

2017

Hourly Roudning in th Emergency Department

Marie Chapnick
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Walden University

College of Health Sciences

This is to certify that the doctoral study by

Marie Chapnick

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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2017

Abstract

Hourly Rounding in the Emergency Department

by

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MSN, Hunter College, 2004

BSN, College of Staten Island College, 2000

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2017

Abstract

The Affordable Care Act of 2010 increased the number of patients seen in a northeast, urban trauma emergency department by 34%. This created a problem as it occurred simultaneously with a nursing shortage. Consequently, patient satisfaction scores fell below the national average benchmark. The rate patients left the emergency department without being seen was 2.6% higher than the national average and patient fall rates increased by 20%. A review of the literature to search for solutions led to the support of an hourly rounding project and an educational workshop promoting proactive nurse behaviors as a way to address the quality and safety gap. The goal of this scholarly project was to develop this evidence based, theory supported project and to conduct a formative and summative evaluation by an expert review panel in order to achieve consensus before implementation. An executive team was formed and led through the process of development of a detailed hourly rounding protocol and workshop, which will be implemented at the facility at a later time. A 10 member expert panel was formed. The panel members consented to participate in an explanatory session, to review all project materials, and to complete an anonymous 20 question survey tool. The panel also consented to review any changes made to materials as part of a summative evaluation. Descriptive analysis of the formative data demonstrated a 90% overall agreement that the workshop was comprehensive and covered key concepts within 5 categories. Minor requested revisions were made in response to formative results. The summative review demonstrated 100% concensus on the revisions. This project will bring about social change by engaging nurses in proactively caring for patients in a safe and efficient manner.

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Dedication

I dedicate this rounding protocol to nurses in the emergency department, whose devotion to healing the physical, psychological, and spiritual needs of patient's decreases pain and suffering. Our ability to provide comfort care to patients and families is a spiritual gift that empowers patients to use energies to promote equilibrium and wellness or die with dignity. I also dedicate this paper to my father whose tears of joy at every turn of my success became my driving inspiration to continue my academic studies.

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Section 1: Overview of the Evidence-Based Project

Introduction

Patient satisfaction scores, in an urban trauma center, have consistently been below the set goal of the 70th percentile (M. Scuzzillino, personal communication, April 4, 2016). Low patient satisfaction scores have been associated with gaps in addressing patient comfort care needs and poor communication with patients (Press Ganey, 2015a). Patient satisfaction scores, fall rate, and the number of patients who leave the emergency department (ED) without being seen has been steadily rising since the Affordable Care Act (ACA) was instituted in 2010 (M. Scuzzillino, personal communication, April 4, 2016; Centers for Medicare and Medicaid Services [CMS], 2014). The ACA increased access to medical care, in an era of nursing shortage, which led to an increase in ED overcrowding. Lack of staff presence in assisting patients in basic needs, such as walking to the bathroom, has been shown to increase patient falls. Failure to communicate delays in wait times and treatment have caused frustrated patients to leave without being seen (LWBS), decreasing access to medical care and reimbursement (Erenler et al., 2014). Patients' perceptions of receiving poor quality care has discouraged them to return for further treatment and has discouraged new patients, threatening the viability and survival of the institution.

This project was in response to the lack of nurse education on using an evidence-based tool and protocol to increase patient assessment and individualize comfort care. The goal was to decrease patient falls, decrease the number of patients who LWBS, and increase patient satisfaction scores. I evaluated evidence and synthesized information to support the development of an educational nurse workshop and educational materials. A formative evaluation of this

developmental quality initiative project was completed by an expert panel. Feedback was used to refine the information and increase content validity. A descriptive analysis was used to report the frequency distribution of data. Minor recommendations were made for revisions of the materials. Feedback indicated that the educational workshop was a comprehensive tool to increase nurse's knowledge of proactive behaviors to increase patient safety, improve quality comfort care, and increase patient's satisfaction of services. A plan implementation of the educational workshop was provided to the facility, which includes short-term and long-term methods for evaluation. The institution was given this training tool at the completion of this doctoral program to train nurses on proactive nurse interventions, which will be implemented at their discretion at later time.

Problem Statement

Press Ganey patient satisfaction scores in the ED range within the 60th percentile, failing to meet the goal set at the 70th percentile (M. Peitro, personal communication, April 4, 2016). The number of insured patients has risen since the passage of ACA in 2010, has increased the amount of patient seeking treatment, causing ED overcrowding in an era of nursing shortage. Lack of adequate nurse staffing to meet the demands of increased patient census created gaps in meeting patient comfort needs. Patient falls have increased by 20% since 2010, as patients ambulate to the bathroom unassisted (M. Scuzzillino, personal communication, April 4, 2016; CMS, 2014). Lack of nurse availability to communicate delays in wait time cause frustrated patients to LWBS. The number of patients who LWBS within the last year is 2.6% greater than the national average in the United States (Centers for Disease Control, 2014; M. Scuzzillino, personal communication, April 4, 2016). Patients who LWBS represent an outcome measure of

underprovided access to health care and the failure of the emergency care system to meet its goals for offering care for those who need it (Johnson, Myers, Wineholt, Pollack, & Kusmiesz, 2009). Lack of nurse availability to address patient care needs and adverse events creates false patient assumptions about lack of nurse caring, listening, and respecting (Standford, 2015). Increased nurse workload predisposes nurses to burnout, compassion fatigue, and decreased job satisfaction (Hooper, Craig, Janvrin, Wetzal, & Reimels, 2010). The problem that I addressed in this project was the lack of nurse education about using an evidence-based tool and protocol that (a) organize nurse workflow and (b) offer efficiencies by giving nurses time back to proactively, rather reactively, anticipate and address patient comfort needs (Halm, 2009). Traditionally, studies have focused on identification of patient safety issues and the need for change in practice to improve quality and patient safety. To date, little attention has been given to developing new evidence-based practices. The significance of this DNP project was the development of an evidence-based and theoretically grounded hourly rounding educational workshop to increase the efficacy of nursing practices that increases patient comfort, decreases patient falls, decreases the rate of patients who LWBS, increases patient satisfaction scores, and increases nurse job satisfaction

Purpose Statement

Gaps in addressing patient comfort needs have consistently produced Press Ganey scores that are below the internal benchmark (M. Pietro, personal communication, April 4, 2016). Survey questions that receive the lowest scores include friendliness/courtesy of the care provider and concern the care provider showed about questions or worries (Press Ganey, 2015a;

M., Scuzzillino, personal communication, April 4, 2016). The rate at which patients LWBS is higher than the national average, creating loss revenue from potential patient visits (CDC, 2014; CMS, 2014). The most common cause for patients leaving the emergency room is lack of communication on delays, which increases patient anxiety and frustration (Johnson et al., 2009). The fall rate has steadily increased as patients attempt to ambulate to the bathroom without assistance, creating undue pain and suffering, increased lawsuits, and decreased reimbursement from Medicaid for never events (M. Pietro, personal communication, April 4, 2016; Agency for Healthcare and Research Quality [AHRQ], 2011). A never event is a medical error or adverse event that is usually preventable (AHRQ, 2011). The purpose of this project resulted in developing an evidence-based and theoretically grounded hourly rounding educational workshop, which is a cost-effective team approach to improve nurse competencies that decrease the quality gap generated by hospital overcrowding and the nursing shortage. An expert panel was used in a formative review. I used descriptive analysis, using a frequency distribution, to report content validity. This training workshop, including lecture content, PowerPoint presentation, and rounding competency tools was given to the nurse director of the emergency room, because it was not my purpose to train nurses at the current time. Rather the intent was to develop an education program that the facility can use later to increase nurse's knowledge on proactive behaviors that increases patient safety and improves quality care.

Project Goals and Objectives

My goal in this quality initiative project was to address patient issues in the ED of the facility by developing an evidence-based, theory-supported nurse educational workshop on hourly rounding and validating this work by creating an expert panel for a formative evaluation.

Data obtained were used to refine the product and improve the content validity that will support this training program to:

1. Decrease the rate of patients who leave the emergency room without being seen.
2. Decrease patient fall rates.
3. Increase patient satisfaction scores.

Nature of Doctoral Project

The nature of the project was to address a gap and problem in the ED, which resulted in the developing an evidence-based educational nurse workshop on the practice of hourly rounding. An expert panel completed a formative evaluation on the educational workshop and provided feedback. The feedback was used for revisions to increase the content validity and improve the efficacy of this quality initiative educational program. The educational contents, plan for implementation, and long-term evaluation methods were given to the facility for use later.

Significance and Relevance to Practice

Traditionally, nurse behaviors have been reactive, waiting to be called by patients to assist with comfort care needs. Sick patients often feel a sense of lost control as they become dependent on others. This creates patient anxiety, frequent patient calls, and increase nurse workload. To preserve patient dignity, wholeness, and integrity, nurses need to use proactive interventions that are based on patient's perception of needs, which communicates listening, caring, and respecting (Standford, 2015). Using proactive nurse interventions will empower patients to become gatekeepers of their care and use behaviors to improve their health outcomes (Mitchell, Lavenberg, Trotta, & Umscheid, 2014; Watson, 2008). Nurses, as part of their code of

ethics, are morally and professionally accountable for examining ways to improve the delivery of care that is safe, efficient, and effective (American Nurses Association, 2009). The significance of increasing patient comfort using an hourly rounding protocols aligns with the Doctoral Education for Advanced Nursing Practice Essential I; providing principles to optimize health, nurse-patient-environment interaction, change in actions for positive outcomes, and the summation of parts to provide holistic care (American Association of Colleges of Nursing, 2006). This doctoral project brings a change in practice from reactive nurse interventions to proactive nurse interventions, which anticipates patient comfort needs during a systemized hourly rounding assessment of patients (Stevens, 2013). The ability of using proactive nurse behaviors to ease patient discomfort can be applied to any patient care unit and empowers patients to use energies to transcend to a level of balance and wellness (Kolcaba, 2010).

Project Question

I used the following question to guide my project: Does using an educational workshop on the implementation of an hourly rounding protocol, reviewed by a panel of experts for content validity, increase nurses' knowledge on proactive behaviors that decrease patient falls, decrease the rate that patients leave the ED without being seen, and increase patient satisfaction?

Significance of the Project

Hourly rounding, based on the Studer Group Model (2007), uses proactive nurse behaviors to address the four *Ps* of patient comfort (pain, potty, possession, position). However, any unit can change the acronym to suit the needs of their patient population. For example, the ED commonly uses the PPD of comfort, which includes pain, potty, and delays in treatment. The significance of using hourly rounding for patients, external key stakeholders, is to provide nurses

with evidence-based interventions to meet or exceed patient's perception having received quality, safe, and individualized comfort care. Using proactive nurse behaviors and scripted cues to assess and anticipate comfort needs, identified in the Studer group's model, will decrease patient falls, decrease the rate of patients who LWBS, and increase patient satisfaction scores.

The significance of hourly rounding for nurses and nursing assistants, internal key stakeholders, include decrease interruptions by patients and families seeking information, decrease nurse workload, decrease burnout, and increase nurse job satisfaction. On a systems level, hourly rounding is a cost-effective method that prevents loss revenue from patients who LWBS, decrease Medicare reimbursement for never events, and increase lawsuits from patient injuries (Cutan, 2010; HealthyPeople, 2020). This doctoral project brings to nursing a change in practice from reactive nurse interventions to proactive nurse interventions, using an education workshop that is rooted in rigorous, systematic, and scientific inquiry (Stevens, 2013). Using formative evaluation of the educational workshop by an expert panel provided data for revisions of the educational workshop and increased content validity. Positive social change occurs when nurses use evidence-based practices to develop new competencies that improves quality and safe care that encourages patients to return to the institution for future treatment, attracts new consumers, increases hospital integrity, maintains institutional survival, and increases access to medical care in the community.

Reduction of Gaps

A major stimulus to implement evidence-based practices was made by the Institute of Medicine (IOM), recommending interventions to close the quality gap and improve health care outcomes (IOM, 1999; IOM, 2003). In the *Future of Nursing Report*, the IOM emphasizes the

need for convergence of knowledge, quality, and new functions in nursing, using interprofessional teams to improve systems, improve competencies in clinical decision making and increase use of evidence-based interventions (IOM, 2008). The ACA of 2010 has increased ED overcrowding, in an era of nurse shortage, creating a gap in providing comfort and safe care (Erenler et al., 2014). Lack of nurse knowledge on the use of proactive nurse behaviors to anticipate patient comfort needs, increases patient falls, increases the rate of patients who LWBS, and lowers patient satisfaction scores. Hourly rounding is an evidence-based intervention that increases patient-nurse communication and increases frequency of patient assessment. The outcomes are providing nurse interventions that are based on patient's goals and expectations, which reduces the gap in patient comfort, safety, and satisfaction.

Implications for Social Change in Practice

Hourly rounding increases access to medical care, improves patient health care outcomes, and increases compliance with treatment plan (Studer Group, 2007; Meade et al., 2010). Health care, traditionally dominated by health care providers, is now patient driven. The ACA of 2010 impacted patient care by using a pay-for-performance payment system, which places financial pressures on medical providers to improve patient satisfaction (Agency for Healthcare Research, 2015). The ACA has also made Americans more accountable for health care costs, penalizing those who refuse to purchase medical insurance plans. Seeking to get the most for their money, educated consumers shop for reputable providers and facilities, before making health care decisions.

Hospital Compare, created through Medicare and the Hospital Quality Alliance, is a consumer-oriented website that helps individuals to make informed decisions on health care, by

comparing hospital performance measures and measures of patient's perspectives of care (CMS, 2015a). To survive this era of competition, institutions need to implement new evidence-based protocols to provide patient centered quality and safe care. This doctoral project contributes to the development of an hourly rounding educational workshop, which will be implemented by the facility later, to increase nurse awareness of proactive evidence-based practices that increase patient satisfaction scores, decrease patient falls, and decrease the rate of patients who LWBS. A formative evaluation of the workshop, by an expert panel, provided feedback, which was used to refine the project and increase the content validity.

Definition of Terms

In this project, I used the following terms:

- *Comfort*: An immediate desirable outcome of patient care that exists in three forms: relief, ease, and transcendence (Kolcaba, 2010).
- *Fall*: An unplanned descent to the floor with or without injury to the patient, which occurs on an eligible reporting nursing unit. Injury level classified as none, minor, moderate, major, or death (American Nursing Association, 2009).
- *Formative evaluation*: Review of content and processes conducted throughout the development stage to improve or refine the effectiveness of a program or training (Carnegie Mellon University, 2015).
- *Hourly rounds*: Systematic nursing bedside rounds that incorporate specific actions, done at specific intervals (McCartney, 2009).
- *Patient satisfaction*: A measure of the extent to which a patient is content with the health care received from their health care provider (Press Ganey, 2015a).

