy use. Secondly, use of research to identify the tasks performed by charge nurses on the units would be beneficial to assist with elimination of those tasks identified as not having value as well as to organize the remaining tasks for greater efficiency. Third, nursing administrators need to identify tactics that can be applied to support the customer service rounding by the charge nurses. Such tactics may include: support for advancing the customer service rounding to the evening shift for increased opportunity for completion and attending the customer service rounds to model its significance.

Two policy questions arise from the project; one is internal the other, external in nature. The internal question states, “should the customer service rounding be written into institutional policies and job descriptions?” Hardwiring the customer service rounding intervention into institutions policies would provide a framework for cultural normalcy within the hospital. Adding customer service rounding to the charge nurse job description would provide a level of importance to guide the charge nurses when
prioritizing job tasks. However, attention would need to be focused on solving the workload issues previously noted if the rounding tasks were to become ingrained tasks of the charge nurses.

The external question is, “Should healthcare payer sources require reporting on customer service rounding completion by healthcare organizations?” Payer sources, including the state and federal governments, are requiring quality metrics be made available for public review. Similar to the reporting of quality metrics such as heart patients prescribed aspirin upon discharge, payer sources may need to stress improvement in patient satisfaction scores through the requirement for hospitals to report metrics of customer service rounds completed on the nursing units. Success with improvement of health metrics since the requirement for publically reporting the figures has been noted and may be of value to improving patient satisfaction scores.

Additionally, two external sources may provide a platform for disseminating this best practice on a national level. The first platform would be the American Nurses Credentialing Center’s (ANCC) Magnet® website. Magnet designation for hospitals is a coveted award that illuminates that the hospital is demonstrating characteristics to attract nurses to work. One of the characteristics reviewed for Magnet status is the quality data of the organization. Those hospitals with high quality metrics, including patient satisfaction, tend to be magnets for nurses. The ANCC website offers a discussion board, called Magnet Learning Communities, for best practices that would be an ideal platform for introduction of this project as a standard of care for nursing leaders (American Nurses Credentialing Center, 2015).
The second platform for national dissemination would be the American Association of Retired Persons (AARP). The AARP establishes policy and white paper recommendations and statements through their Nation Policy Council (made up of volunteers) which are then submitted for approval through their board of directors (American Association of Retired Persons, 2015). Such policy statements involve a wide range of healthcare topics. These policy recommendations are the blueprints for AARPs future advocacy efforts on local, state and national levels. One topic of concern to AARP membership is the cost and quality of healthcare. Sharing the results of the rounding program and its influence on patient satisfaction would be of interest to the membership of this group, especially for public policy endorsement.

**Recommendations for Future Projects**

As demonstrated through Cox’s (1982) model and the positive outcomes from this evidenced-based practice project, nursing leaders and staff nurses need to embrace patient satisfaction rounding as an intervention to impact patient outcomes, including patient satisfaction with care. To enhance success with the implementation of such customer service rounding programs it is recommended that nursing leaders take an active role as project leads for the rounding program. The involvement of scheduled patient satisfaction rounding by senior nursing leaders (directors of nursing, chief nursing officers) with the charge nurses would provide a chance to not only role model rounding behavior, but to hardwire the rounding process into a daily routine.

Involvement of both day and night shift charge nurses would be of great benefit. As one shift may be busy with patient care and the rounding program is determined to be a lower priority, the next shift charge nurse can provide this service and help to maintain
patient satisfaction. Rounding results can then be shared with both shifts of nurses increasing their bedside performance to enhance patient satisfaction as well as to expedite solving patient issues in real time.

Each unit must determine a location that is acceptable to all for the post-rounding huddle. Receiving the rounding information is important to the staff to enhance their behavior at bedside. Additionally, the charge nurses reported that providing the positive feedback to the staff post-huddle as one aspect of the program that they found positive and took enjoyment from. Determining a place for the post-rounding huddle would assist to increase compliance of occurrence. Each unit is unique with its patient care routine, nursing staff and unit activities. Encouraging the nursing staff for each unit to determine a location for the post-rounding huddle would emulate the shared governance model of the organization and increase the occurrence of the huddles.

Incorporating the rounding program house-wide for the hospital would help to increase patient satisfaction to meet organizational goals. The results of this evidenced-based practice project answered the PICOT question to the affirmative that nurse led rounding positively impacts patient satisfaction. Introducing this rounding program to the other nursing units would help to increase patient satisfaction at the unit level and aggregately, at the top of the organization leading to the identified benefits: decreased readmissions; increased reputation in the community leading to an increase in community utilization of services, increased reimbursement for VBP, ultimately, increasing revenue.

Incorporating Doctor of Nursing Practice (DNP) nurses on the nursing unit as clinical leaders for patient care process improvement initiatives would increase the quality of care including patient satisfaction. College curriculums for DNP programs
offer advanced course work for quality improvement, health policy, healthcare leadership, and the incorporation of evidence into practice. Requiring the DNP for the nurse manager job description would provide the front-line nursing leadership with the skills and competencies for improving patient care systems to enhance healthcare quality and decrease costs.

Summary

Today’s healthcare environment is becoming increasingly competitive for patient volume and revenue dollars. The introduction of Value Based Purchasing by the Center for Medicare and Medicaid Services (CMS) will link patient satisfaction and healthcare quality to government reimbursement, further increasing the competitiveness within healthcare organizations. Such competition is predicted to increase in the near future as more public reporting of data and higher quality goal setting by payers are already planned. Nursing leaders of today’s healthcare systems must be poised to take advantage of any opportunities to enhance quality of care, decrease readmissions, and increase market share through increasing patient satisfaction. One evidence based tactic is the incorporation of a nurse led customer service rounding program on medical-surgical units. Bedside nurses involved in such rounding have stated satisfaction with the rounding for two reasons, the opportunity to solve problems and issues that the patients identify in real time; as well as the opportunity to provide positive patient feedback to their peers.

The development of nursing leaders, clinical and administrative, is essential for improving the quality of patient care (including patient satisfaction), decreasing healthcare costs and improve access to care. Such leaders need the right competencies
and skill sets to accomplish projects of such a magnitude, especially those projects involving large populations of need, healthcare policy and the use of technology and informatics. The Doctor of Nursing Practice (DNP) degree is designed to provide the competencies and skills to meet those needs and healthcare leaders of all arenas need to encourage and support nursing leaders to acquire the DNP.
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Value Based Purchasing retrieved August 1, 2011 from

[https://www.cms.gov/hospitalqualityunits/](https://www.cms.gov/hospitalqualityunits/)


APPENDIX A

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Licensed content date Jan 1, 2010
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Issue Number 2
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Title of your thesis / dissertation: Evidenced-Based Project: Nurse Rounding

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Terms and Conditions

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APPENDIX B

THE JOHNS HOPKINS EVIDENCE-BASED PRACTICE

EVIDENCE RATING SCALE
### JHNEBP Evidence Rating Scales

#### Strength of the Evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>Experimental study/randomized controlled trial (RCT) or meta-analysis of RCT</td>
</tr>
<tr>
<td>Level II</td>
<td>Quasi-experimental study</td>
</tr>
<tr>
<td>Level III</td>
<td>Non-experimental study, qualitative study, or meta-synthesis.</td>
</tr>
<tr>
<td>Level IV</td>
<td>Opinion of nationally recognized experts based on research evidence or expert consensus panel (systematic review, clinical practice guidelines)</td>
</tr>
<tr>
<td>Level V</td>
<td>Opinion of individual expert based on non-research evidence. (Includes case studies, literature review, organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience)</td>
</tr>
</tbody>
</table>

#### Quality of the Evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Research</th>
<th>Summative reviews</th>
<th>Organizational</th>
</tr>
</thead>
<tbody>
<tr>
<td>A High</td>
<td>consistent results with sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.</td>
<td>well-defined, reproducible search strategies; consistent results with sufficient numbers of well defined studies; criteria-based evaluation of overall scientific strength and quality of included studies; definitive conclusions.</td>
<td>well-defined methods using a rigorous approach; consistent results with sufficient sample size; use of reliable and valid measures</td>
</tr>
<tr>
<td>Expert Opinion</td>
<td>expertise is clearly evident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Good</td>
<td>reasonably consistent results, sufficient sample size, some control, with fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.</td>
<td>reasonably thorough and appropriate search; reasonably consistent results with sufficient numbers of well defined studies, evaluation of strengths and limitations of included studies, fairly definitive conclusions.</td>
<td>Well-defined methods; reasonably consistent results with sufficient numbers; use of reliable and valid measures; reasonably consistent recommendations</td>
</tr>
<tr>
<td>Expert Opinion</td>
<td>expertise appears to be credible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Low quality or major flaws</td>
<td>little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn</td>
<td>undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results; conclusions cannot be drawn.</td>
<td>Undefined, or poorly defined methods; insufficient sample size; inconsistent results; undefined, poorly defined or measures that lack adequate reliability or validity</td>
</tr>
<tr>
<td>Expert Opinion</td>
<td>expertise is not discernable or is dubious.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*A study rated an A would be of high quality; whereas, a study rated a C would have major flaws that raise serious questions about the believability of the findings and should be automatically eliminated from consideration.*

APPENDIX C

PERMISSION FROM ONCOLOGY NURSING SOCIETY
July 3, 2013

Dear Mr. Tuswing,

Thank you for your interest in reusing the model and for writing to the Oncology Nursing Society for permission. Attached is a high-resolution electronic version of the model that you can use as described in your e-mail below. Please be sure, as you have indicated, to fully and clearly acknowledge the source of the model when incorporating it into your project.

