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Nursing Staff Responsiveness to Patients and Hourly Rounding

Lucretia Wilson Wilson
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Lucretia Wilson

has been found to be complete and satisfactory in all respects,
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Review Committee
Dr. Mary Verklan, Committee Chairperson, Nursing Faculty
Dr. Barbara Gross, Committee Member, Nursing Faculty
Dr. Tracy Wright, University Reviewer, Nursing Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

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Abstract

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Lucretia D. Wilson

MSN/Ed, University of Phoenix, 2010

BSN, Medical University of South Carolina, 1997

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The Center for Medicare/Medicaid Services reduced the hospital's reimbursement by $500,000 due to patient care linked to the poor outcomes of marginal fall rates and low patient satisfaction survey scores as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The HCAHPS scores for fiscal years 2013 and 2014 for the medical-surgical unit fluctuated between 40-42.9%, without significant improvement, while the house-wide scores were 63.17%. To address the problem, a quality improvement project (QIP) was implemented. An evidence-based (EB) hourly rounding intervention was initiated following an education program for nursing staff (n=47) tailored to enrich patient communication. The Iowa Evidenced-Based Practice Model that guided the QIP focused on improving patient perceptions of staff responsiveness to call lights, hourly rounding, decreasing patient falls, and increasing the overall HCAHPS score. Random chart audits and participant observations were used to collect data specific to hourly rounding and response to call lights while patient satisfaction and fall data were captured from the facility's HCAHPS survey and balanced scorecard. A descriptive comparative design with scatter plot was used to evaluate the hourly rounding program pre- and post-implementation. The hourly rounding improved from 0% to 79% with an increase in the HCAHPS score from 46% to 78% for 3 consecutive months. The staff responsiveness increased from 46% to 85% and the patient fall rate decreased from 1.2 to 3.8 falls to 0 to 1.4 falls per 1,000 hospital days. The nurse-led EB project was successful in creating positive social change and developing a process to enhance clinical practice through structured staff communication with patients about their care needs.

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Dedication

I would like to dedicate this project to my husband, (the love of my life and greatest cheerleader), and five children, our grandson (who has gone to be with the Lord). Without their love and continued support, this would not be possible. Additionally, I honor my 95-year-old mother, seven siblings, and spiritual mentors for cheering me on to the finish line.

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A special thanks to my faculty mentor, Dr. Mary Verklan, who provided unending guidance throughout the Project process. Additional, thanks go to the facility mentor Dr. S. Ehrhardt. I acknowledge the Nurse Manager of the medical-surgical unit, C. Robinson, and staff for their hard work and support. Lastly, but not least, I thank the Infection Control Team and many other departments at the project site for assistance and encouragement throughout this process. A God bless you to the leadership team of the project facility for affording me the opportunity to impact practice change in their hospital.

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Section 1: Nature of the Project

Introduction

Application of evidence-based research and findings to nursing practice positively impacts patient satisfaction and outcomes (Woods, 2011). Evidence-based findings may assist with goals to improve the patient experience through best practice and address patient priorities for optimal care (Woods, 2011). The goal to improve staff responsiveness to patient initiated call light requests to increase patient satisfaction scores on a medical-surgical unit was a necessity to positive patient outcomes. These scores were measured by the Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS) survey. The evidence-based quality improvement project implemented nursing hourly rounding with a purpose to execute timely responses to patients' requests, thereby reducing call light usage, increasing overall HCAHPS survey scores, and further decreasing patient fall rates to less than three per 1000 patient days. In the following paper, the project implemented and how the evidence-based intervention showed improvement in patient-centered care on a medical surgical unit will be discussed. Section 1 will include a discussion of the context/background, problem and purpose statement.