- *Patients who leave without being seen:* Persons encountering health services for specific procedures and treatment, but it is not carried out (ICD-10-CM diagnostic codes, 2016).
- *Quality:* The degree to which health services for individuals and populations increases the likelihood of desired health care outcomes and are consistent with current professional knowledge (IOM, 2003).

Role of the DNP Student

My role as a DNP student in this project was to provide the institution with an evidence-based and clinical evaluated educational workshop, implementation plan, and long-term evaluation method for use later when hourly rounding protocols are adopted. This workshop will increase nurse's knowledge on the use of proactive behaviors and scripted cues to decrease patient falls, decrease the rate of patients who LWBS, and increase patient's perceptions of receiving quality and safe-care. Presenting benefits of hourly rounding and dispelling myths of increase nurse workload will motivate nurses to buy into the system on an organizational level and decrease resistance to change. I took the lead on developing an hourly rounding education workshop and created a panel of clinical experts for a formative evaluation of the educational training workshop and educational materials that increased the validity of contents.

Assumptions and Limitations

Assumptions

An *assumption* is defined as a statement that is accepted as true, or at least plausible, without being scientifically tested (Grove, Burns, & Gary, 2013). The major assumption of this project was the use of a formative evaluation by an expert panel to obtain data for revisions of the educational workshop and educational materials that increased the efficacy and validity of

the content. I also assumed that using evidence-based proactive nursing interventions, described by the Studer model, and providing comfort care, described in Kolcaba's theory, would decrease patient falls, decrease the number of patients who LWBS, and increase patient satisfaction scores.

Limitations

A *limitation* is defined as a weakness in a study for uncontrolled variables that may impact or influence the study outcome (Grove et al., 2013). A limitation of this project was potentially a lack of generalizability of outcomes for other organizations.

Summary

Overcrowding in the ER was created by the ACA in 2010. Furthermore, there has been a nursing shortage and use of reactive nursing interventions to meet patients care needs. As a result, there patient satisfaction scores have decreased and the rate of patient falls and patients who LWBS has increased at the urban trauma center under study. I developed an hourly rounding educational workshop, implementation plan, and method for evaluation for use in this facility later. An expert panel was created for a formative review of the educational workshop. Feedback was used for revisions to increase the efficacy and validity of the content. Using an evidence-based hourly rounding workshop to educate nurses on proactive nurse interventions will individualize patient comfort care needs, increase patient safety, and increase patient satisfaction with care. Providing patient-centered care will encourage patients to return for future services, attract new patients increase institutional integrity, and maintain institutional survival.

Section 2: Review of Scholarly Literature

Specific Literature

I conducted an exhaustive literature search using Thoreau Multi-Database, Cumulative Index of Nursing and Allied Health Literature, Cochrane Database of Systematic Review, Nursing & Allied Health Collections, ProQuest, Nursing & Allied Health Source, MEDLINE, and PubMed. I extended the search to published literature from 2006 to 2016, to compare data from the first study done on hourly rounding using the Studer's Group model in 2007. Older articles were considered if they provided sound clarification of the problem at hand and answers for remedying the dilemma of low patient satisfaction scores, patient falls, and patients who LWBS.

Key search terms, used separately and in combination, were hourly rounding, purposeful rounding, comfort rounds, ED, patient's satisfaction, nurse satisfaction, nurse caring, patient fall prevention, call light usage, nurse-patient communication, nurse-patient connectedness, and patients who LWBS. Articles in the search were peer-reviewed evidence-based studies. Exclusion criteria included articles with informal means of communication, language other than English, studies using primary care facilities, and qualitative research studies. I included articles that used the variables patient satisfaction, call light usage, patient falls, and patients who LWBS. Decubitus ulcers were not assessed in review of the literature as a patient outcome of hourly rounding.

My literature review supports using hourly rounding as a team-based action plan that engages nurses and nurse leaders to bring about a sustainable change of practice that increases patient satisfaction in the ED, decrease patient falls, and decrease the rate that patients LWBS

(Meade et al., 2010; Studer Group, 2007; Tzeng, 2010). Hourly rounding is a nurse sensitive indicator that empowers nurses to meet the physical, psychospiritual, environmental, and sociocultural comfort needs of patients and families (Kolcaba & Fisher, 1996). Structured timed nurse bedside rounds incorporate specific actions that increases patient satisfaction and decreases the number of patients who leave the emergency room without being seen by increasing nurse-patient communication (Meade et al., 2010). Patient falls are decreased with increase nurse presence to assist patients with comfort care needs (Halm, 2009; Meade et al., 2010). During rounding, structured interventions are used by trained nurses and nursing assistants in anticipation of patient comfort needs, referred to as the four *Ps* (e.g., pain [physical and psychological], potty [toileting], possessions [water pitcher, phone, call bell, overhead table], and positioning [turning, transferring, ambulating]). The four *Ps* may change according to the needs of the unit. For example, the intensive care unit may use an additional *P* (five *Ps*), to assess peripheral intravenous lines and intravenous pumps (Deitrick, Paxton, & Swavely, 2012). The emergency room commonly uses the acronym PPD (e.g., pain, plan of care, and delays [Baker, 2012]). When patient comfort needs are addressed, the nurses conclude the round by asking, “Is there anything else I can do for you? I have the time,” conveying caring and listening (Standford Health, 2015). Hourly rounding is a tool that nurses can use to enhance patient-nurse connectedness, promote continuity of care, and improve health care outcomes, which not only increases patient satisfaction but also increases nurse job satisfaction (Andrus, 2015; Studer Group, 2007; Ford, 2010). Anticipating patient care needs decreases the steps in providing nursing interventions resulting in decrease staff workload. Increased nurse presence and increased patient-family communication decrease nurse interruptions that risks medical errors

and lawsuits, decrease nurse stress, and decrease nurse burnout (Studer Group, 2007; Tzeng, 2010).

Meade et al. (2006) completed a rigorous study on the effects of hourly patient rounding. The study used a quasiexperimental and nonequivalent group design that included 27 nursing units (e.g., medicine, surgery, telemetry) in 14 hospitals nationwide. Quality measures included patient falls, call light usage, and patient satisfaction. At the completion of the 6-week project, the study reported a significant decrease in call light usage with hourly rounding ($p = .07$) and bihourly rounding ($p = .06$). Using a 100-point scale, patient satisfaction significantly increased using 1-hour rounding from 79.9 to 91.9 ($p = .001$) and 2-hour rounding from 70.4 to 82.1 ($p = .001$). Patient falls were significantly decreased by 52% in hourly rounding but was not significantly decreased in bihourly rounding. Factors attributed to the success of the project include staff cooperation, provision of formal staff training, and consistency of nurse leadership. This study demonstrated the significant benefit of structured hourly rounding to improve patient satisfaction and clinical outcomes, serving as a catalyst for organizations to re-examine their health care delivery approach to improve patient's perception of care and improve patient safety.

Patient Falls

Orlich, Kalman, and Nigolian, 2012 performed a quasiexperimental study to examine the effects of hourly rounding on call-light usage, patient falls, and patient satisfaction. This study was piloted during a 15-month period. Data analysis report patient satisfaction increased with 1-hour and 2-hour rounding ($p = .001$), but patient falls decreased with only 1-hour rounding ($p = .672$). These results are similar to results reported by Meade et al. (2006,) which did not find a significant decrease in falls with 2 hours rounding, suggesting the importance of nurse presence

to increase patient safety. Most studies have tested the effects of patient falls using 1-hour rounds, which reported significant decreases in patient falls and injuries (Assi, Wilson, Bodino, & Lemenski 2008; Brosely and March, 2015; Culley, 2008; Ford, 2010; Haack, 2007; Halm, 2009; Meade et al., 2010; Studer Group, 2007; Weisgram and Raymond, 2008; Woodard, 2009). Rounding is a cost-effective strategy to maintain patient safety and increase patient satisfaction. Brosey and March (2015) evaluated the monetary effect of hourly rounding on patient falls. After implementation of an hourly rounding protocol, fall rates decreased from 3.18 falls per 1,000 patient days to 2.19 patient fall rate per 1,000 patient-days, which led to saving of \$46,563 in savings from related injuries.

Call Light Usage

Studies in the literature support Meade's et al., (2006) findings that hourly rounding significantly reduces call light usage (Culley, 2008; Haack, 2007; Halm, 2009; Meade et al., 2006; Studer Group, 2007; Weisgram and Raymond, 2008). The anticipation of nurse presence to assist with comfort care needs every hour, decreases patient anxiety, and decreases patient calls for assistance (Ford, 2010). Less responses decreases nurse workload and increases nurse job satisfaction (Duffin, 2010).

Nurse Perception of Call Light Usage

Tzeng (2010), studied the perspectives of staff nurse's response to call lights using an exploratory, cross-sectional survey study in four United States Hospital. A total of 808 surveys were completed using licensed and unlicensed nursing staff members. A descriptive and binary logistic regression analyses were conducted. The most common causes for call light usage include; toileting assistance, pain medication, and intravenous problems, with toileting being the

most common. Each staff responded to 6 to 7 call per hour, which was answered within four minutes. Forty-nine percent of staff perceived calls mattered to patient safety, 77% agreed the calls were meaningful, 52% thought the call required the attention of a nurse, and 53% perceived answering calls prevented them from doing critical aspects of their job. Across hospitals new nurses were more likely to overlook the importance of answering call light. This is not surprising, since the transition from nursing school to working in a hospital is overwhelming and overloading (Nelson, 2010). New nurses are task oriented, and with experience will develop the skill of multi-tasking. Nurse's leaders need educate nurses on the value of communication and patient safety over speed. Vital patient communication during illness is one way that cognitively intact patients can control over their care (Tzeng, 2010). In a study by Deitrick et al., (2012), the most common causes for patient dissatisfaction include; delays in staff answering call lights, the amount of time it took to complete the patient's request once the light was answered, and the patient's request not being completed once the call light was answered. According to Meade et al., (2006), call lights are patients' life line to communication.

Patient Leaving the ED Without Being Seen

According to the Pulse Report (2010), patients wanted their pain controlled, and wanted to be kept informed about delays, and a plan of care. The Studer Group (2007), evaluated 32 emergency rooms that implemented hourly rounding using the PPD protocol as a guideline to meet patient needs. The study reported a significant reduction in patients who LWBS (23.4%) and a significant decrease in the number of patients who left against medical advice (22.6 %). Similar results were reported at Regional Medical Center in Texas, which has 50,000 patients' visits annually in the ED (Baker, 2012). After implementation of hourly rounding and using the

PPD hourly rounding protocol, the rate of patients who LWBS decreased from 6% to 2%, with a return on investment of \$480,000. This monetary value was based on seeing an additional 2,000 patients per year at an average treat and release rate of \$240 per patient.

Barriers to Implementing Hourly Rounding

False Perceptions

Barriers to implementing hourly rounding in the ED is based on false perceptions that nurse workload is increased. However, evidence-based studies report hourly rounding is a resource that improves work organization, thereby decreasing nurse workload and conserving nurse energy. Carins (2010), investigated nurse's perceptions on the use of hourly rounding in a large urban teaching hospital. At the one-year completion of the project, nurses were asked to rate their perception of hourly. Analysis of the data report 94 % of nurses agreed it was beneficial for patients, 85% of nurses agreed it was beneficial for staff, and 72% nurses agreed workload was decreased. Nurses need to be educated on the benefits of hourly rounding to translate evidence into nurse care practice (White and Dudley-Brown, 2012). Hourly rounding in the ED, even in the face of nursing shortage, can be implemented and sustained if collaboration and a team approach is used. Most literature refers to hourly rounding being done by nurses or nursing assistants. In the ED, hourly rounding usually is the responsibility of the triage nurse. However, multiply other disciplines can be utilized to achieve the same results as nurses and nursing assistants, which include; registration clerks, security, chaplains, case managers, patient services, ancillary staff, and volunteers (Baker, 2012).

Lack of Leadership

An additional barrier in implementing hourly rounding is familiarity with old behaviors and interventions, even if it doesn't improve clinical outcomes. Dyck, Thiele, Kubicz, & Erenberg, 2013, initiated hourly rounding in a long-term care facility, after in-servicing nursing staff. Although, the study reports a significant decrease in patient falls, the program failed to sustain improved outcomes. Main challenges cited were establishing a shared vision, neglecting to include interpersonal stakeholders, role confusion, and lack of accountability. Nurses assumed hourly rounding would produce more work, creating resistance. Conflict was created because it was unclear who was to do the hourly rounds, and lack of nurse manager follow-up passively communicated that continued participation wasn't important. In a second attempt to sustain hourly rounding, the institute brought together interpersonal health care providers from across the region with the purpose of building leadership skills. These providers, educated nurses on the rounding process, stated the purpose for needed change, and clarified roles. Nurse leaders maintained an active role by communicating the critical nature of increasing patient satisfaction, sharing data of the project during daily huddles, and held the team accountability by checking daily signed hourly rounding logs. Re-analysis of data after a second pilot project, there was 100 % staff compliance and sustained increase in patient satisfaction scores. Hourly rounding found its way into the organizational culture (Dyck et al., 2013). Culley (2008) highlighted the importance of dedicated education and use of staff champions as role models when initiating an hourly rounding project. Utilizing a reward system also increases nurses to buy into the system. However, it is not an increase in monetary rewards that increases sustainability but rather recognition of nurse's contribution to the success of the program (Baker, 2012). A method for

positive reinforcement is the distribution of project data on clinical outcomes within a timely manner (Baker, 2012; Dyck, et al., 2013; Olrich et al., 2012). Leaders also need to initiate hourly round on patients to verify if staff are consistent with rounding. It is also important to illicit patient feedback by asking questions such as “Our goal is to manage your pain effectively. Did your nurse reassess your pain?” (Baker, 2012)

General Review of the Literature

Literature Background

Patient satisfaction surveys provide organizational leadership with valuable insights into the performance of their ED. The topic of patient satisfaction evolved with the development of Press Ganey surveys in 1985 by Irwin Press, PhD, a medical anthropologist, and Rod Ganey, PhD, a sociologist and statistician (Press Ganey, 2015b). To improve quality health care, the rigorous and valid scientific survey created a new market of patient experience measurement, performance analytics, and strategy advisory solutions for health care organizations (Press Ganey, 2015a; Siegrist, 2013). According to the American Academy of Emergency Physicians (2011), improving patient satisfaction increases the likelihood of patients to be more compliant with care, reduces malpractice claims, improves staff morale, generates hospital revenue, encourages patients to return to the institution for future, and attracts potential new patients.

Hospital Consumer Assessment of Health Care Providers and Systems

In 2012, Press Ganey Survey was replaced by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) to measure inpatient quality initiatives (CMS, 2014; HCAHPS, n.d.). Outpatient facilities, such as the ED, continue to use Press Ganey surveys, which was developed by the CMS (2014) and AHRQ (2011). HCAHPS is the first

national, standardized, public reporting of patients' perspective on health care (CMS, 2014).