This is your official letter of approval. Please keep a copy of it for your records.

Best of luck with your studies.

____________________________________________________________
Mike Minjock
Production & Permissions Manager, Publishing
Oncology Nursing Society
125 Enterprise Drive
Pittsburgh, PA 15275-1214
+1-412-859-6251 (phone)
+1-412-859-6163 (fax)
mminjock@ons.org
APPENDIX D

LITERATURE GRIDS
<table>
<thead>
<tr>
<th>Author (date)</th>
<th>Research Design/ Sample</th>
<th>Independent Variable/ Intervention</th>
<th>Dependent Variable/ Outcome</th>
<th>Significant Results</th>
<th>Limitations/ Gaps</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blakley, D., Kroth, M., Gregson, J. (2011) <em>MEDSURG Nursing, 20</em>(6), 327 – 332.</td>
<td>The Impact of Nurse Rounding on Patient Satisfaction in a Medical-Surgical Hospital Unit.</td>
<td>Case Study Method</td>
<td>What is the impact of intentional, regular, and consistent nurse rounding on a patient’s satisfaction with his/her hospital experience? What is the impact of rounding on the delivery of patient care from the nursing staff’s perspective?</td>
<td>Patient Satisfaction</td>
<td>Generalizability is limited by our single-center study design.</td>
<td>VC</td>
</tr>
<tr>
<td></td>
<td>CASE STUDY</td>
<td>What is the impact of intentional, regular, and consistent nurse rounding on a patient’s satisfaction with his/her hospital experience? What is the impact of rounding on the delivery of patient care from the nursing staff’s perspective?</td>
<td>Nurse Perception of care delivery</td>
<td>Rounding process made a difference in patient and employee satisfaction.</td>
<td>Case study at the lowest strength for evidence.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N = 200 patients Medical-Surgical Nursing Staff and patients who had been inpatients within 6 mos.</td>
<td>N = 200 patients Medical-Surgical Nursing Staff and patients who had been inpatients within 6 mos.</td>
<td>Call light usage</td>
<td>Patient satisfaction scores steadily increased during implementation: Patient satisfaction was 3.5 (1-4 scale) end of second quarter and 3.6 end of third quarter.</td>
<td>Lack of acknowledgment of IRB and patient consent.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting: Medical/Surgical Units.</td>
<td>Setting: Medical/Surgical Units.</td>
<td>Nurses find rounding helpful in their practice.</td>
<td>Staff had perception that patients used call light less once rounding started.</td>
<td></td>
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<tr>
<td></td>
<td>Data pulled via observations, interviews, questionnaires, and surveys.</td>
<td>Data pulled via observations, interviews, questionnaires, and surveys.</td>
<td>Patients report nurse demonstrated care and concern during their hospitalization.</td>
<td>Patient complaints re: staff rudeness decreased 43%.</td>
<td></td>
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</tbody>
</table>

Patient satisfaction scores steadily increased during implementation: Patient satisfaction was 3.5 (1-4 scale) end of second quarter and 3.6 end of third quarter. Staff had perception that patients used call light less once rounding started. Patient complaints re: staff rudeness decreased 43%. Patients cited that staff answered call lights almost immediately.
<table>
<thead>
<tr>
<th>Author (date)</th>
<th>Research Design/ Sample</th>
<th>Independent Variable/ Intervention</th>
<th>Dependent Variable/ Outcome</th>
<th>Significant Results</th>
<th>Limitations/ Gaps</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measuring the effects of patient comfort rounds on practice environment and patient satisfaction: a pilot study.</td>
<td>Quasi-experimental pretest-posttest non-randomized parallel group train design Study</td>
<td>Nurses rounding</td>
<td>Patient Satisfaction</td>
<td>Nurses who participated in rounding experienced improvements in their perceptions of quality of care, resource adequacy and professional relations.</td>
<td>Generalizability is limited by our single-center study design.</td>
<td>IIB</td>
</tr>
<tr>
<td></td>
<td>Hypothesis: An acute surgical ward that has 1-hourly patient comfort rounds will record higher patient satisfaction scores than a ward without patient comfort rounds. An acute surgical ward that has 1-hourly patient comfort rounds will record more positive nurse perceptions of the practice environment than a ward without comfort rounds. Acute surgical wards at Royal Brisbane &amp; Women’s Hospital</td>
<td>Rounding performed by nursing assistants.</td>
<td>Nurse Satisfaction</td>
<td>Practice Environment Scale of the Nursing Work Index. Validated.</td>
<td>Cultural limitation: Australia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Study Hypothesis: An acute surgical ward that has 1-hourly patient comfort rounds will record higher patient satisfaction scores than a ward without patient comfort rounds. An acute surgical ward that has 1-hourly patient comfort rounds will record more positive nurse perceptions of the practice environment than a ward without comfort rounds. Acute surgical wards at Royal Brisbane &amp; Women’s Hospital</td>
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<td>Pilot study: produced few significant findings.</td>
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<td>Small study with small sample size.</td>
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<td></td>
<td></td>
<td>Patients may have been reluctant to “complain” about nursing care.</td>
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</tbody>
</table>
in Australia. 61 consenting patients and 23 consenting nurses in the intervention ward and 68, 16 on the control ward.

Setting: Surgical Units of an Australian Hospital. No further information given.
<p>| Author (date)                                                                 | Research Design/Sample                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Independent Variable/Intervention                                                                 | Dependent Variable/Outcome                                                                                      | Significant Results                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Limitations/Gaps                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Level of Evidence |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| Effects of Nursing Rounds on Patient’s Call Light Use, Satisfaction, and Safety. | Quasi-Experimental non-equivalent groups design study                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Hypothesis: nursing rounds on medical, surgical, and medical-surgical units conducted on a regular schedule by nursing staff who perform a specific set of actions would: Reduce call light use, increase patient satisfaction, improve patient safety, as measured by frequency of patient falls. n = 27 nursing units. N = 14 hospitals Setting: Adult Medical/Surgical Units. | Call light use; Patient satisfaction; and patient falls. Tools: Call light logs, Rounding logs, Patient satisfaction surveys developed by commercial vendors (Press Ganey; NRC=Picker and Professional Research Consultants) | There were dramatic declines in the call use in both the one-hour and two-hour rounding conditions, compared to control. Patient Satisfaction: Significant increase One hour rounding: pre mean score was 79.9 and post 91.9. Two hour rounding: pre 70.4 and post 82.1. Analysis revealed a significant reduction in falls pre compared to post. Control group remained at 17 -18. One hour dropped 25 to 12; and two hour rounding dropped 19 to 13. | 19 nursing units data excluded due to issues with reliability and validity of their data. Units data may not have been equivalent. Reliance on vendors to report accurate data for patient satisfaction. No control for staff members floating into experimental units and their contamination. Study participation may modify behavior of staff. | IIB                                                                                                                            |</p>
<table>
<thead>
<tr>
<th>Author (date)</th>
<th>Research Design/ Sample</th>
<th>Independent Variable/ Intervention</th>
<th>Dependent Variable/ Outcome</th>
<th>Significant Results</th>
<th>Limitations/ Gaps</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Effects of Emergency Department Staff Rounding on Patient Safety and Satisfaction. Meade, C., Kennedy, J., Kaplan, J. (2010) <em>Journal of Emergency Medicine</em>, 38(5), 666 – 674.</td>
<td>Quasi-Experimental, non-equivalent, time sampling design Study</td>
<td>Hypothesis: Systematic rounding using three different well-defined rounding protocols that addressed the issues causing greatest patient dissatisfaction with ED care would result in improved outcomes including: reduced LWBS, reduced AMAs, reduced patient falls, reduced patient call lights; reduced patient or family members visits to nursing station to check on patient treatment</td>
<td>Patient Satisfaction</td>
<td>Post study implementation: declines in all five areas of LWBS, AMAs, falls, call light use and nursing station encounters.</td>
<td>Large multi-site study encompassing thousands of patients (although final count not given in the article)</td>
<td>IIB</td>
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<tr>
<td></td>
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<td>Three techniques: Rounds every 30 min.; rounds very hour; rounds every hour with an Individualized Patient Care Tactic (patients named most important expectation of the ED).</td>
<td>Nurses Rounding.</td>
<td>LWBS declined 23.4%AMA declined 22.6%Falls declined 58.8%Call light use decreased 34.7%Nursing station encounters decreased 39.5%</td>
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<td></td>
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<td></td>
<td>Patient Satisfaction</td>
<td>Treatment protocol that produced the greatest outcomes was hourly rounding with IPC.</td>
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<td></td>
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<td>Patient Left Without Being Seen (LWBS)</td>
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<td>Patients Leaving Against Medical Advice (AMA)</td>
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<td>Patient falls.</td>
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<td>Call Light use.</td>
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<td></td>
<td>Nursing Station Encounters.</td>
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<td></td>
<td>Patient Satisfaction increased: 5-point scale for patient satisfaction: how well pain managed 80.17 to 81.89; overall satisfaction with ED care 85.69 to 88.31; being kept informed + 2.62; Being kept informed about delays showed a insignificant increase of +.79.</td>
<td></td>
<td></td>
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<tr>
<td>Status; increased patient satisfaction.</td>
<td>Setting: Emergency Department</td>
<td>Those with 4 point satisfaction scales: overall satisfaction with ED care 58.35 to 67.28; how well pain managed 68.94 to 71.43 and kept informed about care 61.58 to 70.88. Nursing felt rounding was beneficial for patients: 83% based on content analysis of qualitative statements. 78% of staff felt rounding beneficial to nurses because kept them up to date on what’s happening with patients, patients condition, forced them to check patients more frequently, gave peace of mind, required fewer trips to patient room, improved communication with patients, family members happier and chance to voice concerns/complaints.</td>
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<tr>
<td>Author (date)</td>
<td>Research Design/ Sample</td>
<td>Independent Variable/ Intervention</td>
<td>Dependent Variable/ Outcome</td>
<td>Significant Results</td>
<td>Limitations/ Gaps</td>
<td>Level of Evidence</td>
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</tr>
<tr>
<td>The nursing rounds system: Effect of patient’s call light, bed sores, fall and satisfaction level.</td>
<td>Quasi-Experimental Non-Equivalent Groups design.</td>
<td>Nursing Rounds System</td>
<td>Patient Satisfaction; Use of Patient call light; incidences of patient falls; incidences of hospital-acquired bed sores.</td>
<td>Overall monthly use of call bells was reduced to $29.3 \pm 7.4$ compared to $98.8 \pm 21.2$ before rounding implementation. Fall incidence reduced 25 vs. 4 Pressure ulcers reduced from 2 to 1. Patient satisfaction increased by 7.5% Hypothesis supported.</td>
<td>Generalizability is limited by our single-center study design. Cultural limitation: Saudi Arabia.</td>
<td>IIB</td>
</tr>
</tbody>
</table>
Nurse Rounding and Patient Satisfaction SYNTHESIS TABLE (EVIDENCE SUMMARY)