Context/Background

The project site's HCAHPS survey scores were consistently poor, mainly in answering call lights and responsiveness to patient's needs in a timely manner (C. Wise, personal communication, June 15, 2015). The issue was linked to the nursing staff's lack

of consistent hourly rounding and appropriate responses to the patient's requests once the call is answered. During the initial and planning phase of the project, several staff verbalized that hourly rounding was neglected due to high acuity assignments, increased nurse-to-patient ratio, and limited ancillary staff (S. Gilliard, P. Govan, V. Maynard, personal communication, June 15, 2015). However, on fully staffed days, through informal observation by the DNP student of staff's work performance regarding patient call light requests, a delay in timely responses to patients' requests continued to exist, lasting as long as 20 minutes. Through anonymous observation of the staff by the DNP student, ineffective workflow patterns, low morale, and lack of timely response to patient requests were noted. Through informal observation of the staff's current practice and management of the call light system on several occasions by the DNP student, patient demands revealed repeated calls for the same requests through call light usage due to untimely response by the staff on the initial request. Staff reported this as a result of the geographic location of their assignments (C. Wise, personal communication, July 10, 2015).

The adult medical-surgical unit has a census of 30 beds for full capacity. The unit has two hallways consisting of 15 private patients per room per hall. The leadership team comprises of a Director, Nurse Manager, Unit Base Educator, and five Clinical Coordinators. The approved staff consists of 24 registered nurses (RNs), two part-time RNs, five as-needed RNs (PRN), one full-time licensed practical nurse (LPN), one part-time LPN, 16 full and part-time combined certified nursing assistants (CNAs), and five

other like institutions (Woods, 2011). The HCAHPS scores at the project site full time administrative assistants. The unit has two 12-hour shifts, day and evenings. Daily operations of the unit at full capacity has a staffing ratio on day shift of one clinical coordinator, one nurse to six patients, one CNA to seven patients, and one administrative assistant. Night shift staffing consists of one RN to six patients, one CNA to 10 patients, and one administrative assistant.

A hospital-wide nursing rounding policy was recently implemented, but had not been followed or embraced by staff. The key stakeholders, being the RNs and CNAs, were represented on the planning committee policy by the unit base educators from each inpatient unit (E. Middleton, personal communication, June 16, 2015). The nurse leader verbalized that staff were not held accountable to the policy. In addition, the hourly rounding form per the Cerner electronic documentation system was removed from the nurses' scheduled task list due to the many nursing staff complaints related to other numerous requirements on the task list. As such, HCAHPS scores continued to decline in patient satisfaction.

The HCAHPS survey is a clinical tool that measures "patients' perceptions of care" (Press Ganey, 2015, p. 1) and allows organizations to compare those findings with comparison rate to the national average are identified in Tables 1 and 2. Information annotated on the tables was ascertained from different sources. The national benchmark and average survey rate results were retrieved from the HCAHPS website (HCAHPS, n.d.). The project site's HCAHPS' information was retrieved from their learning

management systems for fiscal years 2013 and 2014. Lastly, the fall rates were obtained from the project's site monthly fall report dashboard. The chief nursing officer of the hospital established measurable *baseline* goals (Young, personal communication, June 2015) for the inpatient units based on information from the Press Ganey data bank (M. Farr, personal communication, September 10, 2015).

Table 1

Hospital Rating and National Benchmarks for Fiscal Year 2013 in Percentages (%)

	*National Benchmark	Hospital Baseline	Medical-Surgical Unit	Average Survey Rate
Overall Hospital Rating	69%	67%	64%	NA
Level of Staff Responsiveness	68%	63%	62%	NA
Fall Rate	3.5	3	2.8	NA
State of South Carolina				30%

*HCAHPS Hospital Consumer Assessment of Healthcare & Providers Systems (n.d.)
**Leader Evaluation Manager (LEM), 2013
*Fall rate is per 1000 hospital days

Table 2

Hospital Rating & National Benchmarks for Fiscal Year 2014 in Percentages (%)

	National Benchmark	Hospital Baseline	Medical-Surgical Unit	Average Survey Rate
Overall Hospital Rating	71%	68%	60%	NA
Level of Staff Responsiveness	68%	64%	62%	NA
Fall Rate	3.5	3	2.8	NA
State of South Carolina				29%