Studies report a strong correlation on Press Ganey scores and in-patient HCAHPS scores.

Positive ED experiences positively correlate with higher HCAHPS scores, making the ED the "front door to the hospital" (American College of Emergency Physicians, 2011). Nurses need to increase their knowledge on quality initiative measures on Press Ganey Surveys and HCAHPS survey to have a synergetic view of the organizational culture rather than the sum of its parts (American Association of Critical Care Nurses, 2016).

Hospital Value-Based Purchasing Program

CMS no longer provide reimbursements to hospitals based on quantity of care provided to Medicare patient. Instead, CMS bases reimbursement on the quality of care received using an approved set of hospital performance measures, which is compared to the national benchmark (CMS, 2015a). As part of its Hospital Value-Based Purchasing Program, CMS has decreased the hospitals base operating diagnosis-related group revenue by 1% (CMS, 2015b; Zusman, 2012). This was created to promote an incentive fund, estimated at \$850 million, to improve quality cost-effective health care initiatives. This money is redistributed to 3,500 hospitals across the country based on their overall performance, 30% of which is based on HCAHPS patient satisfaction scores (CMS, 2015c; Guadagnino, 2012, Rau, 2011, Zusman, 2012). Hospitals that fail to achieve VBP benchmarks will see financial impact of up to 2% of total CMS reimbursements by 2017 (Davis, 2015). This incentive drives competition among organizations to implement new strategies to improve patient's hospital experiences.

HCAHPS and Public Reporting

The ACA of 2010 has made health care more affordable and accessible to all Americans (CMS, 2015b). However, it also has made individuals more accountability for health care costs by requiring most legal residents of the United States to obtain health insurance. Those that do not comply, pay a penalty tax that is approximately \$695 per person (CMS, 2014). Consumers paying into their health care are now more vested in making informed decisions when shopping for health care, choosing providers, and deciding on treatment (CMS, 2015c). Press Ganey Survey scores and HCAHPS scores are available for consumers to review on public websites, which empowers consumers to make informed decisions by using comparisons of hospitals performance of quality measures (CMS, 2014; Medicare.gov, 2016; Zusman, 2012). Poor performance on Hospital compare can impact a hospital's reputation, causing consumers to seek health care services elsewhere, threatening the survival of the institution.

Barriers to Patient Satisfaction

Barriers that create negative perceptions of quality care in the ED include; overcrowding, lack of communication on wait times and treatment plan, patient and organizational demographics, nursing shortage, burnout, and compassion fatigue (Baidoo, Asare-Kumi, Nortey, & Kodom, 2016; Isaac, Cleary, Zaslavsky, & Landon, 2010; Rathert, Williams, McCaughey, & Ishqaidef, 2012).

ED Overcrowding

Historically, high costs of health insurance premiums left many Americans without insurance and without access to health care, requiring them to utilize the emergency room for primary care type illnesses causing overcrowding and long waits to be seen (Erenler et

al., 2014). Using the ED as a primary care facility, imposes on an already stressful, chaotic, and high acuity unit. In 2010, the Department of Health and Human Services (HHS) working with the states, implemented a new regulation to protect Americans against inflated insurance premiums (HHS, 2012a; HHS, 2012b). The proposed regulation required insurance companies to publicly report reasons for increases in premiums above 10%, along with justification for increases. To hold insurance companies accountable, the ACA awarded the Department of Health and Human Services \$46 million to oversee unreasonable insurance rate hikes and increased federal sentencing guidelines by 20% to 50% for crimes health care fraud resulting in over \$1 million in loss (CMS, 2010; HHSa; HHS, 2012b). The assumption for promoting these laws were to increase access to primary care facilities and decrease overcrowding in emergency rooms. However, since the ACA was instituted in 2010, the number of visits to the emergency room have increased by 34%, while the number of emergency room closures have increased by 11% (CMS, 2015c). Reasons for increased overcrowding include; physician shortage estimated to reach more than 45,000 by 2020, doctors that will not accept Medicaid insurance, primary care facilities that do not provide hours to accommodate the working population, individuals that don't have doctors, and habitual practice of using the ED for minor illnesses (ACEP, 2011). Overcrowding decreases communication, increases the risk of patients that leave the emergency room without being seen, increases interruptions by patients and families seeking information, increases medical errors and law suits, increases patient falls, increases nurse workload, increases patient falls, and result in poorer patient outcomes (Handel et al., 2010).

Lack of Communication

Johnson et al., (2009), conducted a study on wait times and patients that leave the ED without being seen at an ED with 65,000 yearly visits. Within eight days, 56.7% of those patients were interviewed by phone to evaluate contributing factors for leaving. It was not the wait time that was the ultimate factor for leaving, which was the assumption, but rather the lack of communication on delays and plans of care (Myers et al., 2009). Lack of communication, causes patients and families to frequently request information, increasing the risk of medical errors (Carmargo et al., 2012). A National Emergency Department Safety Study in 62 EDs in the United States to evaluate medical errors (2012). The results reported 402 adverse events (incidence rate of 4.1 per 100 patient visits) and 532 near misses (incidence rate of 5.4 per 100 patient visits), of which 37% adverse events and all near misses were preventable medical errors (Carmargo, et al., 2012).

Nursing Shortage, Burnout, and Compassion Fatigue

The American Association of Colleges of Nursing (2014), estimates that by 2020, there will be a need for an additional 3.44 million registered nurses (RN), a 20.2% increase from 2014. The need for additional nurses are based on the increase health care needs of this aging population and increase RN vacancies as “baby boomers” retire. In 2014, the RN turnover rate was 17.2%, with a job vacancy of 6.7%. In 2015, it took nurse recruiters 53 to 110 days to fill empty RN positions, an increase of more than 14 days from the previous year. The average cost of turnover for a bedside RN averages \$36,900 to \$57,300 According to the RN Retention Report of 2015, the average cost from RN turnover per hospital in the United States is \$4.9 to \$7.6 million. Lack of staffing creates gaps in providing quality comfort care to patients (Larson,

2012). Chaotic and stressful EDs, overcrowding, nurse shortage, excessive call light usage, and adverse events depletes nurse's energy, rendering them powerless to care for self and others (Watson, 2008; Larson, 2012). In a study by Meade et al., (2006), nurses are called an average of 12 to 15 times an hour to assist with comfort care needs. Persistent ringing of call bells can become very frustrating, especially when the ED is short-staffed and each nurse has been assigned an overwhelming patient load. Inability of nurses to respond to patient calls within a timely manner compromises safety, such as patient falls resulting from unassisted patient ambulation to the bathroom. Patient falls in the ED are the most common adverse events reported in hospitals (Terrell, Weave, Giles, & Ross 2009).

Hooper et al., 2010 conducted a study on registered nurse burnout and compassion fatigue in the emergency room. Approximately 82% of RN's had moderate to high levels of burnout and 86% had moderate to high levels of compassion fatigue. Emotional distress felt by nurses' result in physical illness, occupational injuries, interpersonal work conflict, low staff morale, sick calls, and high nurse turnover (Wisniewski, 2012). Burn out and compassion fatigue decreases responsiveness to patient care needs causing lack of positive nurse-patient connectedness, decrease patient satisfaction scores, and decreases nurse job satisfaction (Palese, et al., 2011). Peltier and Dahl (2009), report efforts to create higher employee satisfaction have a very desirable outcome on improving quality care and increasing patient loyalty. The report recommends that one effective method of increasing patient satisfaction is meeting the needs of employees and by viewing employees as internal customers (Sheffield, 2016).

Perception of Nurse Caring

According to Branley and Matiti (2014), being mindful of patients perceived needs and fulfilling those needs shows empathy and compassion. Bramley and Martiti, studied the perception of patient's experience with nursing care, using a qualitative descriptive design. Semi-structured interviews were conducted using 10 patients in a large teaching hospital. Themes that emerged include; compassion: knowing me and giving me your time (e.g., the use of touch for comfort, providing encouragement in the time of adversity, and listening) and compassion: how it feels to be in my shoes (e.g., reflection of motivation of nurses to resolve the discomfort and relieve suffering). Lastly, the theme communication and essence of nursing had conflicting patient responses. Some patients felt nursing is an intrinsic value that someone is born with. Other patients felt compassion is a trait that can be learned, especially if the organizational culture treat their employees well, which in return cause nurses to treat their patients well.

Understanding patients' expectations and motivations for seeking treatment in the ED is an important part of maximizing patient satisfaction. Rhmati, Gholamlipoor, Hashemi, Forouzanfar, & Hosseini (2015), conducted a survey using 123 patients on patient's perception of care. The study correlates low patient satisfaction with staff attitude. Nurse behaviors can significantly balance out negative perceptions of caring by dimensions which include; courtesy, reliability, communication, competence, understanding, access, patient outcomes, responsiveness, and collaboration. However, the largest determinant of patient's perception of caring is nurse empathy (Baidoo et al., 2016). Nurse-patient interpersonal interactions are a critical predictor of patient satisfaction. The perception of nurse comfort care, such as the alleviation of pain, supersedes nurse's technical competence (Welch, 2010).

Conceptual Model and Theoretical Framework

The review of literature brought together two sources to form the conceptual model and framework for this project, which include; Kolcaba's theory of comfort (1991) and the Studer Group model (2007). Kolcaba's Comfort Theory, is a middle range nursing, which was derived from numerous sciences, such as; nursing, medicine, psychology, psychiatry, and economics. Assessment can be based on objective nurse findings or subjective based on the patient's perceptions of needs. Comfort exists in the form of ease, relief, and transcendence, which exists in the domain of physical, implement intervention that promote comfort in the state of ease, relief, and transcendence. Transcendence is described as the state of comfort in which patients can rise above their challenges and use health seeking behaviors to improve health care outcomes. Domains in which comfort can occur include; physical, environmental, psychospiritual, sociocultural. Press Ganey patient satisfaction questions can be used to in each domain to provide individualized patient centered care (Appendix A). Nursing is the process of the intentional assessment of comfort needs that is based on objective patient and subjective observations. Meeting patient care needs would increase patient's perception of receiving quality care, patient satisfaction, and institutional integrity.

The Studer Group model (2007) and Kolcaba's theory of comfort (1991), used specific nurse behaviors in anticipation of the 4 *P*'s of comfort care needs (pain, position, potty, and possession). During structured times for patient assessment, key words, scripted cues, and select questions were used to create individual plans of care and communicate nursing caring, listening, respecting. Patient anxiety is decreased knowing they will see a nurse or nursing assistant, on a continuous set time schedule to address comfort needs. Enhanced patient security decreases

nurse calls for assistance and decreases nurse workload. Utilizing a team approach, hourly rounding is a holistic and cost-effective approach to improve quality of care, promote a safer environment, and increase patient satisfaction of nursing care, decrease nurse workload, and increase nurse job satisfaction.

Summary

Kolcaba's theory of comfort (1991) and Studer's Group model (2007) were the conceptual frameworks used to guide this quality initiative project. Both theories focused on providing individualized patient care to enhance comfort and maximize health care outcomes. However similar, Studer's Group model advances the concept of comfort to include scheduled assessments in anticipation of comfort care needs. Anticipation of needs changes the traditional practice of reactive nurse interventions to proactive nurse interventions to prevent patient falls, decrease the rate of patients who LWBS, and increase patient satisfaction of care.

Section 3: Methodology

Introduction

Patient satisfaction scores, in the urban trauma center examined in this study, have been persistently below the set goal of 70th percentile (M. Scuzzillino, personal communication, April, 2016). Low patient satisfaction scores have been associated with gaps in addressing patient comfort care needs, lack of communication on delays for treatment, and lack in patient safety (Press Ganey, 2015a). Patient satisfaction scores, fall rate, and the number of patients who leave the ED without being seen has steadily risen since the ACA was instituted in 2010 (M. Scuzzillino, personal communication, April 4, 2016; CMS, 2014). The ACA increased access to medical care, in an era of nurse shortage, increasing ED overcrowding. Lack of staff presence

increases patient falls as they attempt to ambulate to the bathroom without assistance, resulting in injuries, extended length of stay, and decrease reimbursement for never events. Failure to communicate delays in wait times and treatment cause frustrated patients to LWBS, decreasing access to medical care (Erenler et al., 2014). Patients' perceptions of receiving poor quality care discourages them to return for further treatment and via word of mouth discourages new consumers, threatening the viability and survival of the institution.

This quality initiative project was in response to the lack of nurse education on the use of an evidence-based tool and protocol to increase patient assessment and provide individualized comfort care to decrease patient falls, decrease the number of patients who LWBS, and increase patient satisfaction scores. An evidence-based hourly rounding educational workshop was developed to increase nurse's knowledge on proactive nurse practices, based on the Studer's Group model (2007) and Kolcaba's theory of comfort (1991), to provide quality and safe patient care. Because this educational workshop and educational materials will be used by this facility later, an implementation plan and evaluation plan were included with the lecture content and PowerPoint presentation.

Project Design and Methods

The problem that I addressed in this project was the lack of nurse education on the use of an evidence-based tool and protocol that organizes workflow, offers efficiencies by giving nurses time back to proactively, rather reactively, anticipate and address patient comfort care needs (Halm, 2009). Evidence to address this gap was reviewed and synthesized. The evidence supported the development of a quality improvement project in which an hourly rounding educational program, instructional course materials, implementation plan, and long-term

evaluation plan was designed and developed. I presented the information in a classroom, to an expert panel, using face-to-face lecture format and PowerPoint presentation.

All activities related to the presentation of the educational workshop and formative evaluation occurred after IRB approval was obtained. The list of purposeful sample and email addresses was obtained by the nurse director of the ED. An email was sent to each participant to introduce the gap and problem identified in the ED. They were asked to participate in a formative evaluation of a nurse education workshop on hourly rounding. All 10 participants volunteered to participate in the project and was provided with date, time, and location for the formative evaluation of the educational workshop and educational materials. An agenda for presentation of the project and objectives was sent one day prior to the presentation via email.

Protection of Human Subjects

Protection of human subjects was maintained always during the study. Participation in this study was voluntary. Participant personal identifiers were not collected on the evaluation forms. I honored any concern from the participants about withdrawing from the project upon their request. No one requested to withdraw during this study. Consent was obtained from the Walden University Institutional Review Board (IRB); the approval number for this study was 01-19-18-0439992.

Anticipated Population and Sampling

The population of this study was a 10-member expert panel which included the nurse manager of the ED, nurse director of the ED, medical director of the ED, nurse supervisor, and six seasoned nurses (three from day shift and three from night shift). The nurse manager has been working in the ED for more than 15 years. She is responsible for the collection of data on

quality initiative projects, reports data to the director of nursing for analysis, and assesses the overall functioning of the ED. The director of nursing has worked at the facility for 20 years and is vested in implementing evidence-based tools and protocols to improve quality and safe-care. She is knowledgeable in the analysis of research data and communicates the need for change through her understanding of gaps in care.