<table>
<thead>
<tr>
<th>Author (date)</th>
<th>Research Design/ Sample</th>
<th>Independent Variable/ Intervention</th>
<th>Dependent Variable/ Outcome</th>
<th>Significant Results</th>
<th>Limitations/ Gaps</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Effect of Routine Rounding by Nursing Staff on Patient Satisfaction on a Cardiac Telemetry Unit. Sobaski, T., Abraham, M., Fillmore, R., McFall, D., Davidhizer, R. (2008) The Health Care Manager, 27(4), 332 – 337. Purpose: to demonstrate that regularly scheduled rounding by both licensed and unlicensed nursing personnel, performing prescribed actions during rounding on hospitalized adult cardiac telemetry patients increases patient perception of having needs met as measured by the Press Ganey Patient Satisfaction.</td>
<td>Quasi-Experimental Study. Pre-test, Post-test design. Large community – owned, Not for Profit hospital in Midwest. Two research questions: Does a protocol of routine rounding on the cardiac telemetry unit by nursing staff increase the patient satisfaction of the hospitalized patients? Are there set duties or protocols that nursing staff can perform to improve the patient’s perception of the quality of healthcare they receive while hospitalized as measured by Press Ganey Patient Satisfaction Survey Scores? N = 335 Adult hospitalized patients discharged from the telemetry unit. Setting: Cardiac Telemetry Unit.</td>
<td>Nurses rounding every 1 – 2 hours between 0700 and 2200. Patient Satisfaction Tool: Press Ganey Patient Satisfaction Survey.</td>
<td>Baseline: satisfaction scores were below 90% in all categories except “skill of nurses” (90.4%). Satisfaction scores were higher than baseline scores in every category for each of the 3 months that routine rounding was preformed except in the second month. 2nd month of implementation demonstrated a drop. The second and third months had scores in the 86.3 – 89.9 range for 3 categories (promptness of call light; attention to personal needs; nurses kept you informed). Third month demonstrated a rebound in higher scores</td>
<td>Generalizability is limited by our single-center study design. Unit experienced a high census the 2nd and 3rd months, increasing nurse to patient ratios which may have affected nurse rounding. Nursing staff floated in from units not participating in rounding process. Nursing staff too busy with high priorities to implement rounding.</td>
<td>IIB</td>
<td></td>
</tr>
<tr>
<td>Author (date)</td>
<td>Research Design/Sample</td>
<td>Independent Variable/Intervention</td>
<td>Dependent Variable/Outcome</td>
<td>Significant Results</td>
<td>Limitations/ Gaps</td>
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</tr>
<tr>
<td>Woodard, J. (2009) Clinical Nurse Specialist, 23(4), 200 – 206.</td>
<td>Quasi-Experimental: pre-test, post-test design.</td>
<td>Charge nurse rounding</td>
<td>Patient falls. Patient Certainty of caregiver.</td>
<td>After one quarter of charge nurse rounding, a drop in falls and call light frequency was noted as well as an increase in patient satisfaction. From about 10, 4th quarter of 2006 to 2, 2nd quarter of 2007 to 3, 3rd quarter of 2007. Call frequency also dropped from about 13, 4th quarter of 2006 to 5, 3rd quarter of 2007. Patients surveys: Non study unit: 52% were neither certain or uncertain that a caregiver would help them if needed immediately. 3/25 not certain; 2/25 certain. Study unit: 72% were certain to get help if need.</td>
<td>Generalizability is limited by our single-center study design. Small, single site study with small sample size. Qualitative data not collected re: barriers perceived by charge nurses. Perceptions of patients/families not captured.</td>
<td>VB</td>
</tr>
</tbody>
</table>
charge nurses identify?

Midwestern teaching hospital on a medical-surgical unit (27 beds)

N = 25 patients surveyed.

Setting: Medical/Surgical Units
APPENDIX E

DATA QUALITY RELEASE FORM
# Data Quality Release Form

## Project Title: Nurse Rounding

### Data Quality Release Checklist:

<table>
<thead>
<tr>
<th>Check</th>
<th>Required Information</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Today's Date</td>
<td>December 3, 2012</td>
</tr>
<tr>
<td></td>
<td>If this request is time sensitive, please include important dates/deadlines:</td>
<td>January 2013</td>
</tr>
<tr>
<td></td>
<td>Requestor Name:</td>
<td>Todd Tusling, MS, RN</td>
</tr>
<tr>
<td></td>
<td>Title:</td>
<td>Director, Nursing Services</td>
</tr>
<tr>
<td></td>
<td>Department:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone Number:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>List names and titles of other individuals associated with this request</td>
<td>Mary Nash, chief Nurse Executive (committee member)</td>
</tr>
<tr>
<td></td>
<td>Provide background information regarding the program, study, or initiative related to this request – including specific aims, study time period, population, etc.</td>
<td>This is an Evidenced Based Practice project for my Doctor of Nursing Practice degree program. I will be initiating a customer service rounding project on 2 med/surg units at and utilizing the HCAHPS scores to measure improvement. Additionally, a summary of patient responses from rounding logs will be constructed. No patient identifiers will be utilized in any reports. The project is projected to last 3 – 4 months.</td>
</tr>
<tr>
<td></td>
<td>Where will the data be released?</td>
<td>X Publication of research/study (Potentially for publication)</td>
</tr>
<tr>
<td></td>
<td>If vendor/contract is involved, provide additional information:</td>
<td>Name of Vendor:</td>
</tr>
<tr>
<td></td>
<td>Business units involved in your project:</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Type of quality data being released:</td>
<td>X Other, please explain: HCAHPS scores and summary of nurse customer service rounding logs.</td>
</tr>
<tr>
<td></td>
<td>Level of data restriction (see definitions on page 5):</td>
<td>X De-identified data as defined by HIPAA</td>
</tr>
<tr>
<td></td>
<td>Provide a complete list and description of data being published and/or reported (attach spreadsheet, data)</td>
<td>1) HCAHPS scores for and for months in 2013 (when project starts).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) Nurse Customer Service rounding</td>
</tr>
</tbody>
</table>
# Data Quality Release Form