*HCAHPS Hospital Consumer Assessment of Healthcare & Providers Systems (n.d.)
**Leader Evaluation Manager (LEM), 2014
*Fall rate is per 1000 hospital days

Problem Statement

Documentation revealed that throughout the facility, the HCAHPS scores shown no significant improvement for fiscal years 2013 and 2014. As a result, the hospital reported a deficit of approximately one-half million dollars in revenue from the Center for Medicare/Medicaid Services (CMS) and other regulatory agencies. The total financial impact of a negative $423,090.69 cost consisted of a loss of $24,473.05 of withheld funds, $245,720.06 not earned based on performance, and $152,897.58 not received from Blue Cross Blue Shield. In addition, the lack of reimbursement caused the hospital to lose money. The loss of revenue prevented wage increases, and thereby contributed to low staff morale (C. Wise, personal communication, June 10, 2015). According to Wise (2015), staff has not received a wage increase for performance evaluations or cost of living raises for the past two years. Moreover, as of July, fiscal year 2015 scores disclosed an overall hospital rating of 69 and 54 for the medical-surgical unit.

Several activities in informal observation of staff's current practice by the DNP student revealed responsiveness to patient call light demands ranged from 3-20 minutes. During an introductory session for the DNP project, staff stated reasons for the delay to be related to staff shortage, geographical location of the daily assignment, and patient acuity. Yet, when staffing was adequate according to the unit's matrix, the project facilitator observed staff's response time continued to fluctuate resulting in a 20-minute delay to patient's request. The matrix is a tool used by the hospital to help determine the

amount of staff needed at any point in time during a 24-hour period (E. Middleton, personal communication, September 14, 2016). The concept should be explored further for evidence basis, but this is out of the scope of the DNP project.

In a recent workshop given by the Lean Quality Improvement Team at the project site, the initial and target state of the institution was reported. The initial state reported to have poor response rates to the HCAHPS survey submitted to patients by Press-Ganey. According to Farr (personal communication, September 1, 2016) the response rate fluctuated monthly, on an average between 14-20%. The Lean Team also reported the current performance of the hospital regarding the quality metrics being 30 points out of a possible 100 points.

The target state report attribute impacted all units house-wide, and was considered by the medical-surgical unit to include patient-centered care, scores for each measure at or greater than the CMS Achievement Threshold (50th percentile), improved response rate to HCAHPS survey, and accountability for staff at all levels (Smith, 2015). The report listed the baseline scores established by the chief nursing officer for the inpatient units. For this project, the baseline score for staff responsiveness was 65% and the overall HCAHPS scores were set at 69%. The practice change of nursing responsiveness to patients and hourly rounding" was piloted on the medical-surgical unit, and then implemented throughout the facility.

Purpose Statement

Nursing hourly rounding with a purpose has proven to be effective in several areas of patient care in other facilities (Halm, 2009). These areas include patient safety for reducing falls (Assi et al., 2008; Haack, 2007; Meade et al., 2006; Weisgram & Raymond, 2008; Woodard, 2009), increased patient satisfaction (Assi et al., 2008; Bourgault et al., 2008; Haack, 2007; Meade et al., 2006; Sobaski et al., 2008; Tea et al., 2008; Woodard et al., 2009), overall improvement of HCAHPS scores, and decrease in patient call lights (Assi et al, 2008; Haack, 2007; Meade et al, 2006; Weisgram & Raymond, 2008; Woodward, 2009). The evidence indicates that performing patient rounds yields a securer, suitable, and useful intervention for practice (Halm, 2009). Despite the policy and procedure of the hospital, the medical-surgical unit of hospital staff has failed to consistently check on patients at systematic intervals (Halm, 2009). Following identification of low HCAHPS scores related to staff responsiveness to call lights, the aim of this project was to show how intentional nursing hourly rounding with a purpose, addressing *five Ps*, mainly "potty" (Rieder, 2012, slide #17) or personal needs, pain, positioning, personal needs, and plug-ins, positively impacted patient outcomes (Popovich & Drew, 2014). The five Ps is a recent approach used with nursing hourly rounding to enhance patient satisfaction (Death, 2016). The fifth "P" represented the intravenous pump, sequential compression hose or any other plug-in available for patient care (Popvich & Drew, 2014).