Because the nurse educator is out on family leave, the nurse supervisor has become the clinical expert in the ED for training nurses on program development initiatives. She has worked at the institution for 5 years. The six seasoned nurses have worked in the ED for more than 3 years. They are frontline team players in the identification of problems, implementation of new protocols, mentoring new nurses, and reporting of barriers that prevent meeting patient's expectations of care. The ED director of medicine works in collaboration with the ED nurse director, to maintain compliance with policies and procedures. He has been at this hospital for 3 years and provides medical care to the acute care population.

Instrument

The validated ADDIE worksheet was a mixed quantitative and qualitative formative evaluation tool, developed to provide data on the efficacy and content validity of project (Culetta, 2013). Permission for use of an adapted version of this tool was obtained from the University of Texas Medical Branch at Galveston, which is a faculty development program (Appendix B). The survey contains twenty closed ended (yes or no) questions. Each closed ended question is followed by open ended comment section. The five phases of the ADDIE model include; analysis, design, development, implementation, and evaluation (Appendix C).

Collection of Data

The participants met in a conference room where they were served coffee/tea and danish during the sign in. Each participant was given a paper name tag, which contained their first name only. A copy of the PowerPoint objectives was given to the participants at the onset of the program. In addition, they were provided with the hourly rounding tools, which included the hourly rounding sign in log and competency check list. This was followed by a 2-hour lecture and PowerPoint presentation given by the DNP student. At the completion of the presentation, each participant was handed an anonymous adapted ADDIE worksheet, with directions for completion and return, and an unmarked envelope. The expert panel was given a one-week time for completion and return of the confidential evaluation. All surveys were dropped off in the assigned box, located in the director of nurse's office. The sealed envelopes were given to the DNP by the director of nursing. All ten surveys were returned.

Summary

The problem addressed in this proposed project was the lack of nurse education on the use of an evidence-based tool and protocol that organizes workflow, offers efficiencies by giving nurses time back to proactively, rather reactively, anticipate and address patient comfort care needs. Hourly rounding is an evidence based tool and process identified in review of the literature as a solution to address the gap in comfort care. An hourly rounding educational workshop, including lecture, PowerPoint presentation, and educational materials were developed by the DNP student. The contents were grounded in Kolcaba's theory of comfort (1991) and the Studer's Group model (2007). A purposeful expert panel consented to participate in a formative evaluation for feedback on the content validity. Following the presentation, the anonymous

adopted ADDIE model paper worksheet was given to the expert panel, attached to an envelope unmarked envelope. Directions were given for completion of the survey and for return of the contents. All 10 surveys were received and given to the DNP student by the director of nursing.

Section 4: Findings, Discussion, and Implications

Introduction

The ACA of 2010 increased access to medical care for all Americans, in an era of nursing shortage, which has caused overcrowding in this city trauma ED. As a result, the rate of patient falls has increased, the rate of patients who LWBS has increased, and patient satisfaction scores have decreased. Evidence-based studies support the use of an hourly rounding protocol to improve quality care, increase patient safety, and individualize patient comfort interventions. The problem that I addressed in this project was the lack of nurse awareness on the use of proactive behaviors and scripted cues that anticipates and addresses patient comfort needs during a systemized time protocol.

In response to this need, I developed an evidence-based and theoretically grounded hourly rounding nurse training workshop and educational materials, based on Kolcaba's theory of comfort (1991) and the Studer's Group model (2007). A voluntary expert panel was created for a formative evaluation of the educational workshop and educational materials, using an adapted ADDIE worksheet. The unmarked worksheets and envelopes were provided to the panel after the presentation. The confidential surveys were returned in the attached sealed envelopes and were placed in a box located in the designated location. All 10 surveys were returned and given to the student by the director of nursing.

Findings and Implications

Formative Evaluation

A frequency distribution was used to record the data provided by the expert panel (Appendix D). There was minimal open feedback and lack of grouping themes was not

warranted. The adapted ADDIE worksheet consists of 20 questions. Questions were categorized into five sections which included analyze, design, develop, implement, and evaluate. Each section had subsections for participants to answer a closed ended yes-or-no question, followed by the potential to add open ended comments (Appendix E).

Formative Evaluation Revisions

The formative evaluation feedback was used to revise the training program by adding a section to the hourly rounding training agenda sheet to include the lecturers name, department, email, and office phone number and including a checkoff list on the hourly log indicating who performed the round (nursing or nursing assistant). Limitations of this hourly rounding educational workshop was the lack of open feedback from the expert panel. Including additional staff, such as nursing assistants who are frontline team players, may have increased feedback that could have improved the content validity of the hourly rounding educational workshop. Breaking the workshop into individual days during lunch works would likely not have increased participation, because many interruptions could have occurred (e.g., cardiac arrest).

Summative Evaluation of Revisions

Following the revisions, a meeting was held with the expert panel. A presentation and poster was used to review the modified contents and to update the participants on the revisions. There was 100% consensus on acceptance for the revisions.

Implications for Change/Recommendations for Change

The formative evaluation data indicated the educational workshop was comprehensive, increased nurse's knowledge on proactive nurse behaviors to promote comfort care, provided a feasible plan for implementing hourly rounding, and provided an evaluation plan for the process.

Providing nurses with tools to provide patient centered care is a cost-effective approach to decrease patient falls and decrease the rate of patients who LWBS. Hourly rounding uses evidence-based practice for implementing new behaviors to increase patient satisfaction and nurse job satisfaction, providing a win-win solution in this era of nursing shortage and ED overcrowding. A social change has occurred in the population as patient in need of health care are now considered consumers of care. A change in traditional practices from reactive nurse behaviors to proactive nurse behaviors is needed to meet consumer's perceptions of nurse caring, listening, and respecting. Meeting patients comfort care needs increases patient compliance with treatment, decreasing comorbidities and mortality. Ultimately, increased patient satisfaction promotes institutional integrity and survival, and provides the community access to medical care. This aligned with the goal of Healthy People 2020, the social change of disparities to access health care that limits people's ability to reach their full potential and negatively affects their quality of life.

Discussion of Findings in the Context of Literature and Framework

The researcher was given the opportunity to use evidence-based studies to change nursing practice by the development of an hourly rounding educational workshop. The use of Kolcaba's conceptual framework (1991) and the Studer Group model (2007) incorporated nurse interventions to promote comfort interventions to perceived patient needs. Kolcaba identified common comfort needs of patients within the concepts of relief, ease, and transcendence. Studer's model took this one step further by anticipating most commonly reported comfort needs that studies have correlated to patient falls, patients leaving without being seen, and decreased patient satisfaction with care. The use of proactive nursing behaviors and scripted cues, during

timed schedules, addresses these common needs and decreases the risk of adverse events, decreases impaired communication, and decreases patient frustration. The incorporation of both frameworks complement each other and provides goals to achieve optimum patient care outcomes.

Project Strength, Limitations, and Recommendation for Remediation of Limitations

Project Strength

The first strength of this project was the use of an evidence based solution to decrease the gap in nursing practice. The second strength was the development of an hourly rounding workshop, PowerPoint presentation and educational materials that was formatively reviewed by an expert panel for feedback. The data from the adapted ADDIE worksheet indicated efficacy and validity of content. The workshop was considered comprehensive, increased nurse's knowledge on proactive nurse behaviors to promote comfort care, provided a feasible plan for implementing hourly rounding, and provided an evaluation plan for the process.

Project Limitations

The first limitation of this project was the busy schedules of the expert panel, which may have rushed them through the surveys, and prevented more detailed comments for feedback. The second limitation of the project was the lack of nursing assistant's participation to increase representativeness of the target population.

Remediation of Limitations

One recommendation for future projects in this chaotic ED would be to change the method for obtaining feedback from the clinical expert panel. To facilitate the time clinical experts should concentrate and evaluate the validity of the educational materials and contents.

The adapted ADDIE worksheet should be distributed and completed directly after the conclusion of the training workshop to help facilitate the time clinical experts should concentrate and evaluate the validity of the educational materials and contents. Feedback could be increased to create a conducive learning environment (e.g., serving coffee and dessert, providing a quiet room to concentrate and answer survey questions). The second remediation is the inclusion of seasoned nursing assistants as part of the clinical expert team to increase the representativeness of the emergency room team. Lastly, it would be recommended to revise the agenda to include the lecturers contact information to facilitate communication.

Analysis of Self as a Scholar, Practitioner, and a Project Developer

Scholar

The journey through the DNP program has increased the student's knowledge and ability to implement evidence-based solutions to fill the gaps in nursing practice. The development of this educational hourly rounding protocol reflected the acquisitions of skills obtained in the application of analysis, design, development, and evaluation of quality initiative project, guided by various scientific disciplines and theories. The student's concern over the gaps of care in this trauma center was the lack of education using evidence-based interventions that could not only improve patient outcomes but also improve nursing outcomes. In addition, the student increased understanding of health care policies, in such a complex system, provided a holistic viewpoint on providing quality, cost-effective, and safe care. Lastly, creating and working with an expert panel increased my organizational skill as a team leader, as well as increased communication skills to enhance interactions within the organizational system.

Practitioner

The student's motivation as a practitioner for this project was to advocate for the delivery of comfort care that would be patient centered and guided by patients' set goals, empowering them to be the gatekeeper of their care. Traditionally, nursing care was implemented to suit the needs of all patients. However, using a patient centered approach in providing nursing care emphasized the uniqueness of each patient in achieving wellness. To individualize care would create an environment that is healing and allow patients to use energies to self-soothe and ultimately improve health care outcomes. In addition, the student's role as a practitioner in this project was guided by the AACN DNP position statement (AACN, 2006), which advocates for advanced competencies, organizational and systems leadership roles to promote change, enhanced knowledge to improve practice and patient outcomes, enhanced leadership skills to strengthen practice and improve the delivery of care, integrated sciences, and addressed health care concerns through policy.

Project Developer

As the project developer for this educational hourly rounding workshop, the student realized there were two customer concerns, the internal customer (nurse) and external customer (patient). To improve patient care outcomes (e.g., decreasing patient falls, decreasing the number of patients who LWBS, increasing patient satisfaction scores), the needs of the internal customer had to be combined for a holistic view of the human connection (e.g., nurse stress, nurse workload, nurse interruptions). In this quality improvement project, all stakeholder needs were addressed when choosing an evidence based solution. Hourly rounding protocol is a systems approach to meet the needs of nurses, patients, organization, and community.

Summary and Conclusion

The development of an hourly rounding training workshop for emergency room nurses and nursing assistants provided an evidence-based guideline to increase awareness of proactive behaviors to increase patients' perception of receiving comfort care that reflected nurse caring, respecting, and listening. Hourly rounding decreases patient falls, decreases the number of patients who LWBS, and increases patient satisfaction of care. A formative evaluation of this quality initiative educational workshop, presented to an expert panel, provided data for revisions to increase the efficacy and content validity of the project. Suggestion for revisions include adding nursing assistants in the expert panel, identifying methods to enhance communication between lecturer and trainees, and providing a conducive environment to increase feedback. Overall, the PowerPoint educational workshop and educational materials were an effective teaching tool, which will be implemented for use in the ED later.

Section 5: Scholarly Product

Project Dissemination Plan

The DNP capstone projects are valuable sources of information in today's nursing's era of evidence-based practice to optimize patient health care outcomes. Capstone projects represent and illustrate the result of knowledge and skills gained throughout DNP courses and activities (Resnick, 2013). Information can be shared in the form of articles, oral lectures, media interview, poster presentation, policy briefs, seminars, journal clubs, newsletters, flyers, brochures, and conferences (Zaccagnini & White, 2011).

Poster Presentation

I plan to disseminate this project at the urban trauma center via poster presentation (Appendix F). My goal is to provide the stakeholders in the ED with the data results of a formative evaluation provided by an expert panel on an educational workshop and material for the process of hourly rounding. The poster board will include revisions of the feedback to increase the constructive validity of the education content and material. The information will establish how hourly rounding is effective. Increasing nurses' awareness of the benefits of hour rounding may persuade may persuade them to use evidence-based interventions to decrease the quality gap in patient care. The poster board will be placed in the charting room to engage colleagues in a dialog about the work. Summary handouts will be available and kept next to the poster board with my contact information (email and office number), should anyone have questions about the presentation. A sign-up sheet will also be available for those who would like to be contacted.

Manuscript Publication

The intent of this student will be to publish the manuscript by sending query letters to editors from scholarly journals. According to *American Nurse Today* (2017), when choosing a journal, key questions that should be asked include: (a) What are the most important points in the capstone project? (b) Who are the readers that would benefit from the information? and (c) Where would this group of readers be found? In reviewing these questions, I choose the *Journal of Emergency Nursing*, because the topic is of relevance to nursing practice in the ED. Educating nurses about evidence-based tools will change practice from reactive to proactive interventions that will decrease adverse events; increase patient safety; decrease nurse workload; and increase patient's perception of nurse caring, listening, and respecting.

Lecture Presentation

An oral lecture will be presented, in June 2017, during nurse grand rounds to increase nurse's awareness of gaps in quality care in the ED. The goal is to communicate the need for the use of evidence-based protocols to change practices that will improve outcomes on an organizational, patient, nurse, and community level. The 2-hour presentation will be highlighted with a PowerPoint slide show (Appendix G). The educational contents and materials developed were provided to the director of nursing for future use in a pilot project on the implementation of hourly rounding in the ED (Appendix H).

Discussion

The expert panel provided feedback on an hourly rounding workshop using a formative evaluation. The data indicated constructive validity for the educational contents and educational materials. This tool will service as an educational resource for the nurses and nurse assistants

when an hourly rounding protocol is implemented. Minor revisions were made following the feedback from the adapted ADDIE worksheet. The revisionist included adding the lecturers name, title, department, and contact information to facilitate future communication, describing the persons' role on the hourly rounding log to improve accountability (nurse or nurse assistant). Suggestion for revisions include adding nursing assistants in the expert panel, identifying methods to enhance communication between lecturer and trainees, and providing a conducive environment to increase feedback.

Conclusion

This project was an initial step toward developing an educational workshop for nurses and nurse assistants at this urban trauma center. This educational workshop included lecture contents, PowerPoint slides, and hourly rounding tools (hourly log, leadership competency checklist, and nurse behaviors and purposes during rounding). This project used a formative evaluation, by an expert panel, for feedback on revisions to increase the efficacy and validity of the contents. A review of the revisions was provided in a follow-up meeting with the key stakeholders prior to the finalization of the educational workshop and materials. This review ensured the accuracy and approval of the project.