<table>
<thead>
<tr>
<th>Check</th>
<th>Required Information</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>dictionary, or data collection tool)</td>
<td>log summary. Patients will NOT be identified, just broad statement extracted from their comments to the nurse rounders.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data source(s):</th>
<th>Chart review (prospective/retrospective)</th>
<th>Information Warehouse</th>
<th>Internal database/application, please specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other, specify: Nurse Customer Service Rounding</td>
<td>Can the public or other third parties access the same information from another source? If checked, please explain:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for publishing or releasing data (please check all that apply):</th>
<th>To conduct research and share new knowledge</th>
<th>Required by law or regulatory agency, specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To obtain comparative data for quality improvement</td>
<td>Need for managed care contracting</td>
<td>Center of Excellence designation or certification</td>
</tr>
<tr>
<td>Other, please specify:</td>
<td>To promote or enhance medical center's Image</td>
<td></td>
</tr>
</tbody>
</table>

| If data is part of a research study, please provide a description of study and findings | This is NOT a research study. It is an Evidenced Based Practice Project for improving patient satisfaction on two medical-surgical units at UH. |

| IRB Information | IRB approval obtained, if needed (please attach IRB approval, or IRB number, specify whether OSU IRB or WIRB) | Not applicable |

| Identify the quality committee responsible for oversight and addressing opportunities for improvement. |

<table>
<thead>
<tr>
<th>Resources Required</th>
<th>Personnel, specify (% FTE): 2 - 4 RNs per Nursing unit. Assigned to round on patients 2 - 3 hours per week. Less than 0.05 FTE.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment, explain type / estimated cost:</td>
<td>$396 to $792 (cost of 2 - 4 nurses at $33/nurse for 3 hours of orientation to the rounding protocol prior to implementing the project).</td>
</tr>
<tr>
<td>Training/Education; estimated cost:</td>
<td>Participation fee (annual or one-time):</td>
</tr>
<tr>
<td>Software, estimated cost:</td>
<td>IT resources; estimated hrs:</td>
</tr>
<tr>
<td>Administrative resources; estimated hrs:</td>
<td>Other financial considerations; explain and provide estimated cost:</td>
</tr>
</tbody>
</table>

After the form is completed, please obtain the signatures from the appropriate Nursing Director, Nursing Quality Director, Clinical Department Chair or Administrator to ensure that they are aware of the data being released, resources required (if any), and have an opportunity to address any questions of concerns.
Data Quality Release Form

Nursing Director:

Date

Director, Nursing Quality/Improvement & Patient Safety

Date

Clinical Department Chair, Signature:

Date

Administrator, Signature

Date

Comments/Concerns:
Data Quality Release Form

*This page is for Risk Management, Quality Management and Legal Services Use ONLY*

<table>
<thead>
<tr>
<th>Name</th>
<th>Date Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Contact(s)</td>
<td></td>
</tr>
<tr>
<td>Legal Services Contact(s)</td>
<td></td>
</tr>
</tbody>
</table>

☐

<table>
<thead>
<tr>
<th>Check</th>
<th>Risk/Quality Use ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑</td>
<td>Add topic/request to the Data Quality Release Tracking Log</td>
</tr>
<tr>
<td></td>
<td>Estimate QI resources (hours)</td>
</tr>
<tr>
<td></td>
<td>Limited resources, cannot support this request at this time</td>
</tr>
<tr>
<td></td>
<td>High risk to peer review protection / discoverability</td>
</tr>
<tr>
<td></td>
<td>Data is not de-identified</td>
</tr>
<tr>
<td></td>
<td>Data being requested demonstrates opportunities for improvement</td>
</tr>
<tr>
<td></td>
<td>Duplication with another project/initiative</td>
</tr>
<tr>
<td></td>
<td>Other, specify:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check</th>
<th>Legal Use ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contractual Concerns:</td>
</tr>
<tr>
<td>☑</td>
<td>Choice of state law is other than Ohio</td>
</tr>
<tr>
<td></td>
<td>Request for OU to indemnify</td>
</tr>
<tr>
<td></td>
<td>Able to identify OSU or physicians to other participants/parties without prior approval</td>
</tr>
<tr>
<td></td>
<td>Need for HIPAA Business Associates Agreement</td>
</tr>
<tr>
<td></td>
<td>Need for HIPAA Data Use Agreement</td>
</tr>
<tr>
<td></td>
<td>Other, specify:</td>
</tr>
</tbody>
</table>

FINAL REVIEW AND APPROVAL

**Chief Quality Officer Signature**

Date: June 14, 2013

**Chief Medical Officer Signature**

Date: 1/15/2013

☑ Approved

☐ Not approved, reason:
Data Quality Release Form

HIPAA Glossary

Individually Identifiable Health Information - A subset of health information that identifies the individual or can reasonably be used to identify the individual.

De-Identified - Under the HIPAA Privacy Rule, data are de-identified if either (1) an experienced expert determines that the risk that certain information could be used to identify an individual is "very small" and documents and justifies the determination, or (2) the data do not include any of the following eighteen identifiers (of the individual or his/her relatives, household members, or employers) which could be used alone or in combination with other information to identify the subject:

1. names
2. geographic subdivisions smaller than a state (including zip code),
3. all elements of dates except year (unless the subject is greater than 89 years old),
4. telephone numbers,
5. FAX numbers,
6. email address,
7. Social Security numbers,
8. medical record numbers,
9. health plan beneficiary numbers,
10. account numbers,
11. certificate/license numbers,
12. vehicle identifiers including license plates,
13. device identifiers and serial numbers,
14. URLS,
15. Internet protocol addresses,
16. biometric identifiers,
17. full face photos and comparable images, and
18. any unique identifying number, characteristic or code;

Limited Data Set - Set of data that may be used for research, public health or health care operations without an authorization or waiver of authorization.

A limited data set includes:
- dates of admission, discharge or other services;
- dates of birth or death;
- age of participant (including those over 90 years of age);
- full five digit zip code and any other geographic subdivision such as county,
- city, precinct, and equivalent geocode (except street address).

A limited data set may NOT include:
- name;
- social security number;
- street address;
- e-mail address;
- telephone number;
- fax number;
- certificate/license number;
- vehicle identification number;
- personal Web page URL;
- IP address;
- full-page photos or other comparable identifying images;
- medical record number;
- health plan beneficiary number;
- any other account number; medical device identifier or serial number;
- biometric identifiers include fingerprints and voice prints.

The Privacy Office at OSUMC is committed to the development and sustainability of ethical behavior and integrity in all matters related to privacy and compliance with associated laws.

Contact information:

Jennifer Elliot, Privacy Officer
Phone: (614) 293-4477
Email: Jennifer.Elliot2@osumc.edu

Elizabeth Curtis, MIM Administrative Director
Phone: (614) 293-2082
Email: Elizabeth.Curtis@osumc.edu

https://onsource.osumc.edu/departments/Privacy/Pages/default.aspx
May 18, 2015

Protocol Number: 20145848
Protocol Title: NURSE ROUNDING: AN EVIDENCED-BASED PRACTICE PROJECT, Todd Tusing, Esther Chiappi, Nursing
Type of Review: Initial Review—Expedited
IRB Staff Contact: Joseph R. Stoeckert
Phone: 614-292-6526
Email:

Dear Dr. Tusing,

The Behavioral and Social Sciences IRB APPROVED BY EXPEDITED REVIEW the above referenced research. The Board was able to provide expedited approval under 45 CFR 46.108(b)(1) because the research meets the applicability criteria and one or more categories of research eligible for expedited review, as indicated below.

Date of IRB Approval: May 18, 2015
Date of IRB Approval Expiration: May 18, 2016
Expedited Review Category: 7

In addition, the research was approved for a waiver of the consent process.

If applicable, informed consent (and HIPAA research authorization) must be obtained from subjects or their legally authorized representatives and documented prior to research involvement. The IRB-approved consent form and process must be used. Changes in the research (e.g., recruitment procedures, advertisements, enrollment numbers, etc.) or informed consent process must be approved by the IRB before they are implemented (except where necessary to eliminate apparent immediate hazards to subjects).

This approval is valid for one year from the date of IRB review when approval is granted or modifications are required. The approval will no longer be in effect on the date listed above as the IRB expiration date. A Continuing Review application must be approved within this interval to avoid expiration of IRB approval and cessation of all research activities. A final report must be provided to the IRB and all records relating to the research (including signed consent forms) must be retained and available for audit for at least 5 years after the research has ended.

It is the responsibility of all investigators and research staff to promptly report to the IRB any serious, unexpected and related adverse events and potential unanticipated problems involving risks to subjects or others.

This approval is issued under HRP Federalwide Assurance #00005378. All forms and procedures can be found on the ORRP website. Please feel free to contact the IRB staff contact listed above with any questions or concerns.