Project Objectives

Several objectives were identified. The first objective was to implement the Iowa Model of Evidence-Based Practice (IMEBP) approach using problem-solving steps to promote quality patient-centered care on a medical-surgical unit (Zaccagnini & White, 2011). A step-by-step process guide, using an algorithm was followed, to assist and guide nurses through application of care using evidence-based practice to improve patient outcomes. The initial step, which is critical in the process, was identification of the "clinical problem-focused trigger" (White & Dudley-Brown, 2012, p. 14) and practice question (Melnyk & Fineout-Overholt, 2011). The clinical problem-focused trigger was failure of the nursing staff to consistently hourly round on the medical-surgical unit and provides responses to patient's demands per call lights in a timely manner.

The IMEBP accentuated the use of pilot testing versus the implementation of a practice change. After the pilot testing was conducted on the medical surgical area, a pre-and post-intervention HCAHPS survey was conducted to evaluate its effectiveness (Hodges & Videto, 2011). Plan modifications were done and the program was implemented throughout the facility.

The second objective was a pre-and post-comparison of the education sessions provided to staff regarding hospital policies and procedures for nursing hourly rounding. Education sessions were provided to re-educate staff regarding hospital protocol for nursing hourly rounding with inclusion of integral components of EBP. The re-education sessions were conducted using a PowerPoint Presentation before the project as a part of

the hospital's education to have staff in compliance with the policy. Staffs were given a printed script to follow during initial interaction with patients explaining the hourly rounding process. Staff rounded according to the hospital's policy, which stated that the RNs will round on the even hours and the CNAs will round on the odd hours up to 2200 hour. After 2200 hour nightly, rounding was done every other hour, and staff alternated at that time. Other components of the nursing hourly rounding educational presentations reflected the operations of the current call light system and integration of reviewing the welcoming booklet given to inpatients upon admission. The practice problem was also highlighted during the educational sessions with emphasis regarding the urgency for practice change. Research findings as a result of implementing consistent hourly rounding was discussed with staff. Additional integral components included in the presentation emphasized the process for rounding with a purpose addressing the 5Ps, mainly potty needs, pain assessment, positioning, possessions, and plug-ins. In addition, a review of the hourly rounding form listed on the Cerner electronic documentation system was done with specific instructions for documentation of the 5Ps. A laminated copy of the hourly rounding educational session presentation with a staff signature log was kept at the desk in a specified area for those staff members who were unable to attend the staff meetings and new staff members. New and forthcoming strategies were also included in the Power Point Presentation and discussed during the education session regarding the new call light and monitoring system being installed within the next eight months. The project leader answered all questions posed by staff.

The third objective was to evaluate the effectiveness of the QI project for practice change on the medical-surgical unit. The results of the preintervention HCAHPS survey three months prior to the implementation of nursing hourly rounding was compared to the post survey results after implementing the survey. Monthly, 100% of inpatients are mailed a HCAHPS survey by Press-Ganey. The survey is a standardized way of affording patients the opportunity to rate and document the perspectives of his or her hospital care and consists of 32 questions (HCAHPS, n.d.).

A fourth objective was to evaluate patient safety regarding falls pre-and post-educational sessions per the scorecard maintained by the nurse manager. Preintervention, the fall rate was below the national benchmark of less than three per 1000 hospital days. Pre-and post-evaluations were done for comparison. Current researchers have suggested that when staff responds to patient initiated call lights in a timely manner, patients have less opportunity to fall (Teng, 2010). Therefore, the problem-focused question to answer was to impact all objectives.

Problem-Focused Question

Will instituting hourly rounding on an adult inpatient medical-surgical unit improve staff responsiveness to patients from 64% to 85%, overall HCAHPS scores from 42% to 75%, and maintain patient falls to less than 3 per 1000 hospital days over three months post implementation of the nursing education?