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Appendix A: Kolcaba's Comfort Theory

	Relief	Ease	Transcendence
Physical	Pain Position Potty/elimination Intravenous/IV pumps Possessions	Patient falls Lawsuits Decrease Medicare	Pain is controlled 0 to 2 Patients assisted with turning, ambulation to lavatory or given a bedpan/urinal Intravenous sites show no signs of infiltration or inflammation IV bags are full Telephone, call light, water pitcher, waste basket, and overhead table are within reach Medicaid reimbursements are increased
Press Ganey Survey Questions: Information the care provider gave you about medications (if any)? Friendliness and courtesy of the care provider?			
Psychospiritual	Anxiety Fear of the unknown Lack of communication	Increase call light usage Nurse interruptions Medical errors Nurse burnout Increase sick calls High RN turnover	Nurse patient-ratio is adequate Noise is limited Hourly rounding compliance 100% Patient/families included in treatment plan and discharge plan Adherence to treatment
Press Ganey Survey Questions: Amount of time the care provider spent with you? Care provider's efforts to include you in decisions about your treatment? Degree to which care provider talked with you using words you could understand? Explanations the care provider gave you about your problem or condition? Instructions the care provider gave you about follow up care (if any)?			
Environmental	Overcrowding	Long wait time Delays in treatment Unanswered questions	Patients are high risk for leaving on identified according to patient demographics and

		Patient leaves without being seen	highlighted in medical record Diversion activities in place Patients understand the ED process
Press Ganey Survey Questions: Concern the care provider showed for your questions or worries?			
Sociocultural	Lack of nurse presence	Isolation	Distractions and explanations decrease perception of wait times Recommends facilities to others
Press Ganey Survey Questions: Your confidence in your care provide? Likelihood of your recommending the care provider to others?			

Appendix B: Copyright Permission

From: Rudnicki, Anne T.
Sent: Wednesday, January 25, 2017 4:02 PM
To: Marie Chapnick
Subject: RE: ADDIE model worksheet

Dear Marie,

Yes, you have my permission to use the ADDIE worksheet and adapt it for your doctorate of nurse practitioner developmental project. My name and titles are in my email signature below, for your reference.

Thanks, and let me know how it goes. I will be interested to hear how you apply the worksheet within your project and your outcomes.

Sincerely,

Dr. Anne Rudnicki

Anne Rudnicki, EdD
Senior Medical Educator
Assistant Professor of Pediatrics
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Appendix C: Adapted ADDIE Worksheet Survey

Analyze**Learning Problem**

1. Was a learning need identified?

Yes _____

No _____

Comment:

2. Was the problem and gap in practice relevant to nursing practice and quality care?

Yes _____

No _____

Comment:

3. Was the project development based on evidence-based studies?

Yes _____

No _____

Comment:

Learners

4. Was the audience identified?

Yes _____

No _____

Comment:

5. Was the educational level and job description of the learners aligned with the learning objectives and educational materials?

Yes ____

No ____

Comment:

Prior Knowledge

6. Was a method identified to assess nurse's knowledge on the subject matter?

Yes ____

No ____

Comment:

Content

7. Was the purpose for teaching this content identified?

Yes ____

No ____

Comment:

Delivery and Presentation

8. Was it clear by whom the materials would be presented by?

Yes ____

No ____

Comment:

9. Is the delivery media for training appropriate and feasible?

Yes ____

No ____

Comment:

10. Was the described environment in which the program is to be conducted be a conducive learning environment?

Yes _____

No _____

Comment:

Timeline

11. Was the time line for the project identified and feasible?

Yes _____

No _____

Comment:

Resources

12. Were resources identified that would be needed to develop the instructional materials?

Yes _____

No _____

Comment:

Design

Learning Objectives

13. Can you identify the desired outcomes in terms of knowledge, skills, attitudes, and behaviors to be achieved through this program?

Yes _____

No _____

Comment:

14. Can you identify the instructional goals and target objectives for this program?

Yes ___

No ___

Comment:

Develop

15. Were activities, tasks, and roles clearly identified?

Yes _____

No _____

Comment:

16. Is the proposed educational media appropriate for the target audience?

Yes _____

No _____

Comment:

17. Were supplemental materials included with the presentation?

Yes _____

No _____

Comment:

Implement

18. Were the steps in changing practice clearly identified and outlined?

Yes____

No____

Comment:

19. Were methods of communication described to collect feedback from the learners?

Yes____

No____

Comment:

Evaluation

20. Was the long-term evaluation for this project appropriate?

Yes____

No____

Comment:

*Adapted from: **pedi.edtech** – a faculty development program of the University of Texas Medical Branch and Galveston, with support from the US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions.*

Appendix D: Frequency Distribution

	Frequency	Total	Percent
1. Was a learning need identified?	Yes 10 No 0	N=10	100%
2. Was the problem and gap in practice relevant to nursing practice and quality care?	Yes 10 No 0	N=10	100%
3. Was the problem clearly identified?	Yes 10 No 0	N=10	100%
4. Was the purpose of the project identified?	Yes 10 No 0	N=10	100%
5. Was the solution for the gap in practice based evidence-based studies?	Yes 10 No 0	N=10	100%
6. Was the audience identified?	Yes 10 No 0	N=10	100%
7. Was the educational level and job description aligned with the objectives and learning materials?	Yes 10 No 0	N=10	100%
8. Was a method used to identify nurse's knowledge on the subject matter?	Yes 10 No 0	N=10	100%
9. Was the purpose for teaching the content identified?	Yes 10 No 0	N=10	100%
10. Was it clear by whom the materials would be presented	Yes 10 No 0	N=10	100%
11. Was the media appropriate for the target audience? By?	Yes 10 No 0	N=10	100%

12. Was the training location a conducive learning environment?	Yes 9 No 1	N=10	100%
13. Was the timeline identified and feasible?	Yes 10 No 0	N=10	100%
14. Were resources identified to develop the materials?	Yes 10 No 0	N=10	100%
15. Were outcomes identified for knowledge, skills, and attitudes, behaviors achievable?	Yes 10 No 0	N=10	100%
16. Were instructional goals and target objectives identified for the program?	Yes 10 No 0	N=10	100%
17. Were activities, tasks, and roles clear and outlined?	Yes 10 No 0	N=10	100%
18. Were supplemental materials included in the presentation?	Yes 10 No 0	N=10	100%
19. Were methods to get feedback from the learners identified?	Yes 10 No 0	N=10	100%
20. Were long term evaluation plans identified?	Yes 10 No 0	N=10	100%

Appendix E: Formative Evaluation Results

Learning Problem: The first question in the learning problem sub-section asked, “Was a learning need identified”? One hundred percent of the participants (n=10) answered yes. Comments included “Problem was clearly identified” and “Very interesting topic to improve change in practice.” The second question asked, “Was the problem and gap in practice relevant to nursing practice and quality care?” One hundred percent of the participants (n=10) answered yes. One participant commented “Great cost-effective solution”. The third question asked, “Was the problem clearly identified?” One hundred of the participants (n=10) answered yes with no comments. The fourth question asked, “Was the purpose of the project identified?” One hundred of the participants (n=10) answered yes with no comments. The fifth question asked, “Was the solution for the gap in practice based on scientific inquiry and evidence-based?” One hundred percent of the participants (n=10) answered yes with no comments.

Learners: The first question asked, “Was the audience identified?” All participants (n=10) answered yes with no comments. The second question asked, “Was the education level and job description of the learners aligned with the learning objectives and educational materials?” One hundred percent of the respondents answered yes (n=10). Comments included “Great work on the nurse competencies checklist and hourly rounding logs”, “Very good work”, and “Objectives correlate with problem statement and purpose of program”.

Prior Knowledge: The question asked, “Was a method identified to assess nurse’s knowledge on the subject matter?” One hundred percent of the participant answered yes (n=10). One comment included “When asking this question, you should state nurses and nursing assistant’s

knowledge” and “Excellent pre-test and post-test”.

Content: The question asked, “Was the purpose for teaching the content identified?” One hundred of the participants answered yes (n=10). One comment was stated “Content was very well organized.”

Delivery and Presentation: In the sub-section on delivery and presentation, the first question asked, “Was it clear by whom the materials would be presented by?” Ninety percent answered yes and 10 percent answered no”. One comment stated, “Add the lecturers name, telephone, and email on the agenda so they could be reached for future questions.” The second question asked, “Was the media selection for training appropriate for the target audience?” One hundred percent of participants (n=10) answered yes. Comments included “PowerPoint nicely done”, “Materials complimented the PowerPoint”, and “Love the design and pictures”. The third question asked, “Was the described environment, in which the program to be presented a conducive learning environment?” Ninety percent of the participants (n=9) answered yes and ten percent of the participants (n=9) answered no. Comment included “Since the emergency room is so busy it may be more productive to have the presentation broken up in sections and have it during lunch breaks.”

Timeline: The question asked, “Was the timeline for the project identified and feasible”. One hundred percent of the participants answered yes (n=10) with no comments.

Resources: The question asked, “Were the resources identified to develop the instructional materials?” All participants answered yes (n=10) with no comments.

Learning Objectives: The first question asked, “Were desired outcomes in terms of knowledge,

skills, attitudes, and behaviors to be achieved through this program identified?” One hundred participants (n=10) answered yes. Comments included “Very well organized”, “Project broken down is roles, and Tasks are clear.” The second question asked, “Were instructional goals and target objectives for this program identified?” One hundred percent (n=100) answered yes with no comments.

Develop: The first question asked was “Were activities, tasks, and roles clear and outlined?” One hundred percent of participants (n=10) answered yes. Comments included “Well thought out project” and “Very well detailed plan of action”. The second question asked, “Were supplemental materials included in the presentation?” One hundred percent answered yes (n=10) with no comments. The third question asked, “Were supplemental materials included with the presentation”. One hundred percent of participants answered yes (n=10) with no comments.

Implement: The question asked, “Were methods of communication described to get feedback from the learners?” One hundred percent (n=10) answered yes with no comments.

Evaluation: The last section on evaluation, the question asked, “Was the long-term evaluation for this project appropriate?” One hundred percent of participants answered yes (n=10) with no comments.

Appendix F: Poster Presentation

Title of Poster: Walden University Capstone Project: Hourly Rounding in the Emergency Department and the Process of Formative Evaluation for Content and Material Validity

Name and Affiliation: Marie Chapnick RNC, CCRN, MSN, FNP-BC

Introduction

In the past six years Press Ganey patient satisfaction scores in the ED have ranged within the 60th percentile, failing to meet the goal set at the 70th percentile (M. Peitro, personal communication, April 4, 2016). The number of insured patients has risen since the passage of ACA in 2010. This has increased ED overcrowding, in an era of nursing shortage, created gaps in addressing patient comfort needs. Patient falls have increased by 20% since 2010 (M Pietro, personal communication, April 4, 2016, CMS, 2014a). Lack of nurse availability to communicate delays in wait times cause frustrated patients to leave without being seen (LWBS). The number of patients that left LWBS within the last year is 2.6% greater than the national average (CDC, 2014; M. Pietro, personal communication, April 4, 2016). Patients that LWBS is an outcome oriented measure of impaired access to health care and represents the failure of an emergency care delivery system to meet its goals of providing care to those in need (Johnson, et al., 2009). Lack of nurse availability to address patient care needs and adverse events creates false patient assumptions about lack of nurse caring, listening, and respecting (Standford, 2015). Increased nurse workload predisposes nurses to burnout, compassion fatigue, and decreased job satisfaction (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010).

The American Nurse Association estimates that by 2020, there will be a need for an additional 3.44 million registered nurses (RN), a 20.2% increase from 2014. By 2030, according to the Bureau Census 2015, more than 20% of the United States residents are projected to be age 65 and over, compared to 9.8% of the population in 1970. The need for additional nurses are based on the increase healthcare needs of this aging population and increase RN vacancies as “baby boomers” retire. In 2014, the RN turnover rate was 17.2%, with a job vacancy of 6.7%. In 2015, it took nurse recruiters between 53 to 110 days to fill empty RN positions, an average increase of more than 14 days from 2014. The longer a nurse position is vacant, the more costs occur from burnout and nurse turnover. The average cost of turnover for a bedside RN averages \$36,900 to \$57,300. According to the RN Retention Report (2015), the average cost from RN turnover per hospital in the United States is \$4.9 to \$7.6 million. Lack of staffing creates gaps in providing quality comfort care to patients (Larson, 2012).

Chaotic and stressful EDs, overcrowding, nurse shortage, excessive call light usage, and adverse events depletes nurse’s energy, rendering them powerless to care for self and others (Watson, 2008, Larson, 2012). Hooper, Craig, Janvrin, Wetsel, & Reimels (2010) conducted a study on registered nurse burnout and compassion fatigue in the emergency room. Approximately 82% of RN’s had moderate to high levels of burnout and 86 percent had moderate to high levels of compassion fatigue. Emotional distress felt by nurses’ result in physical illness, occupational injuries, interpersonal work conflict, low staff morale, sick calls, and high nurse turnover (Wisniewski, 2012). Burn out and compassion fatigue decreases responsiveness to patient care needs causing lack of positive nurse-patient connectedness, decrease patient satisfaction scores,

and decreases nurse job satisfaction (Palese, et al., 2011). McHugh and a team of researchers published a study last year in Health Affairs that found that the percentage of patients who reported they would “definitely recommend” a hospital to their loved ones decreased by 2% for every 10% of the nurses who expressed dissatisfaction with their jobs. Peltier and Dahl (2009), report efforts to create higher employee satisfaction have a very desirable outcome on improving quality care and increasing patient loyalty. The report recommends that one effective method of increasing patient satisfaction is meeting the needs of employees and by viewing employees as internal customers.

Background

The ACA of 2010 increased access to medical care in an era of nursing shortage, worsening ED overcrowding in this city trauma ED. Lack of staff presence increases patient falls, as patients attempt to ambulate without assistance. Failure to communicate delays in wait times and treated causes frustrated patients to LWBS, resulting in lack of access to medical care and decrease revenue. Patients’ poor perception of receiving quality care discourages them to return for further treatment, discourages new consumers, which threatens the viability and survival of the institution. This project was in response to the lack of nurse education on the use of an evidence-based tool and protocol to increase patient assessment and provide individualized comfort care that decreases patient falls, decrease the number of patients that LWBS, and increases patient satisfaction scores. An expert panel attended the educational workshop and did a formative evaluation on the constructive validity of the content and materials.

Problem Statement

Press Ganey patient satisfaction scores in the ED range within the 60th percentile, failing to meet the goal set at the 70th percentile (M. Peitro, personal communication, April 4, 2016).