Michael Edwards, PhD, Chair
Behavioral and Social Sciences Institutional Review Board
APPENDIX G

WRIGHT STATE UNIVERSITY

IRB APPROVAL LETTER
DATE: May 18, 2015

TO: Todd E. Tusing, R.N., M.S., DNP Graduate Student  
    College of Nursing and Health  
    Bobbe Gray, Ph.D., Faculty Advisor

FROM: Jodi Blackledge  
    Program Facilitator, WSU-IRB

SUBJECT: SC# 5858  
    'Nurse Rounding: An Evidence-Based Project'

This memo is to verify the receipt and acceptance of your response to the conditions placed on the above referenced human subjects protocol/amendment.

These conditions were lifted on: 05/18/2015

This study/amendment now has full approval and you are free to begin the research project. If this is a VA proposal, you must still receive a letter of approval from the Research and Development Committee prior to beginning the research project. If this is a MVH proposal, you must still receive a letter of approval from the Human Investigation and Research Committee (HIRC) prior to beginning the research project. This implies the following:

1. That this approval is for one year from the approval date shown on the Action Form and if it extends beyond this period a request for an extension is required. (Also see expiration date on the Action Form)

2. That a progress report must be submitted before an extension of the approved one-year period can be granted.

3. That any change in the protocol must be approved by the IRB; otherwise approval is terminated.

If you have any questions concerning the condition(s), please contact me at 775-3974.

Thank you!

Enclosure
RESEARCH INVOLVING HUMAN SUBJECTS

ACTION OF THE WRIGHT STATE UNIVERSITY
EXPEDITED REVIEW
Assurance Number: FWA00002427

Title: 'Nurse Rounding: An Evidence-Based Project'

Principal Investigator: Todd E. Tuising, R.N., M.S., DNP Graduate Student
Bobbe Gray, Ph.D., Faculty Advisor

Department: College of Nursing and Health

Expedited Category: 7

The Institutional Review Board has approved the use of human subjects on this proposed project with conditions previously noted. The conditions have now been removed.

REMINDER: FDA regulations require prompt reporting to the IRB of any changes in research activity, changes in approved research during the approval period may not be initiated without IRB review (submission of an amendment), and prompt reporting of any unanticipated problems (adverse events).

Signed
Program Facilitator, WSU-IRB

Expedited Review Date: April 24, 2015
IRB Meeting Date: June 15, 2015

This approval is effective only through: April 23, 2016
To continue the activities approved under this protocol you should receive the appropriate form(s) from Research and Sponsored Programs (RSP) two to three months prior to the required due date.
If you do not receive this notification, please contact RSP at 775-2425.

133
APPENDIX H

AGENCY PERMISSION FOR

CONDUCTING DOCTORAL PROJECT
Appendix C
Wright State University-Miami Valley College of Nursing and Health

AGENCY PERMISSION FOR CONDUCTING DOCTORAL PROJECT

THE ___________________________________ GRANTS TO

______________________________, a student enrolled in the joint
Doctor of Nursing Practice Program at Wright State University—University of Toledo, the
privilege of using its facilities in order to conduct the following project:

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.

2. The names of consultative or administrative personnel in the agency (may) (may not) be
   identified in the final report.

3. The agency (wants) (does not want) a conference with the student when the report is
   completed.

4. Other:

__________________________
Date

__________________________
Signature of Agency Personnel/Title

__________________________
Student Signature

__________________________
Project Chair Signature

7-6-15

7-20-15
APPENDIX I

LETTER OF SUPPORT FROM CHIEF NURSING OFFICER
June 5, 2014

Re: Evidenced-Based Practice Project

To Whom It May Concern:

I am writing to offer my highest endorsement for the evidenced-based practice project, “Nurse Rounding” to be conducted by Todd Tussing, MS, RN, NE-BC. As Chief Nursing Officer, I see first-hand the link between evidence-based practice and patient outcomes.

Today’s healthcare environment is becoming increasingly competitive for patient volume and revenue dollars. The introduction of Value Based Purchasing by the Center for Medicare and Medicaid Services (CMS) links patient satisfaction and healthcare quality to government reimbursement, increasing the competitiveness between healthcare organizations. Nursing leaders of today’s healthcare systems must develop strategies to increase patient satisfaction and improve the revenue streams for their organizations. The purpose of this evidence-based project is to enhance a charge nurse led, customer service rounding program by incorporating patient feedback to the staff on duty in real time, ultimately changing staff behavior and increasing patient satisfaction scores.

Todd Tussing, MS, RN, NE-BC, will lead the lead on this project as a requisite for his course work in the Doctor of Nursing Practice Program via Wright State University.

I welcome the opportunity to provide additional information if needed. Thank you for your time and consideration of this request.

Sincerely yours,

Jeff A. Mansfield, PhD, RN
Chief Nursing Officer
APPENDIX J

LETTER OF SUPPORT FROM THE
DIRECTOR OF MEDICAL-SURGICAL NURSING
June 5, 2014

Re: Evidenced-Based Practice Project

To Whom It May Concern:

As a Director of Nursing in the Medical-Surgical Nursing division at
it is my pleasure to endorse the evidence-based practice project, “Nurse Rounding” on
and

Today’s healthcare environment is becoming increasingly competitive for patient volume and revenue
dollars. The introduction of Value Based Purchasing by the Center for Medicare and Medicaid
Services (CMS) links patient satisfaction and healthcare quality to government reimbursement,
increasing the competitiveness between healthcare organizations. Nursing leaders of today’s
healthcare systems must develop strategies to increase patient satisfaction and improve the revenue
streams for their organizations. The purpose of this evidence-based project is to enhance a charge
nurse led, customer service rounding program by incorporating patient feedback to the staff on duty in
real time, ultimately changing staff behavior and increasing patient satisfaction scores.

Todd Tusssing, MS, RN, NE-BC, will lead the lead on this project as a requisite for his course work
in the Doctor of Nursing Practice Program via Wright State University.

I offer my full support for this project and to provide additional information if needed. Thank you for
your time and consideration of this request.

Sincerely regards,

Gretny Brehm, MS, RN
Nursing Director
APPENDIX K

LETTER OF SUPPORT FROM THE

NURSE MANAGERS
June 5, 2014

Re: Evidenced-Based Practice Project

To Whom It May Concern:

As the nurse managers for two medical-surgical units at [Redacted], it is our pleasure to endorse the evidence-based practice project, “Nurse Rounding”.

Today’s healthcare environment is becoming increasingly competitive for patient volume and revenue dollars. The introduction of Value Based Purchasing by the Center for Medicare and Medicaid Services (CMS) links patient satisfaction and healthcare quality to government reimbursement, increasing the competitiveness between healthcare organizations. Nursing leaders of today’s healthcare systems must develop strategies to increase patient satisfaction and improve the revenue streams for their organizations. The purpose of this evidence-based project is to enhance an existing charge nurse led, customer service rounding program by incorporating patient feedback to the staff on duty in real time, ultimately changing staff behavior and increasing patient satisfaction scores.

Todd Tussing, MS, RN, NE-BC, will lead this project as a requisite for his course work in the Doctor of Nursing Practice Program via Wright State University.

We offer my full support for this project and to provide additional information if needed. Thank you for your time and consideration of this request.

Sincerely regards,

Sarah Taylor, BSN, RN
Nurse Manager

Krystal Renz, MS, RN-BC
Nurse Manager
APPENDIX L

ETHICS POLICY
POLICY AND PROCEDURE MANUAL

Title: Ethics Policy

Prepared by: Ethics Committee and Legal Services

Authorized by: Original signed by the Executive Director

A. ORGANIZATIONAL ETHICS

has established this policy of organizational ethics in recognition of this institution's responsibility to our patients, staff, physicians, and the community we serve. Our behavior will be guided by the following general principles:

- Services and capabilities offered by meet identified patient and community needs and are fairly and accurately represented to the public.

- adheres to a uniform standard of care throughout the organization, providing services only to those patients for whom we can safely care for within this organization. does not discriminate based upon race, creed, sex, national origin, disability, religion, sexual orientation, or source of payment.

- Patients will be billed only for care and services provided. The Customer Services Unit in Patient Accounts exists to resolve any patient questions about billing issues. The Customer Services Unit is committed to the expeditious resolution of the issue, question or conflict. Assistance is provided to patients seeking to understand the charges relative to their care.

Underlying each of the above principles is the organization's overall commitment to excellence and integrity in fulfilling its patient care, teaching, and research mission and to treating the organization's patients, physicians, staff and other constituents served with the utmost respect. will constantly strive to adhere to these principles and will expand on these principles through the development of additional policy statements as necessary.

B. BIOMEDICAL ETHICS

An important part of good health care is respect for the dignity of patients. Respect for patients includes offering information to patients and helping them take part in decisions about their health
POLLICY AND PROCEDEURE MANUAL

Title: Ethics Policy

care. The members of the treatment team and all employees of have a responsibility to respect and support the rights of patients and families.

A biomedical ethical issue arises whenever the attending physician, other health care professionals and/or the patient or family members are uncertain or in disagreement regarding medical decisions. These dilemmas may involve moral, social or economic situations that impact human life.