Significance

Evidence based practice (EBP) through research findings is the core of nursing practice (Bradshaw, 2010). Implementing best research into nursing practice for best practices is critical to positive patient care. A significant reason for this EBP project is to provide highest quality of care for best patient clinical outcomes (Melnyk & Fineout-Overholt, 2011). Applying a standardized format for purposeful hourly rounding has proven to increase patient satisfaction, decrease patient initiated call lights, improve HCAHPS scores, decrease patient falls thereby improving patient safety (Brosey & March, 2015; Harrington et al., 2013; Mitchell, Lavenberg, Trotta, & Umscheid, 2014; Woodard, 2009).

Evidence-based practice has also been associated with decreased hospital costs (McGinty & Anderson, 2008; Melnyk & Fineout-Overholt, 2015; Melnyk, Fineout-Overholt, Gallagher-Ford, & Kaplan, 2012a). Increasing patient satisfaction was done to help to increase the hospital's revenue (Korda, 2012). Because CMS reimbursement is linked to standards of care, administrators must be mindful of cost when implementing projects and decision-making for healthcare. Oftentimes, providing the best practice can be very costly, causing a challenge for administrators. However, each provider of care should weigh the costs versus benefits or the pros and cons to delivering positive patient outcomes. "But the goal is to provide evidence-based, cost effective care" (Bakke, 2010, p. 606).

The process for translating evidence into practice involved many aspects inclusive of one's empirical reference, identifying the clinical problem, researching current literature regarding the problem, effectively appraising the literature, developing and implementing evidence-based interventions, evaluating outcomes, integrating the findings into practice, then sustaining the practice change can affect and strengthen nursing practice (White & Dudley-Brown, 2012). Additionally, as a doctor of nursing practice professional, the project planner possessed the skills to partner with others to utilize research, and "develop and evaluate patient care delivery approaches to meet both the current and anticipated need of patient populations based on scientific findings" (Terry, 2015, p. 10). Partnering with the staff on the medical-surgical unit and leadership of the hospital afforded the opportunity to fortify patient care. Additionally, it provided an opportunity to strengthen the delivery of health care and nursing practice in providing high quality and best care to patients for positive outcomes.

Reduction of Gaps

Translation of the best research evidence into nursing and health care practice is critical to positive patient outcomes (White & Dudley-Brown, 2012). This was achieved by delivering the evidence-based care derived through best research that promoted high-quality outcomes for patients, families, healthcare providers, and the healthcare system (Grove, Burns, & Gray, 2013). Nursing hourly rounding with a purpose has become the current experiential knowledge in specialty areas of healthcare that is fostered from a synthesis of quality studies (Grove et al., 2013).

Since evidence-base practice is the leading theme of practice, education, and policy in health care, nurse leaders must include staff nurses in the movement (Bradshaw, 2010). The collaborative effort significantly impacted buy-in, staff engagement, improved patient care, and increased patient satisfaction scores via HCAHPS surveys.

Implications for Social Change

The call light system coupled with effective nursing hourly rounding with a purpose or "intentional rounding" (Harrington et al., 2013, p. 523) is crucial to patient communication connection during hospitalization (Tzeng, 2011). Patient call lights are essential to alert the nursing staff of a patient's needs and emergencies (Saleh, Zubadi, Shloul, & Saleh, 2011). To patients, call lights are a "lifeline because they are often the only way of communication for the patient to raise his or her needs to the nurses on duty" (Teng & Kim, 2014, p. 21). The efficiency of the nursing staff's timely response to patient call lights and demands was favorable to the patient's level of satisfaction with nursing care (Kalman, 2014). These interventions were the pivotal influence to improving staff responsiveness to patients' needs and increased patient satisfaction scores via HCAHPS surveys. Researchers have continued to address the nursing staff's delayed response to patient needs once the light has been answered (Tzeng, 2010). Additional researchers also supported that a patient's perception of high-quality nursing care is not mirrored in the nurse's knowledge and competence, but in the patient's perception of his or her accessibility, physical presence, and response to the call light and requests (Woodard, 2009).