The number of insured patients has risen since the passage of ACA in 2010. This has increased ED overcrowding, in an era of nursing shortage, as well as created gaps in addressing patient comfort needs. Patient falls have increased by 20% since 2010, as patients ambulate to the bathroom unassisted (M. Pietro, personal communication, April 4, 2016, CMS, 2014a). Lack of nurse availability to communicate delays in wait times cause frustrated patients to leave without being seen (LWBS). The number of patients that left LWBS within the last year is 2.6% greater than the national average (CDC, 2014a; M. Pietro, personal communication, April 4, 2016).

Patients that LWBS is an outcome oriented measure of impaired access to health care and represents the failure of an emergency care delivery system to meet its goals of providing care to those in need (Johnson et al., 2009). Lack of nurse availability to address patient care needs and adverse events creates false patient assumptions about lack of nurse caring, listening, and respecting (Standford, 2015). Increased nurse workload predisposes nurses to burnout, compassion fatigue, and decreased job satisfaction (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). The problem addressed in this project was the lack of nurse education on the use of an evidence-based tool and protocol that organizes nurse workflow, and offers efficiencies by giving nurses time back to proactively, rather reactively, anticipate and address patient comfort needs (Halm, 2009). The significance of this DNP project was the development of an evidence-based and theoretically grounded hourly rounding educational workshop to increase the efficacy

of nursing practices that increases patient comfort, decreases patient falls, decreases the rate patients leave without being seen (LWBS), increases patient satisfaction scores, and increases nurse job satisfaction. An expert team was used for a formative evaluation of the educational content and material.

Significance of Project

The significance of this DNP project was the development of an evidence-based and theoretically grounded hourly rounding educational workshop to increase the efficacy of nursing practices that increases patient comfort, decreases patient falls, decreases the rate patients leave without being seen (LWBS), increases patient satisfaction scores, and increases nurse job satisfaction. An expert team was used for a formative evaluation of the educational content and material.

Objective

To develop a quality initiative project that addresses patient fall rate, rate that patients leave without being seen, and patient satisfaction, which is formatively evaluated by an expert team for feedback and project revision to increase constructive validity.

Participants

The anonymous formative evaluation was distributed to ten participants, which include; ED director of nursing, director of medicine, nurse supervisor, nurse manager, and six seasoned nurses (three from night shift and three from day shift). The ten surveys were returned within one

week, in the attached unmarked envelop, which was given to the director of nursing. Completion of the survey was used as consent to participate in the project.

Setting

The setting was a conference room, where the DNP student presented the educational workshop on hourly rounding to the expert panel. The lecture was given using a PowerPoint presentation distribution of educational materials to highlight key point. The expert panel evaluated the contents and materials using the validated anonymous ADDIE worksheet.

Method

The validated anonymous ADDIE worksheet was a mixed quantitative and qualitative formative evaluation tool, developed to provide data on the efficacy and content validity of project. Permission for use of an adapted version of this tool was obtained from the University of Texas Medical Branch at Galveston, which is a faculty development program. The survey contains twenty closed ended (yes or no) questions. Each closed ended question is followed by open ended comment section. The five phases of the ADDIE model include; analysis, design, development, implementation, and evaluation.

Collection of Data

At the completion of the presentation, each participant was handed an anonymous adapted ADDIE worksheet, with directions for completion and return, and an unmarked envelope. The

expert panel was given a one-week time for completion and return of the confidential evaluation. Surveys were dropped off in the assigned box, located in the director of nurse's office. The sealed envelopes were given to the DNP by the director of nursing. All 10 surveys were returned.

Formative Evaluation; Frequency Distribution

A frequency distribution was used to record the data provided by the expert panel. There was minimal open feedback and lack of grouping themes was not warranted. The adapted ADDIE worksheet consists of 20 questions. Questions were categorized into five sections which includes; analyze, design, develop, implement, evaluate. Each section had sub-sections for participants to answer a closed ended yes or no question, followed by the potential to add open ended comments.

	Total	Percent
1. Was a learning need identified?	N=10	100%
2. Was the problem and gap in practice relevant to nursing practice and quality care?	N=10	100%
3. Was the problem clearly identified?	N=10	100%

4. Was the purpose of the project identified?	N=10	100%
5. Was the solution for the gap in practice based evidence-based studies?	N=10	100%
6. Was the audience identified?	N=10	100%
7. Was the educational level and job description aligned with the objectives and learning materials?	N=10	100%
8. Was a method used to identify nurse's knowledge on the subject matter?	N=10	100%
9. Was the purpose for teaching the content identified?	N=10	100%
10. Was it clear by whom the materials would be presented by?	N=10	100%
11. Was the media appropriate for the target audience?	N=10	100%

12. Was the training location a conducive learning environment?	N=10	100%
13. Was the timeline identified and feasible?	N=10	100%
14. Were resources identified to develop the materials?	N=10	100%
15. Were outcomes identified for knowledge, skills, and attitudes, behaviors achievable?	N=10	100%
16. Were instructional goals and target objectives identified for the program?	N=10	100%
17. Were activities, tasks, and roles clear and outlined?	N=10	100%
18. Were supplemental materials included in the presentation?	N=10	100%
19. Were methods to get feedback from the learners identified?	N=10	100%
20. Were long term evaluation plans identified?	N=10	100%

Formative Evaluation Results

Learning Problem: The first question in the learning problem sub-section asked, “Was a learning need identified”? One hundred percent of the participants (n=10) answered yes. Comments included “Problem was clearly identified” and “Very interesting topic to improve change in practice.” The second question asked, “Was the problem and gap in practice relevant to nursing practice and quality care?” One hundred percent of the participants (n=10) answered yes. One participant commented “Great cost-effective solution”. The third question asked, “Was the problem clearly identified?” One hundred of the participants (n=10) answered yes with no comments. The fourth question asked, “Was the purpose of the project identified?” One hundred of the participants (n=10) answered yes with no comments. The fifth question asked, “Was the solution for the gap in practice based on scientific inquiry and evidence-based?” One hundred percent of the participants (n=10) answered yes with no comments.

Learners: The first question asked, “Was the audience identified?” All participants (n=10) answered yes with no comments. The second question asked, “Was the education level and job description of the learners aligned with the learning objectives and educational materials?” One hundred percent of the respondents answered yes (n=10). Comments included “Great work on the nurse competencies checklist and hourly rounding logs”, “Very good work”, and “Objectives correlate with problem statement and purpose of program”.

Prior Knowledge: The question asked, “Was a method identified to assess nurse’s knowledge on the subject matter?” One hundred percent of the participant answered yes (n=10). One comment included “When asking this question, you should state nurses and nursing assistant’s knowledge” and “Excellent pre-test and post-test”.

Content: The question asked, “Was the purpose for teaching the content identified?” One hundred of the participants answered yes (n=10). One comment was stated “Content was very well organized.”

Delivery and Presentation: In the sub-section on delivery and presentation, the first question asked, “Was it clear by whom the materials would be presented by?” Ninety percent answered yes and 10 percent answered no”. One comment stated, “Add the lecturers name, telephone, and email on the agenda so they could be reached for future questions.” The second question asked, “Was the media selection for training appropriate for the target audience?” One hundred percent of participants (n=10) answered yes. Comments included “PowerPoint nicely done”, “Materials complimented the PowerPoint”, and “Love the design and pictures”. The third question asked, “Was the described environment, in which the program to be presented a conducive learning environment?” Ninety percent of the participants (n=9) answered yes and ten percent of the participants (n=1) answered no. Comments included “Since the emergency room is so busy it may be more productive to have the presentation broken up in sections and have it during lunch breaks.”

Timeline: The question asked, “Was the timeline for the project identified and feasible”. One hundred percent of the participants answered yes (n=10) with no comments.

Resources: The question asked, “Were the resources identified to develop the instructional materials?” All participants answered yes (n=10) with no comments.

Learning Objectives: The first question asked, “Were desired outcomes in terms of knowledge, skills, attitudes, and behaviors to be achieved through this program identified?” One hundred participants (n=10) answered yes. Comments included “Very well organized”, “Project broken down in roles, and Tasks are clear.” The second question asked, “Were instructional goals and target objectives for this program identified?” One hundred percent (n=100) answered yes with no comments.

Develop: The first question asked was “Were activities, tasks, and roles clear and outlined?” One hundred percent of participants (n=10) answered yes. Comments included “Well thought out project” and “Very well detailed plan of action”. The second question asked, “Were supplemental materials included in the presentation?” One hundred percent answered yes (n=10) with no comments. The third question asked, “Were supplemental materials included with the presentation”. One hundred percent of participants answered yes (n=10) with no comments.

Implement: The question asked, “Were methods of communication described to get feedback from the learners?” One hundred percent (n=10) answered yes with no comments.

Evaluation: The last section on evaluation, the question asked, “Was the long-term evaluation for this project appropriate?” One hundred percent of participants answered yes (n=10) with no comments.

Formative Evaluation Revisions

The formative evaluation feedback was used to revise the training program by adding a section to the hourly rounding training agenda sheet to include the lecturers name, department, email, and office phone number and including a checkoff list on the hourly log indicating who performed the round (nursing or nursing assistant). Limitations of this hourly rounding educational workshop was the lack of open feedback from the expert panel. Including additional staff, such as nursing assistants who are frontline team players, may have increased feedback that could have improved the content validity of the hourly rounding educational workshop. Breaking the workshop into individual days during lunch works would likely not have increased participation, since many interruptions could have occurred (e.g., cardiac arrest).

Conclusion

The finding of this project indicates the hourly rounding educational workshop a valuable and constructive tool that can be used to increase nurses’ knowledge on proactive behaviors during hourly rounding to decrease fall rate, decrease rate patient LWBS, and increase patient satisfaction survey scores.

Appendix G: PowerPoint Slides

Walden University
 Scholarly Product for Dissemination
 Nursing 8510
 January, 2017
 MARIE CHAPIK

Problem

Lack of nurse education on the use of an evidenced based tool and Protocol that organizes workflow, offers efficiencies by giving nurses time back to proactively, rather reactively, anticipate and address patient comfort care needs. Patient perceptions reactive nurse behavior decrease patient satisfaction with care received.



Problem Statement

Lack of nurse education on the use of an evidenced based tool and protocol that

- Organizes workflow
- Increases work efficiency using proactive nurse behaviors
- Anticipates and addresses patient's perception of comfort care needs
- Increases patient satisfaction

Purpose Statement

- Increase nurse education on proactive behaviors to anticipate and address patient's perception of comfort needs
- Provide patient centered care
- Decrease waiting, listening, repeating



Section 1: Background New York City Trauma Center

What problems need to be solved?

- Patient falls increase 37% from 2010
- Patient leave without being seen 2.8% > than national average
- From Query score at ICP possible Failure of most internal benchmark set at 10% possible

How was the problem identified?

Patient satisfaction survey (Press items)
 Fall rates (incident reports)
 Patient that left without being seen rate (admission/discharge log).


Background of Problem Affordable Care Act of 2010

Advantage

- Increase access to medical care

Disadvantage

- Increase emergency room visits by 26%
- Increase overcrowding
- Increase stress and chaos




Patient satisfaction and Patients Perception of Care

- Less time to provide critical care
- Less time to update patients on delays
- Less time to have interaction


- Lack of room cleaning
- Lack of room cooling

- Anxiety
- Frustration
- Anger




Consequences: Nursing Staff

- Increase nurse workload
- Increase nurse interruptions
- Increase nurse burnout
- Increase compassion fatigue
- Decrease job satisfaction
- Increase nurse errors
- Increase lawsuits
- Increase nurse turnover in an era of nursing shortage



Nursing Shortage

- 2014: 8% job vacancy in RN (baby boomer retirement)
- 2020: A need for an additional 3.44 million registered nurse
- 2020: 20% of the US residents projected to be age 65 and over



Consequences: Increase Patient Falls

- Increase pain and suffering
- Increase comorbidities
- Increase length of stay
- Lawsuits
- Never events: Medicare no longer pays for injuries related to patient falls (2008)
- Decrease hospital reimbursement




Patient satisfaction and Reimbursement

- American college of physicians (2011): Strong correlation between Press Ganey Scores (JD) and HCAIP scores (e.g. Medical-surgical units)
- Patients dissatisfied with the ED experience correlates with patient satisfaction of entire hospitalization
- Hospital reimbursement from Center for Medicaid and Medicare Services (CMS) calculated to HCAIP scores
- Hospital value-based purchasing program decreased hospital revenue by 1% (total \$650 million)
- Redistributed to hospital based on satisfactory measures (e.g., patient satisfaction)

Community Threatened Institutional Integrity and Survival

- Treated patients that leave the ED without being seen 2.6% greater than the national average
- Considered by Healthy People 2020 as a lack of access to health care
- Patients unsatisfied of care do not return for further treatment
- Word of mouth discourages new consumers of care
- Decrease hospital census
- Increase risk of hospital closure



Hospital Compare Hospital quality Initiative by CMS

- Increase consumer awareness on quality of health care services using the web
- Developed to improve quality of care by distributing objective, easy to understand data on hospital performance and quality information from consumer perspectives
- Competition among organizations for reimbursement, return of patients for further care, attraction of new consumers
- Goal for hospital survival is to promote comfort care that is patient centered and based on patient's perception of care received

Evidenced Based Practice Solution Hourly Rounding

- Change in nursing practice
- Reactive nurse behaviors to proactive nursing behaviors
- Reactive: waiting to be called for assistance
- Proactive: anticipating patient care needs via PPD assessment (pain, personal needs, and communication in desired)
- Cost-effective team approach to improve systems
- Improves nurse and nursing student competencies
- Decreases outcomes of hospital overcrowding and the nurse shortage



Evidence Based Studies on Hourly Rounding Implications for Change Stakeholder: Patient:


- Decrease patient falls
- Decrease pain and suffering
- Decrease complications (mortality/morbidity)
- Prevent loss in reimbursement for nurse visits
- Prevent prolonged hospital stay
- Avoid lawsuits
- Decrease rate patients leave without being seen
- Increase scores in medical care
- Prevent late admission

Evidence Based Studies on Hourly Rounding Implications for Change Stakeholders: Organization

- Increased patient satisfaction
- Increases reimbursement
- Enhances organizational competition Hospital Compare
- Patients return for future care
- Attracts new consumers of care
- Maintains institutional integrity and survival

Significance for Change of Practice

- Preserve patient dignity, wholeness, and integrity
- Provide interventions based on patient's perception of needs
- Increase empowerment: Patient governance of facilities
- Minimize overall and professional accountability to delivery of care



Social Impact for Change in Practice

- Increase access to medical care
- Increase compliance with treatment plan
- Improve patient healthcare outcomes



Workshop on Hourly Rounding Analysis: Intended Audience

Characteristics

Nurses: Licensed registered nurse that provide patients with treatments as ordered, administer medications, and provide comfort care to patients and significant others