The goals of biomedical ethics consultation include improving patient care, clarifying any uncertainties regarding medical decisions, exploring the values and principles underlying disagreements, facilitating communication between the attending physician, the patient, members of the treatment team and the patient's family, and mediating and resolving disagreements.

Procedure

• Whenever a biomedical ethical dilemma occurs, the physician or the persons involved should discuss the situation with the members of the treatment team and patients and family members to clarify the issue(s) and attempt to reach resolution.

• The Ethics Consultation Service is a resource that may be contacted at any time for assistance with biomedical ethical dilemmas.

• Ethics consultations will be performed by members of the Ethics Committee.

• To contact the Ethics Committee, call Pastoral Care at between the hours of 7:30 a.m. and 4:30 p.m. After hours, contact the On Call Chaplain through the Medical Center Operator at 393-8000.

• Ethics consultations may be requested by any physician, nurse, other allied medical personnel, and patient or family member. If requested by someone other than the attending physician, the attending physician will be informed by the consultant that a biomedical ethics consult has been requested.

• In general, the consultation should include an interview with the physicians, nurses, and other involved care givers as well as the patient and family members to identify the values and principles
underlying any disagreements.

- The member(s) of the Ethics Committee performing the consultation will recommend one or more alternative approaches to resolve the ethical dilemma and will provide ongoing assistance as necessary.

- All biomedical ethics consultations and recommendations will be documented in the chart on the consult form.

C. OTHER RELATED POLICIES

Other policies of which provide specific guidance for issues regarding organizational ethics and patient rights include:

Mission Statement

2-11 Conflict of Interest
3-01 Patient Admission, Registration and Operating Room Scheduling Policy/Procedure
3-02 Transporting Inpatients to Other Institutions for Health Care Services
3-11 Management of HIV Infection in the Healthcare Facility
3-18 Consent for Inpatient & Emergency Department Care and Treatment
3-22 Patient Confidentiality
3-23 Patient Rights and Responsibilities
3-24 Do-Not-Resuscitate Orders
3-25 Discharge Policy
3-26 Advance Directives
3-27 Informed Consent for Surgical or Medical Procedures
3-28 Patient Complaint Management
3-29 Discharge Planning
8-01 Patient and Third Party Payor Refund Policy
8-03 Bad Debts and Collection Agencies
8-06 Collection and Credit

Medical Staff Bylaws - 3335-43-10(I) Ethics Committee
APPENDIX M

ORIENTATION CURRICULUM CHECKLIST
Nurse Rounding Project

Orientation Curriculum Checklist

Date _______________________________

<table>
<thead>
<tr>
<th>Topic</th>
<th>Completed during discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Purpose of the project: Patient Satisfaction; changes in accountability and reimbursement.</td>
<td></td>
</tr>
<tr>
<td>B. Two concepts: Patient Satisfaction and Nurse Rounding.</td>
<td></td>
</tr>
<tr>
<td>C. Measurement of Patient Satisfaction; Press-Ganey Patient Satisfaction Survey Tool.</td>
<td></td>
</tr>
<tr>
<td>D. Rounding Process: charge nurse role in the process; introduction of rounding log; post rounding huddle; submission of rounding log to nurse manager.</td>
<td></td>
</tr>
<tr>
<td>E. Coaching staff for performance.</td>
<td></td>
</tr>
<tr>
<td>F. Patient Complaints: triage and resources available.</td>
<td></td>
</tr>
</tbody>
</table>

Attendees Names:

1.
2.
3.
4.
5.
6.
7.
8.
APPENDIX N

NURSE ROUNding PROJECT ORIENTATION CHECKLIST
Nurse Rounding Project

Rounding Orientation Checklist

Date _______________________________

<table>
<thead>
<tr>
<th>Topic</th>
<th>Completed during rounding</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Obtain unit census report with length of stay.</td>
<td></td>
</tr>
<tr>
<td>Identify patients day three or greater.</td>
<td></td>
</tr>
<tr>
<td>B. Introduce self and purpose to each patient.</td>
<td></td>
</tr>
<tr>
<td>C. Ask the four rounding questions during discussion with each patient.</td>
<td></td>
</tr>
<tr>
<td>D. Summarize each patient’s response on the Patient Satisfaction Rounding Log.</td>
<td></td>
</tr>
<tr>
<td>E. Any issues identified for follow up? For each issue, resources were contacted.</td>
<td></td>
</tr>
<tr>
<td>F. Post Rounding Huddle completed with all available unit personnel.</td>
<td></td>
</tr>
</tbody>
</table>

Attendees Names:

1. 

2. 

3. 
APPENDIX O

PATIENT SATISFACTION ROUNDED LOG
<table>
<thead>
<tr>
<th></th>
<th>Are the nurses treating you well?</th>
<th>Is your call light being answered timely?</th>
<th>Is discomfort/pain being managed to your expectation?</th>
<th>Are you getting the information you need about your care to make the needed decisions?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient 2</td>
<td></td>
<td></td>
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<td>Patient 3</td>
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<td>Patient 4</td>
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<tr>
<td>Patient 5</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient 6</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Patient Satisfaction Rounding Log  
Rounder: _________________________________  Date: ____________________________

Post- Rounding Huddle Completed by Charge Nurse: Y or N. If N, why not?  Nurse Manager Comments:
APPENDIX P

PROJECT LEAD CHECKLIST
## Nurse Rounding

Project Lead Checklist during Project Implementation

Month _________________________

<table>
<thead>
<tr>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rounding Log Completed For each day since last check?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rounding Log indicates Post Rounding Huddle Completed?</td>
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<tr>
<td>Nurse Manager or designee signature?</td>
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</tbody>
</table>

Notes
APPENDIX Q

NURSE ROUNDED PROJECT ORIENTATION CURRICULUM
Nursing Rounding Project  
Orientation Curriculum

1. Welcome from the Project lead and message from the nurse managers.

2. Thank you for your support of this customer service initiative!! Overview of the orientation process: will review the content of this curriculum with project lead. Each member will complete a rounding experience with the project lead before being released to be independent with the project.

3. Purpose: The purpose of the project is to implement a customer service focused nurse rounding program on __________ and __________ to increase patient satisfaction and ultimately the Press-Ganey patient satisfaction scores.
   
a. Patient satisfaction with health care has many benefits: increased compliance with treatment, decreased readmission rates, and increased reputation of the hospital in the community leading to increase patient visits and ultimately increased dollars.

b. There is an emphasis from private and federal insurers to reimburse healthcare organizations based on success in meeting identified metrics such as patient satisfaction. Some reimbursement dollars can add up to millions of dollars for healthcare organizations to either gain or lose.

4. Two concepts to the program:
   
a. Patient satisfaction and nurse rounding: Patient satisfaction is the patient’s perception of the quality of services he receives.

b. Nurse rounding is the process in which a nurse is physically present and elicits information from the patient/family regarding their perception of the care rendered thus far.
5. Measurement of patient satisfaction is through Press-Ganey Patient Satisfaction Survey Tool and is sent to patient at their home address post discharge. Patients complete the survey and return it via the postal service.
   
a. Questions on the survey include: “How well did the nurse keep you informed?”, “Explanations about what would happen during tests or treatments?”, “Friendliness/courtesy of the nurses?”, “How well was your pain controlled?”, “Promptness of response to your call button?”, and “Amount of attention paid to your special or personal needs?” among many others.

b. Patient responds on a Likert Scale of 1 – 10 with 10 indicating “Very Good”.

c. Nursing leaders, such as your nurse manager, receive reports monthly that give statistical information on how well the unit is doing on various aspects of the survey. Patient can make comments free hand and those are shared as well.

d. For the sake of this project, we’ll be using the Press-Ganey scores to measure the effect the nurse led customer service rounding has on patient satisfaction. The program will run three months, which will include rounding weekly by one of the nurse leads and monitoring the Press-Ganey scores.