Educational level: Bachelor of nursing science to masters of nursing science

Nursing assistant: Certified nursing assistant that assist with direct patient care, including activities

of daily living, provide comfort care, and perform vital signs

Educational level: Accredited certified nursing assistant program

Analysis Learning Objectives

1. Communicate the purpose of hourly rounding in the ED
2. Describe the eight rounding behaviors of hourly rounding as a measure to increase patient satisfaction
3. Correlate the effects of patient satisfaction surveys and CMS reimbursement
5. Identify the patient, nurse, institutional, and community benefits of improving patient satisfaction using an hourly rounding protocol
4. Review appropriate tools for implementing hourly rounding protocols

Hourly Rounding Workshop Schedule

8 am to 8:30 am Registration and Breakfast

8:30 am to 9:00 am Pre-test on hourly rounding

9:00 to 10:00 Power Point presentation

Patient satisfaction surveys HCARE's Hospital Consumer Web

10:00 to 10:15 Break

10:15 to 12:00 pm PowerPoint presentation

12:00 pm to 12:30 pm Lunch

12:30 pm to 2:00 pm PowerPoint Presentation

2:00 pm to 3:00 pm Post-test and review

3:00 pm to 4:00 pm Questions and answer session

Distribution of literature materials

Audience Participation

- ▶ Ask question at any time during the presentation
- ▶ Raise hand to be called upon
- ▶ No cross talking in the room
- ▶ Silence cell phones



Distribution of Materials

Workshop schedule

Hourly rounding tool

Handouts

- ▶ Emergency room welcome cards
- ▶ Nurse behaviors during rounding
- ▶ Proactive Nurse Behavior During Hourly Rounding
- ▶ Competency check list
- ▶ Hourly log

Handout Hourly Rounding Welcome Card

Welcome to our hospital

Our goal during your emergency stay is to provide you with:

- ▶ Very good care based on your perceptions of comfort needs
- ▶ Provide you with quality and safe care
- ▶ Provide treatment in a timely manner

An important part of providing comfort care is by doing hourly rounding to anticipate and meet your needs, such as:

- ▶ Monitor your pain level
- ▶ Assist you in contacting the bathroom

- ▶ Update you with delays in wait times

Schedule:

Hourly rounds Day (8 am to 11 pm)

Hourly rounds Night (12 pm to 4 am)

Name of Admitting Nurse



Pre-test and Post-test Hourly Rounding

Hourly rounding is a tool that increases communication by using structured statements, key words, and questions to address common care needs.

True () False ()

Hourly rounding is an evidence-based tool that decreases the risk of patient falls.

True () False ()

Hourly rounding is a tool that increases communication by using structured statements, key words, and questions to address common care needs.

True () False ()

Hourly rounding is an evidence-based tool that decreases the risk of patient falls.

True () False ()

Hourly rounding increases patient's perception of nurse caring behaviors which increases patient satisfaction scores.

True () False ()

Pre-test and Post-test Hourly Rounding

Hourly rounding is a tool that increases communication by using structured statements, key words, and questions to address common care needs.

True () False ()

Hourly rounding is an evidence-based tool that decreases the risk of patient falls.

True () False ()

Hourly rounding is a tool that increases communication by using structured statements, key words, and questions to address common care needs.

True () False ()

Hourly rounding is an evidence-based tool that decreases the risk of patient falls.

True () False ()

Hourly rounding increases patient's perception of nurse caring behaviors which increases patient satisfaction scores.

True () False ()


Pre-test and Post-test Hourly Rounding

Hourly rounding increases nurse workload.

True () False ()

The main reason patients leave the emergency room without being seen is because of overcrowding.

True () False ()



Handout Proactive Nurse Behaviors During Hourly Rounding Introduction

Behavior	Purpose
<ul style="list-style-type: none"> • Introduce yourself and greet patient • If appropriate smile • Take a moment to be present • Lower yourself below patient's eye level if possible • Allow patient of appropriate waiting time • Explain delays in care • Open to patient on treatment plan • Offer alternatives (e.g., television, magazines, reading items) • Provide appropriate services 	<ul style="list-style-type: none"> • Develop rapport • Decreases anxiety • Decreases frustration • Increases communication • Increases patient perception that you were there longer than you were • Increases patient's perception of importance • Decreases the risk of leaving without being seen • Promotes a customer service culture

Handout Proactive Nurse Behaviors During Hourly Rounding Explanation

Behavior	Purpose
<ul style="list-style-type: none"> • Use key words "my good" care • Describe rounding schedule • Address anticipated comfort needs • How is your pain? • Are you comfortable? • Do you need to use the bathroom? • Do you need us to move the phone, call light, water, trashcan, or overbed table within reach? 	<ul style="list-style-type: none"> • Increase patient understanding the ED process • Creates an expectation of what will occur • Identifies quality indicators of patient satisfaction

Handout Proactive Nurse Behaviors During Hourly Rounding Complete Tasks

Behavior	Purpose
<ul style="list-style-type: none"> • Treatment • Wound care as needed • Medication • Include family in treatment plan • Tell the patient what you are doing • Speak in terms that patients understand • Update patient on treatment/tech • Use rubber gloves and a bag to address patient care needs 	<ul style="list-style-type: none"> • Increases adherence to treatment • Decreases anxiety • Increases the use of family support to comfort the patient • Increases use of supplies that to great patients, provide information, and provide comfort measures (e.g., warm blankets) decreases nurse workload • Decreases risk of nurse interruptions as performance focuses by the patient information

Handout
Proactive Nurse Behaviors During Hourly Rounding
Address personal needs or questions

Behavior	Purpose
<ul style="list-style-type: none"> Use active listening and open body language Ask "what is your biggest concern?" Update white boards placing patients name on board and nursing plan of care/goals for patient 	<ul style="list-style-type: none"> Promote caring and empathy Provides reassurance Alleviate fears Increases collaboration Promotes teamwork Makes patient status visible Organizes workflow

Handout
Proactive Nurse Behaviors During Hourly Rounding
Conduct environmental check

Behavior	Purpose
<ul style="list-style-type: none"> Move items within reach Maintain a clean environment 	<ul style="list-style-type: none"> Increase patient safety Promotes hospital cleanliness Increase access for communication Promotes professionalism

Handout
Proactive Nurse Behaviors During Hourly Rounding
Closing Remarks

Behavior	Purpose
<ul style="list-style-type: none"> Ask "Is there anything else I can do for you before I go? I have the time." Listen without interruption Tell the patient that you will round again in one hour 	<ul style="list-style-type: none"> Communicates listening Conveys caring Decreases anxiety Builds trust Enhances the nurse-patient relationship/ patient centered care

Handout
Proactive Nurse Behaviors During Hourly Rounding
Completion of Hourly Round

Behavior	Purpose
<ul style="list-style-type: none"> Document the round on the hourly log 	<ul style="list-style-type: none"> Shared collaboration



Handout
Woodhull Emergency Department Competency Checklist

Employee Name _____ Title _____

Competency	Met	Not Met	Comments
Perform all vital parameters in 60 sec			
Perform a patient triage			
Perform vital signs			
Perform vital signs on all patients			
Use chart to patient			

Handout
Emergency Department Competency Checklist

Complete Hourly Rounding Process

Competency	Met	Not Met	Comments
Complete hourly rounding on all work team patients			
Document round on hourly log			
Complete appropriate assessment on all patients			
Use appropriate to round			

Handout Emergency Department Competency Checklist

Assessment of Critical Care Needs (PCC)

Assess patient care in your unit			
Assess patient care in your department			
Assess patient care in your institution during your shift			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			

Handout Emergency Department Competency Checklist

Assess Environment

Assess patient care in your unit			
Assess patient care in your department			
Assess patient care in your institution during your shift			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			

Performance Scheduling Table

Assess patient care in your unit			
Assess patient care in your department			
Assess patient care in your institution during your shift			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			

Handout Emergency Department Competency Checklist

Clinical Network

Assess patient care in your unit			
Assess patient care in your department			
Assess patient care in your institution during your shift			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			

Handout Emergency Department Competency Checklist

Documents and Signs Hourly Rounding Log

Assess patient care in your unit			
Assess patient care in your department			
Assess patient care in your institution during your shift			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			
Assess patient care in your unit to see the future			

Evaluator _____ Date _____

Handout Hourly Rounding Log

Time	Name of Nurse	Name of Patient	Name of Nurse
08:00			
08:15			
08:30			
08:45			
09:00			
09:15			
09:30			
09:45			
10:00			
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Design: PowerPoint Presentation Learning Content

Topic Patient satisfaction surveys

- Slide 1: Definition of patient satisfaction
- Slide 2: List of 10 quality indicators
- Slide 3: The history of how survey data is collected, along with the survey statistical validity. The importance of patient satisfaction in improving patient care, and how it is used to improve patient care.

Topic Hospital consumer assessment of healthcare providers and systems (CAHPS)

- Slide 4: The importance of patient satisfaction in improving patient care, and how it is used to improve patient care.

Design: PowerPoint Presentation Learning Content

Topic: reimbursement

Slide 5: Definition of ICAPPT

- Lecture: ICAPPT survey will be discussed to increase patient/hospital quality outcomes. The importance will be emphasized on the positive and negative correlation of Press Ganey and ICAPPT scores. The hospital value-based purchasing program reimbursement system will be discussed, with an emphasis on distribution of funds according to patient satisfaction scores and nurse events. This lecture will take 15 minutes to complete.

Topic: Public reporting of patient satisfaction scores

- Slide 6: Definition of Hospital Compare
- Lecture: The affordable care act will be discussed and its role on creating consumer or external customers. Emphasis will be placed on decision making for health care providers based on public reporting. This lecture will take 10 minutes.

Design: PowerPoint Presentation Learning Content

Topic: Barriers to patient satisfaction

- Slide 6: Lists barriers to patient satisfaction, which include emergency department overcrowding, lack of communication, patient demographics, nursing shortage, nurse turnover
- Lecture: This discussion will identify components of patient dissatisfaction, such as increased patient and family without being seen (WBS), patient fall, increased medical errors by incompetent nurses and increased nurse WBS. Patient and organization factors that increase the risk of patients WBS will be identified, such as income level less than \$15,000, male gender, life expectancies, and income source. Including an engaging slide show will be included, and if effects are more learned and competent nurses. This lecture will take 20 minutes.

Topic: Perception of nurse coding

- Slide 7: Lists dimensions of coding based on Sakuma's theory

Design: PowerPoint Presentation Learning Content

- Slide 8: Definition of hourly rounding
- Slide 9: List of positive effects of hourly rounding
- Lecture: A discussion of the effects of hourly rounding, based on evidenced based studies will review patient fall rate, patient satisfaction, cost of care, patient WBS. This lecture will take 45 minutes.

Topic: Role of leadership

- Slide 10: Lists transformational leadership characteristics
- Lecture: The role of leadership qualities will be discussed as it pertains to implementing change and sustaining change. This lecture will take 15 minutes.

Design: PowerPoint Presentation Learning Content

- Hourly rounding
- Slide 11: List eight nurse behaviors of hourly rounding
- Lecture: This section discusses the processes of hourly rounding, including the eight rounding behaviors used during rounds, key words, and pre-scripted questions. Outcomes for each stage of behavior are discussed. This lecture will take 45 minutes.

Long Term Evaluation Plan Hardware Hourly Rounding Weekly Meeting Agenda

- What is working well?
- What are the barriers?
- Reward and recognize success
- Patient feedback
- Leaders report on Press Ganey scores and percentage of hourly logs completed
- Percentages of competency checklist completed by leadership
- Actions to improve results
- Steps discussed and agreed upon

Long Term Evaluation Plan Leader Rounding

Leader Rounds

- Random compliance check list
- Patients alone staff have checked on them every hour
- Patients have no complaints on care received
- Compliance of nurse and nursing signing logs after each round
- White boards have patients name, nurse name, patient goals, patient concerns, and hourly of red rounding and by whom
- Data on Press Ganey scores placed on white board in chatting room
- Daily huddle nurses encouraged to report effects of hourly rounding on workflow and interpersonal connection to staff and patients.

Evaluation of Mastered Objectives

Post-presentation:

- ▶ Comparison of pre-test and post-test
- ▶ Focusing (80% or greater)
- ▶ Test failure: Review PowerPoint modules
- ▶ Date and time will be determined by nursing educator and learner



Formative Evaluation by Expert Panel Directions

ADDF Hourly Rounding Educational Program Evaluation Worksheet

- ▶ **Directions:** This anonymous and confidential survey is a formative evaluation survey of the content and materials presented in the hourly rounding workshop. At the completion of the PowerPoint presentation, you will be asked to complete the survey, which also acts as your consent for participation in the project. You will have one week to complete the survey and place it in the attached unsealed envelope. You should place the sealed unsealed envelope in the designated box located in the Director of Nurse's office. The feedback of data will be used to make revisions that will increase the feasibility of the project and increase validity of the content and materials. Within two weeks you will be notified by email the date, time, and place for a scheduled meeting to discuss the data findings and revisions. Thank you for your participation and evaluation of the program.

Appendix H: Hourly Rounding Educational Workshop

Title: The Development of an Hourly Rounding Protocol in the Emergency Department
Marie Chapnick, RNC, CCRN, MSN, FNP-BC, DNP-student
Walden University

Team Roles and Functions

Team roles were categorized according to functions. These roles include; executive sponsors (Director of Nursing and Nurse Supervisor), improvement leaders (nurse manager and nurse champion), and project sponsors (printing department and department of technology), Defining stakeholder prior to initiation of an hourly rounding protocol will identify matter experts. In addition, defining roles will give the team clear expectations and understanding of responsibilities.

Executive Sponsors

Director of Nursing: One month prior to training nurses the director of nursing will meet weekly with nurses, nursing assistants, and ancillary staff to introduce the concept of hourly rounding. Benefits of change in evidence-based practice from a reactive to proactive nurse interventions will be identified to close the gap that results in:

- Decrease patient satisfaction
- Increase patient falls
- Increased rate patients leave without being seen

Nurse Educator: The nurse educator will prepare for the training sessions and prepares a conducive learning environment. In addition, she will work with various disciplines to provide tools and materials needed to present the workshop, this includes:

- Develops outline and objectives for training session

- Develops tools for hourly rounding, which include; hourly rounding competency check list and hourly rounding log
- Develops PowerPoint presentation
- Develops and administers pre-test and post-tests and creates a team for assess for content validity
- Schedules rooms for training sessions
- Arranges with IT projector needed for PowerPoint presentation
- Order from printer orientation handouts, objective sheets, stickers “we care”, nurse hourly logs, leader hourly logs, competency check lists, pre-test and post-tests, poster-boards

Improvement Leaders

Nurse Manager: The nurse manager will communicate with staff on the need to attend the mandatory in-service and will arrange scheduling to meet the need of the workshop and needs of patients in the ED.