6. Rounding Process:

a. Charge nurses will complete patient rounding on their respective shifts during the day/early evening hours.
b. Bring the Patient Satisfaction Rounding Log (see attached); when you arrive for the rounding time, run a list of the patients from the electronic medical record and identify those patients who have been in-hospital for 3 days or longer. The premise behind the three day trigger is that by the third day, the patient should have some idea as to what is going on with them medically as well as what the plan of care is, including anticipated discharge. If there’s going to be “issues”; those issues will be forefront by the third day.

c. Check with the assigned nurse to ensure that you can round on the patients you have identified and to disregard the patients that are identified as “No Visit”.

d. Begin by completing appropriate hand hygiene and knocking at the door. Greet all those who are in the room by stating, “Hello, my name is ________ I am a nurse on the unit. Today I am checking with our patients to ensure they are receiving the best care possible. I’d like to ask you a few questions if I may?”.

e. Ask the following questions: Are the nurses treating you well? Is your call light being answered timely? Is comfort/pain being managed to your expectation? Are you getting the information you need about your care? Give the patient time to respond. You may wish to make brief notes on the back of the rounding from and complete the rounding form once your visit is complete. If there are visitors in the room, be sure to seek permission from the patient complete the questions with their presence. If
concerns are identified, make note and use the established HEAT model from your customer service training. See section 7 for the handling of patient issues/complaints. Once the visit is complete, thank them for the time spent and ensure that the call light is within reach and that all their immediate needs are met before leaving. Complete hand hygiene as you exit the room.

f. Complete the Rounding Log. If you need additional space for comments, please feel free to use the back of the page. If you do use the back, please indicate which patient you are documenting on. Move on to the next patient until the rounding process is complete.

g. Once the rounding process is complete, call the remainder of the clinical staff to the nursing station (barring those involved in direct patient care that can’t leave) for a brief summary of your rounding. Scan the documents and provide an overall summary of what was shared by the patients. For Example, “Overall, our patients really complimented us on our friendliness; one even stated that his nurse held his hand when he was in pain and that helped tremendously. He wanted me to thank Susie’s for that.” …or “One concern that was mentioned by two patients is that we don’t seem to be answering call lights timely, esp. on the 3 – 11 shift; so let’s try to monitor those lights at that time.” If the patient mentions a specific staff member along with a complaint, do not reveal this in the summary to the staff. Such issues will be given to the nurse leadership team to resolve. The purpose of the summary is give the staff some real-
time feedback on what the patients are perceiving about their care so that the staff can adjust their actions/behaviors to support the image of higher quality. At the end of the summary, thank everyone for their time and encourage them to incorporate the feedback into their routine. Provide coaching as necessary, see last page of this document. On the patient assignment board, place a magnet near the room number of the patients you rounded on. Remove magnets of those patients who have been discharged or transferred off the unit.

7. Patient complaints:

If you should have a patient complaint, utilize the HEAT model that the hospital teaches (see #6). If the complaint is of a minor nature (i.e. food served cold; call light not attended to; forgetfulness of a request; loudness in the hallways) inform the nurse assigned to the patient so that they are aware and can make adjustments in care as necessary. You may also notify Guest Services office at extension 614-293-8944 for additional assistance. For those complaints of a serious nature (i.e. missing/perceived stolen personal items; abuse by a staff member; rudeness by a staff member, etc) notify either the assistant nurse manager or the nurse manager (or designee) immediately. Document all of the issues and your follow up on the Rounding Log.

8. Leave the rounding Log in the nurse manager’s mailbox on the unit. The nurse manager will review the Rounding Log and sign off on it indicating it has been reviewed.

9. Questions?
10. Contact information:
   a. Todd Tussing, Director of Nursing
   b. Email: Todd.tussing@osumc.edu
   c. Cell: 937.369.5606

Coaching for Patient Satisfaction

1. Put staff member at ease.
2. Find out what they already know.
3. Present information or demonstrate.
4. Repeat as necessary.
5. Evaluate and provide feedback.
6. Reward.

Adopted from:

http://www.wright.edu/~scott.williams/LeaderLetter/coach.htm#Steps inCoaching

APPENDIX R

PROCESS GUIDE FOR STAFF
Patient Satisfaction Rounding
Process Guidelines for Staff

Goal: To involve clinical staff in patient satisfaction rounding and allow them the opportunity to assist with increasing patient satisfaction with the nursing care on the unit.

Process:

1) Each charge nurse will be coached on proper rounding technique by a project lead.
2) Patient Rounding will be completed by the active duty charge nurse.
3) Patient chosen for the rounding will be patients on the unit ≥ 3 days of stay.
4) Unit census with admission date will be utilized for identification of patients for rounding.
5) Charge Nurse will round and record information on the Patient Satisfaction Rounding Log.
6) After rounding, nurse will call staff to the nursing station and share the experiences discovered during rounding. (Particular personnel issues will be left out of this discussion and will be referred to the nurse manager.)
7) Completed rounding log to be given to nurse manager for review of issues/concerns needing nursing leadership attention.

Potential Patient Concerns/Issues:

Periodically patients and/or families will voice concerns and/or issues. Many such concerns are easily solved by the bedside nurse or the charge nurse (e.g. cold meal trays; needing pain medication; requesting to know about delays in care, etc…) however, occasionally there are issues/concerns raised that will need the official nursing leaders of the unit to be involved (E.g. rudeness of staff; inappropriate staff behavior; theft of personal items, etc…). Members rounding who discovers such patient issues should notify the nurse manager (or nursing supervisor/HAM) immediately for follow-up. Once the follow up has been initiated, please complete the complaint database.
APPENDIX S
PRESS-GANEY PATIENT SATISFACTION SURVEY
DATA SPREADSHEET
PRESS-GANEY PATIENT SATISFACTION SURVEY

DATA SPREADSHEET

2015

<table>
<thead>
<tr>
<th>Dimension</th>
<th>A-APR</th>
<th>A-JUN</th>
<th>A-JUL</th>
<th>A-AUG</th>
<th>B-APR</th>
<th>B-JUN</th>
<th>B-JUL</th>
<th>B-AUG</th>
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<td>Communication about Medications.</td>
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<td>Overall</td>
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</tr>
</tbody>
</table>

Number of Responses Received:
APPENDIX T

PRESS-GANEY PATIENT SATISFACTION SURVEY TOOL
SURVEY INSTRUCTIONS: You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient. Answer all the questions by completely filling in the circle to the left of your answer. You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:  ○ Yes
○ No  →  If No, Go to Question 1

Please answer the questions in this survey about your stay at
Do not include any other hospital stays in your answers.

YOUR CARE FROM NURSES
1. During this hospital stay, how often did nurses treat you with courtesy and respect?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

2. During this hospital stay, how often did nurses listen carefully to you?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always
   ○ I never pressed the call button

YOUR CARE FROM DOCTORS
5. During this hospital stay, how often did doctors treat you with courtesy and respect?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

6. During this hospital stay, how often did doctors listen carefully to you?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

THE HOSPITAL ENVIRONMENT
8. During this hospital stay, how often were your room and bathroom kept clean?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

9. During this hospital stay, how often was the area around your room quiet at night?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

YOUR EXPERIENCES IN THIS HOSPITAL
10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
    ○ Yes
    ○ No  →  If No, Go to Question 12

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
    ○ Never
    ○ Sometimes
    ○ Usually
    ○ Always

12. During this hospital stay, did you need medicine for pain?
    ○ Yes
    ○ No  →  If No, Go to Question 15

continued...
13. During this hospital stay, how often was your pain well controlled?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

15. During this hospital stay, were you given any medicine that you had not taken before?
   ○ Yes
   ○ No → If No, Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else’s home, or to another health facility?
   ○ Own home
   ○ Someone else’s home
   ○ Another health facility → If Another, Go to Question 21

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
   ○ Yes
   ○ No

20. 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?
   ○ Yes
   ○ No

OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. 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?
   ○ 0 Worst hospital possible
   ○ 1
   ○ 2
   ○ 3
   ○ 4
   ○ 5
   ○ 6
   ○ 7
   ○ 8
   ○ 9
   ○ 10 Best hospital possible

22. Would you recommend this hospital to your friends and family?
   ○ Definitely no
   ○ Probably no
   ○ Probably yes
   ○ Definitely yes

UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL

23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
   ○ Strongly disagree
   ○ Disagree
   ○ Agree
   ○ Strongly agree

24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
   ○ Strongly disagree
   ○ Disagree
   ○ Agree
   ○ Strongly agree

25. When I left the hospital, I clearly understood the purpose for taking each of my medications.
   ○ Strongly disagree
   ○ Disagree
   ○ Agree
   ○ Strongly agree
   ○ I was not given any medication when I left the hospital
ABOUT YOU

26. During this hospital stay, were you admitted to this hospital through the Emergency Room?
   ○ Yes
   ○ No

27. In general, how would you rate your overall health?
   ○ Excellent
   ○ Very good
   ○ Good
   ○ Fair
   ○ Poor

28. In general, how would you rate your overall mental or emotional health?
   ○ Excellent
   ○ Very good
   ○ Good
   ○ Fair
   ○ Poor

29. What is the highest grade or level of school that you have completed?
   ○ 8th grade or less
   ○ Some high school, but did not graduate
   ○ High school graduate or GED
   ○ Some college or 2-year degree
   ○ 4-year college graduate
   ○ More than 4-year college degree

30. Are you of Spanish, Hispanic or Latino origin or descent?
   ○ No, not Spanish/Hispanic/Latino
   ○ Yes, Puerto Rican
   ○ Yes, Mexican, Mexican American, Chicano
   ○ Yes, Cuban
   ○ Yes, other Spanish/Hispanic/Latino

31. What is your race? Please choose one or more.
   ○ White
   ○ Black or African American
   ○ Asian
   ○ Native Hawaiian or other Pacific Islander
   ○ American Indian or Alaska Native

32. What language do you mainly speak at home?
   ○ English
   ○ Spanish
   ○ Chinese
   ○ Russian
   ○ Vietnamese
   ○ Some other language (please print):

ADDITIONAL QUESTIONS ABOUT YOUR STAY

Now that we have asked you to tell us about what happened during your stay, we want to ask you about how well we met your needs.