- Instructs staff of mandatory 8-hour day training seminars via email (date, time and place)
- Checks confirmation of attendance via email
- Arranges for per-diems to fill in on days when staff are in training
- Works with the dietary department to arrange for the delivery of coffee and danish on training days
- Encourages questions and illicit feedback to increase understanding of process and increase compliance

Nurse Champion: The nurse champion will be present to provide welcome the expert panel.

- Develops and collects attendance sheet for hourly rounding seminar
- Provides agenda for program
- Disseminates handout on objectives to be mastered
- Places “we care” stickers on staff identification badges at the end of the seminar training.

Project sponsors

Printing Department:

- Provides materials needed to perform the workshop.
- Develops and reproduces orientation programs, patient pamphlets on hourly rounding, leader and nursing log sheets, competency check lists

Department of Technology:

- Provides materials needed to perform the workshop.
- Provides for project on days of rounding training and oversee technical difficulties should they occur

Conflict Resolution

It is not uncommon in the development of a program to have differences in opinions that can lead to conflict. Ineffective conflict resolutions can decrease motivation, decrease team member participation, and jeopardize the success of the project (Mattson, 2015). A conflict resolution plan was developed with suggestions to discuss these coping strategies prior to the design and development of an hourly rounding protocol. Educating stakeholders in the process of conflict resolution may prevent escalations that wastes time, energy, and money.

Acknowledge the conflict: Avoiding conflict can build resentment and sabotage the success of the project. Handling small disagreements as they occur prevents later disputes that are over exaggerated, crosses professional boundaries on codes of conduct, and tears down the team.

Time out: Take a minute to think through what you are trying to achieve, in a proactive stance. Taking a time out to compose oneself may avoid reactive self-destructive behaviors, resulting in insults, pointing fingers, ultimatums and rigid demands, defensive attitudes, gossiping, and making assumptions about other behaviors.

Clarify positions: Use active listening allowing team members to express their point of view from prevent miscommunication and allow them to bring more understanding about their position.

List facts and assumptions of each position: Once a person has expressed their opinion, list the facts and assumptions that have been made. Listing it on paper may make things clearer, especially to those lacking in reasoning.

Break into smaller groups and separate exiting alliances: Friends within teams may feel obligated to agree with their peers, for fear of causing hurtful feelings and losing the relationship. Temporarily restructuring the group avoids this dilemma and allows everyone to speak out freely.

Reconvene: meeting a compromise and moving forward with the project.

Celebrate the solution as a team: recognizing success promotes team bonding.

Agenda, Timeline, and Objectives

Once the team has been created, roles and functions defined, and content materials have been developed, the training process on proactive nurse comfort interventions during hourly rounding commences. It was recommended to the institution to use a face-to-face lecture presentation in a classroom or conference room setting. An agenda was created to outline the training schedule and to provide a list of the objectives to master. In addition, a Ganatt chart outlined the goals set for the course of the project.

Agenda and Learning Objectives

Name of Lecturer _____ Date _____

Office phone _____ Email _____

8:30 am-9:00 am	Sign in on log (name, title, and department)
9:00 to 10:30 AM	<p>Pre-test on Hourly Rounding</p> <p>Lecture Objectives</p> <ul style="list-style-type: none"> • Describe the problem of patient satisfaction • List common cause of low patient satisfaction • List common cause of low nurse job satisfaction • Identify the effects of low patient satisfaction on reimbursement, sick calls, and nurse turnover
10:30 am to 10:45am	Break (20 minutes) Coffee/Tea and dessert
10:45 am to 1200 pm	<p>Lecture objectives</p> <ul style="list-style-type: none"> • Review the purpose of hourly rounding • Identify barriers for hourly rounding • List the benefits of using hourly rounding • Identify eight nurse behaviors and pre-scripted cues used during rounding • Identify the purpose for each behavior • Review accountability for rounding using proper demonstration of hourly logs
12:00 pm to 1:00 pm	Lunch break
1:00 pm to 3:00 pm	<ul style="list-style-type: none"> • Power Point Presentation • Post-test review • Questions and answer session

Gantt Chart

Task	2017-2018						Start	End
	Oct	Nov	Dec	Jan	Feb	Mar	Date	Date
Phase I: Development of committee with key stakeholders (DNP student, nurse manager, director of nursing, director of nursing, nurse educator)	10/1---10/14						10/1/17	10/14/17
Phase II: Review evidence based studies on patient satisfaction and hourly rounding. Develop goals and objectives for hourly rounding pilot project	10/21---10/2						10/21/17	10/28/17
Phase III: Budge analysis, purchase of supplies, development of rounding tools (hourly rounding, patient's pamphlets, Power point presentation, competency check list)	11/4---11/25						11/4/17	11/25/17
Phase IV: 8-hour training seminars on how to perform hourly rounding	12/1---12/21						12/1/17	12/21/17
Phase V: Pilot project kick off: Patients receive welcome pamphlet explaining hourly rounding, unit clerk compiles data on patient /family request for nurse and cause of request,	12/22-----3/22						12/22/17	3/22/18

<p>patient demographics are recorded by registration receptionist, nurses and aides alternate hourly rounding routine, nurse leaders round to check nurse compliance with rounding, nurse manager collects hourly logs daily to monitor for accountability, call are placed to patients by nurse champion 24 to 72 hours after patients leave without being seen and cause is documented, risk management collects incident reports on falls/injuries, sick calls are recorded by nursing instructor</p>			
<p>Phase VI: Data Collection and data analysis. Permanent change in nursing practice or project is revised and restarts</p>	<p>3/2----3/29</p>	<p>3/32/18</p>	<p>3/29/18</p>

Nurse Behaviors, Questions, and Key Words of Hourly Rounding

To support the implementation of an hourly rounding protocol nurses, need to be aware of behaviors, question, and key words to use during hourly rounding. Nurses need to be provided with coaching resources prior to the project launching. To assist nurses to buy into the system and prevent resistance to change, nurses need to understand the needed behaviors to achieve the goal of hourly rounding.

Behavior	Purpose
<p>Introduction</p> <p>Introduce yourself and greet patient</p> <p>If appropriate smile</p> <p>Take a seat next to the patient</p> <p>Lower yourself below patient’s eye level if possible</p> <p>Inform patient of expected waiting time</p> <p>Explain delays in care</p> <p>Update patient on treatment plan</p> <p>Utilize diversions (e.g., television, magazines, coloring books)</p> <p>Provide interpreter services</p>	<p>Conveys respect</p> <p>Decreases anxiety</p> <p>Decreases barriers</p> <p>Increases communication</p> <p>Increases patient perception that you were there longer than you were</p> <p>Increases patient’s perception of importance</p> <p>Decreases the risk leaving without being seen</p> <p>Promotes a customer services culture</p>
<p>Explanation of Hourly Rounding</p> <p>Use key words “very good” care</p> <p>Describe rounding schedule</p> <p>Address anticipated comfort needs</p> <ul style="list-style-type: none"> • How is your pain? • Are you comfortable? • Do you need to use the bathroom? • Do you need us to move the phone, call light, water, trashcan, or overhead table within reach? 	<p>Increases patient understanding the ED process</p> <p>Creates an expectation of what will occur</p> <p>Identifies quality indicators of patient satisfaction</p>
<p>Complete Tasks</p> <p>Treatments</p> <p>Nursing care as needed</p> <p>Medication</p>	<p>Increases adherence to treatment</p> <p>Decreases anxiety</p> <p>Increases the use of family support to comfort the patient</p> <p>Increase use of ancillary staff to greet</p>

<p>Include Family in Treatment Plan</p> <p>Tell the patient what you are doing</p> <p>Speak in terms that patients understand</p> <p>Update patient on treatment/tests</p> <p>Use volunteer greeters and clergy to address patient care needs</p>	<p>patients, provide information, and provide comfort measures (e.g., warm blanket) decreases nurse workload</p> <p>Decreases rate of nurse interruptions as patients and families try to gather information</p>
<p>Address personal needs or questions</p> <p>Use active listening and open body language</p> <p>Ask “what is your biggest concern?”</p> <p>Update white boards: placing patients name on board and nursing plan of care/goals for patient</p>	<p>Promotes caring and empathy</p> <p>Provides reassurance</p> <p>Alleviates fears</p> <p>Increases collaboration</p> <p>Promotes teamwork</p> <p>Makes patient status visuals</p> <p>Organizes workflow</p>
<p>Conduct environmental check</p> <p>Move items within reach</p> <p>Maintain a clean environment</p>	<p>Increases patient safety</p> <p>Promotes hospital cleanliness</p> <p>Increases access for communication</p> <p>Promotes professionalism</p>
<p>Closing Remarks</p> <p>Ask “Is there anything else I can do for you before I go? I have the time.”</p> <p>Listen without interruption</p>	<p>Communicates listening</p> <p>Conveys caring</p> <p>Promotes patient centered care</p>
<p>Tell the patient that you will round again in one hour</p>	<p>Decreases anxiety</p> <p>Builds trust</p> <p>Enhances the nurse-patient relationship</p>
<p>Document the round on the hourly log</p>	<p>Shared collaboration</p> <p>Accountability</p>

Short-term Evaluation

To evaluate an increase in nurses' knowledge, a pre-test and post-test was developed, and it was evaluated by an expert team for constructive validity. The pre-and post-test modes for each question was determined by how often a category was chosen in the pre-test compared to the post-test. Increased scores for each question indicated an apparent increase in a nurses' knowledge of the subject matter in question. In the future it is recommended for the expert team to analyze the scores using a t-test and SPSS program (SPSS, 2010). This analysis would determine the significance of the change in scores, most commonly set at $p=0.05$.

Pre-test and Post-test

Name _____ Date _____

1. Hourly rounding is a tool that increases communication by using structured statements, key words, and questions to assess comfort care needs.
True (X) False ()
2. Patient rounding is an evidence-based tool that decreases the risk of patient falls, decreases the rate patients leave the emergency room without being seen, and increases patient satisfaction scores.
True (X) False ()
3. Hourly rounding is associated with increase patient falls, increased rate that patients LWBS, and decreased patient satisfaction scores.
True () False (X)
4. Hourly rounding increases patient's perception of nurse caring behaviors which includes; caring, listening, and respecting.
True (X) False ()
5. Hourly rounding increases nurse workload.

True () False (X)

6. The main reason patients leave the emergency room without being seen is because of overcrowding.

True () False (X)

7. Never events increase hospital reimbursement from the Center of Medicare and Medicaid Services (CMS).

True () False (X)

8. Word of mouth is a stronger indicator of patient satisfaction than HCAHPS scores.

True () False (X)

9. The eight behaviors of nurse rounding include; introduction, explanation of rounding, environment assessment, address personal needs or questions, performance of scheduled tasks, closing remarks, inform patients when someone will return, and documentation of round in log.

True (X) False ()

10. Hourly rounding increases nurse job satisfaction because of less patient/family interruption, decrease workload, and increases time spent with patients.

True (X) False ()

Long Term Evaluation Plan

Nurse Performance

A long-term evaluation plan was developed to measure the compliance of performing hourly rounding, by the documentation and signing of an hourly rounding worksheet by nurses and nursing assistants. The set goal of compliance was recommended at 90 percent, leaving a margin of 10 percent for unavoidable causes for rounding (e.g., cardiac arrest). A competency checklist was also provided for leadership to use to evaluate adherence to nurse behaviors with the same recommended set goal of 90 percent adherence.

Leadership Competency Checklist

Name _____		Title _____		
		Yes	No	Comments
Introductions				
Knock and asks permission to enter				
Addresses patient by name				
States name and title				
Smiles and uses good eye contact				
Sits next to patient				
Explains Hourly Rounding Process				
Explains hourly rounding use key words “very good care”				
Explains hours they will be seen and who will see them				
Estimates approximate wait time or time test are				

available			
Uses interpretation as needed			
Assessment of Comfort Care Needs (PPD)			
Asks patient how is your pain?			
Asks patient are you comfortable?			
Asks patient is your intravenous hurting you?			
Asks patient do you need to use the bathroom?			
Asks patient can I help you to ambulate?			
Provides explanation for delays in wait time or care			
Assesses Environment			
Asks patient do you need me to move the phone, call light, water, trashcan, or overhead table within reach?			
Performs Scheduled Tasks			
Administers medications			
Addresses personal needs and questions			
Closing Remarks			
Asks the patient is there anything else I can do before I go? I have the time”			
Communicates the next time of rounding and person who will round			
Updates the white board with patient concerns			
Documents and signs Hourly Rounding Log			
Initials hour of rounding, time of rounding, and comments on what was done during rounding			

Emergency Hourly Rounding Log

Name _____		Date _____	
Time Period	Name and Title	Time of actual Timely visit with patient	Write in Goals achieved during round and any new patient concerns
6:00-7:00			
7:00-8:00			
8:00-9:00			
9:00-10:00			
10:00-11:00			
11:00-12:00			
12:00-13:00			
13:00-14:00			
14:00-15:00			
15:00-16:00			
16:00-17:00			
17:00-18:00			
18:00-19:00			
19:00-20:00			
20:00-21:00			
21:00-22:00			

Long Term Evaluation Plan

Quality Measures

Direction for methods for calculations and measurement on rate of falls, rate patients LWBS, and patient satisfaction scores were also provided. This facility was provided with recommendation for hardwiring the process of hourly rounding.

Calculation of Measures

Patient fall rate: Fall rate is commonly calculated by multiplying the total number of beds occupied each day for one month by the total number of beds available each day for one month. The number of falls of will be divided by the number of occupied bed days for the month. That number will be multiplied by 1,000 which will provide the number of falls per 1,000 occupied bed days. Calculated cost of injuries should be based on Medicare reimbursement codes.

Patient satisfaction scores: Methods of how scores are calculated are not released by Press Ganey Incorporation (2015). A random selection of 30 surveys are needed each quarter for data validity (Press Ganey, 2015). A ten percent increase in scores are considered a significant benefit. At the completion of the three-month project analysis and evaluation of meeting set end point goals of Press Ganey scores are set at the 70th percentile, which is an increase score of 10 percent from previous year of Press Ganey Scores. If goals are not meet, the team will analyze the data, brainstorm solutions for improvement and begin the PDCA cycle again.

Rate of Patients that LWBS: A three-month median rate of patients that LWBS prior to implementation of an hourly rounding protocol will be subtracted by the three-month median rate during protocol implementation. A significance will be set at a decrease of 10 percent. Patient demographics will be tabulated using SPSS. Outliers for patients that LWBS are those known to have altered mental status related to alcohol or substance abuse.

Hardwiring the Process

Goals met: Expand pilot project to pediatric emergency department

Goals not met: Brainstorm solutions for improvement and begin the PDCA cycle again

Staff compliance with protocol: Praises during daily hurdles; results placed on white board in charting room; Celebration breakfast, lunch, dinner

Staff non-compliance with protocol: Coaching with nurse manager and nurse champion

Sustainability of protocol: Competencies results placed in annual staff evaluation