INSTRUCTIONS: Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on your experiences.

ADMISSION

1. Speed of admission process ................................................................. ( )

2. Courtesy of the person who admitted you ........................................... ( )

Comments (describe good or bad experience):

ROOM

1. Pleasantness of room decor ............................................................... ( )

2. Room cleanliness .............................................................................. ( )

3. Courtesy of the person who cleaned your room ............................... ( )

4. Room temperature ........................................................................... ( )

5. Noise level in and around room ....................................................... ( )

Comments (describe good or bad experience):
### MEALS

<table>
<thead>
<tr>
<th>1. Temperature of the food (cold foods cold, hot foods hot)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Quality of the food</td>
<td></td>
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</tr>
<tr>
<td>3. Courtesy of the person who served your food</td>
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</tbody>
</table>

**Comments** (describe good or bad experience): __________

### NURSES

<table>
<thead>
<tr>
<th>1. Friendliness/courtesy of the nurses</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Promptness in responding to the call button</td>
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<tr>
<td>3. Nurses' attitude toward your requests</td>
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<td></td>
</tr>
<tr>
<td>4. Amount of attention paid to your special or personal needs</td>
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<tr>
<td>5. How well the nurses kept you informed</td>
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<tr>
<td>6. Skill of the nurses</td>
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</table>

**Comments** (describe good or bad experience): __________

### TESTS AND TREATMENTS

<table>
<thead>
<tr>
<th>1. Waiting time for tests or treatments</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Explanations about what would happen during tests or treatments</td>
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<tr>
<td>3. Courtesy of the person who took your blood</td>
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</tr>
<tr>
<td>4. Courtesy of the person who started the IV</td>
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</table>

**Comments** (describe good or bad experience): __________

### VISITORS AND FAMILY

<table>
<thead>
<tr>
<th>1. Accommodations and comfort for visitors</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Staff attitude toward your visitors</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Comments** (describe good or bad experience): __________

### PHYSICIAN

<table>
<thead>
<tr>
<th>1. Time physician spent with you</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Physician's concern for your questions and worries</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How well physician kept you informed</td>
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<tr>
<td>4. Friendliness/courtesy of physician</td>
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<td></td>
<td></td>
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<tr>
<td>5. Skill of physician</td>
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</tbody>
</table>

**Comments** (describe good or bad experience): __________

### DISCHARGE

<table>
<thead>
<tr>
<th>1. Extent to which you felt ready to be discharged</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Speed of discharge process after you were told you could go home</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3. Instructions given about how to care for yourself at home</td>
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</tbody>
</table>

**Comments** (describe good or bad experience): __________
APPENDIX U

COMPARISON OF ROUNDED PROGRAM QUESTIONS TO
INTERACTION MODEL OF CLIENT HEALTH BEHAVIOR MODEL VARIABLES
AND
HCAHPS QUESTIONS
<table>
<thead>
<tr>
<th>Interaction Model of Client Health Behavior Variable</th>
<th>HCAHPs Question</th>
<th>Rounding Program Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>How well the nurse kept you informed? Explanations about what would happen during tests or treatments? Instructions given about how to care for yourself at home.</td>
<td>Are you getting the information you need about your care to make the needed decisions?</td>
</tr>
<tr>
<td>Affective Support</td>
<td>Courtesy of the person who admitted you. Friendliness/courtesy of the nurses. Amount of attention paid to your special or personal needs.Courtesy of the person who started your IV. Staff attitude towards your visitors. How well your pain was controlled. Degree to which staff addressed your emotional needs. Response to concerns/complaints made during your stay.</td>
<td>Are the nurses treating you well? Are you getting the information you need about your care to make the needed decisions? Is discomfort/pain being managed to your expectation?</td>
</tr>
<tr>
<td>Decisional Control</td>
<td>Promptness in response to the call button. Nurses’ attitude toward your requests. Amount of attention paid to your special or personal needs. Extent to which you felt ready to be discharged. Staff effort to include you in decisions about your treatment.</td>
<td>Is your call light being answered timely? Are you getting the information you need about your care to make the needed decisions?</td>
</tr>
<tr>
<td>Professional/Technical Competencies</td>
<td>Amount of attention paid to your special or personal needs. Skill of the nurses. Instructions given about how to care for yourself at home. How well your pain was controlled.</td>
<td>Is discomfort/pain being managed to your expectation? Are you getting the information you need about your care to make the needed decisions?</td>
</tr>
</tbody>
</table>
APPENDIX V

PATIENT SATISFACTION ROUNDED LOG

ANALYSIS RULES
Rules for Review

- All comments that indicate satisfaction with care (i.e. treatment, communication, pain/discomfort level, etc.) will be classified as a positive statement.

- All comments that indicate a dissatisfaction with care (i.e. treatment, communication, pain/discomfort level, etc.) will be classified as a negative comment.

- All comments that have both a component of a satisfaction AND dissatisfaction statement (i.e. treatment, communication, pain/discomfort level etc.) will be classified as neutral.

- All comments are neither satisfied nor dissatisfied will be classified as neutral.

- Symbols without a comment that is neither satisfied nor dissatisfied will be classified as neutral.

- Symbols with a comment that is satisfied will be classified as positive.

- Symbols with a comment that is dissatisfied will be classified as negative.

- Symbols with a comment that is satisfied AND dissatisfied will be classified as neutral.

- Illegible comments will be classified as neutral.

- “N/A” responses will be classified as neutral.

- No response provided will be classified as neutral.
APPENDIX W

POST PROJECT FOCUS GROUP OUTCOMES
Nursing manager’s responses:

Question 1: What went well?

- Rounding on nursing helpful to hear that the nursing staff were doing what they were supposed to be doing as reported by patients. For example, addressing pain. Positive affirmation staff doing what they are supposed to do.

- Able to fix patient care issues in real time.

- Data collection form clear to understand.

- Training of staff by project lead.

- Huddle at the end, able to recognize people in front of their peers.

Question 2: What could have been better?

- Sense from charge nurses that the daily project lead phone calls to remind them of the rounding was irritating and lead to avoidance to answer the phone call from him.

- Nurse Manager had to pick up when charge nurses not able to conduct rounding.

- Location to have post rounding huddle. Staff indicated that they didn’t approve of the huddle being held in the break room as they viewed this space as “sanctuary” from unit activities and a place to rest. Felt post huddle intruded on this purpose for the break room.
Question 3: What may have influenced the project outcome?

- Nurse Coordinator role. They provide education and discharge preparation for the patients.

- 60 hospitalist on nursing unit A (who rotate every 7 days) – good doctors have a positive influence on patient satisfaction scores, bad doctors have a negative impact on scores.

- Staffing model changed about year prior to implementation of the rounding project. Charge nurses were now taking patients and each nurse assignment picked up additional patient or two.

- Staffing vacancies were high during the rounding project period. In particular, nursing unit A was short of Patient Care Associates (PCA) for personal care and many times the staff nurse assignments did not include a PCA and the nurse picked up responsibility for PCA duties (bathes, ambulation, blood sugar measurement, etc.). Nursing unit B had significant RN vacancies that contributed to increased nurse to patient ratios.

- Competing priorities – the organization has a requirement of completion of all employees annual evaluation by end of August 31. Nurse managers were busy completing the annual evaluations and had approx. 50 – 60 to be completed within a month or two and felt pulled to meet the evaluation expectation over the project expectation.
• Vacations – project held during the summer months. Nurse Managers often had vacations (2.5 to 3 weeks) and one manager was out for bereavement (1 week), thus less time to devote to the rounding project.

Question 4: What were lessons learned?

• We are doing a good job.

Charge nurses responses:

Question 1: What went well?

• Nice to hear patient say good things.

• Nice to enter a room and not get complaints.

• Nice to have staff members named mentioned in the patient comments and be able to give them that feedback in the post huddle.

Question 2: What could have been better?

• Need more time in the day for the rounding.

• Staffing, taking an assignment and conducting charge nurse duties, including the rounding, was a challenge.

Question 3: What may have influenced the project?

• Staffing, high nurse to patient ratios left little time for rounding and for staff to participate in the post rounding huddle.
• Not enough time to complete the rounding.

• Charge nurses chose those patients were not known “problem patient” or patients who they have had complaints from in the past, citing, there’s nothing more I can do for them as their complaints center around their pain medication orders.

Question 4: What were lessons learned?

• Patients were surprised to be asked how they were doing and if they needed help.

• Patient population, psychiatric and drug seeking, affected the rounding.

• Patient who are not happy about the pain medication ordered often complained about other area of care such as room cleanliness.