During the initial planning phase of the project, the medical-surgical staff eluded to the fact that time management for hourly rounding was a major cause of the variations in practice. The day shift staff verbalized that performing the task, as set by the policy was not doable, because of having to round and document every hour on the patients. Other variables included the acuity level and staffing ratios of the unit. During the education sessions, it was discovered that the culture and mindset of the unit regarding hourly rounding was nonchalant. Maynard, (personal communication, June 15, 2016) stated, "It seems like there should be a technology that can track the nurse or CNA's location and document their presence in a room."

Adhering to a rigorous hourly rounding protocol has shown to be challenging for staff. The challenge is related to multifaceted and rapidly changing of patients on the inpatient units (Sullivan, 2014). Yet through intra and inter professional communication, collaborative teamwork, accountability and delegation (Sullivan, 2014), researchers have shown the intervention to be effective in several areas, such as increasing in HCAHPS scores, staff responsiveness to patient's request, and reduction in patient falls. Nurses and the leadership of the facility looked at the interdisciplinary perspective of patient care. The implications for social change was beneficial in improving nurses' awareness of the importance of communicating effectively, developing and executing patient plans of care, and shifting the culture on the medical-surgical unit to best practice (Sullivan, 2014).

Definition of Terms

The key words used for the project were*:*

Hourly rounding: a systematic, proactive nurse-driven evidence-based intervention to anticipate and address needs in hospitalized patients (Deitrick et al., 2012).

Intentional rounding: care or comfort rounds to check on patients and ensure their fundamental care needs are met (Nursing Times, 2012).

Evidence-based practice: the integration of best research evidence with clinical expertise and patient values to facilitate clinical decision-making (Sackett, Straus, Richardson, et al., 2000).

Responsiveness: a component of most patient satisfaction surveys referring to the promptness of the caregiver when the patient activated the call light (Mitchell et al., 2014).

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): a standardized survey instrument and data collection methodology for measuring patients" perspectives on hospital care (HCAHPS, n.d.).

Assumptions, Limitations, and Delimitations

Assumptions

The desired expectation for this project was to improve the patient satisfaction scores, mainly related to timely response to patient initiated call lights from 64% to 85%, overall HCAHPS scores from 42-75%, and maintain patient safety/falls to <3 per 1,000

patient hospital days. Universally, hospitals will be penalized between 1-2% in reimbursement over the next two years for low patient satisfaction scores and not meeting the standards established by CMS (Smith, 2015). During the time of the planning phase, the average cost of inpatient care was approximately $10,000.00 (Medicare.gov, 2014b). Increasing the patient satisfaction scores has provided a consistent flow of finances for the hospital and enabled staff wages increases and other needs of the facility.

Limitations

Due to the rapid increase of registered nurse turnover on the unit, several agency nurses were hired. The medical-surgical unit had eight RNs resign in one month. Agency nurses were hired which can negatively impact patient care. Agency nurses are not vested into the institution and pose more disadvantages than advantages to staffing (Castle, 2009). The inconsistency can have a profound effect in quality patient-centered care. If not addressed, altered practices will produce inconsistent results and dissatisfaction including increased staff shortages. Long term implications for not addressing hourly rounding could result in a decline in patient care, decrease in patient safety related to falls, increase in pressure ulcers, and decrease in patient satisfaction and HCAHPS scores.

Delimitations

Delimitations of the project were related to staff behavior change, patient acuity and assignments. For the project, the DNP student considered setting hourly rounding to also include when staff members were in patients' rooms providing care. The staff

members and interventions include, but were not limited to, performing assessments, medication administration, evaluation of effectiveness of pain medication, and for dietary or other personal and family assistance. Observations of current practice and assisting with leader rounding have revealed that some patients are now reporting less use of the call light system. One patient reports rarely using call light unless pain medication is needed.

Summary

Effective nursing hourly rounding with a purpose is an established intervention that has shown to improve patient care, satisfaction, and HCAHPS scores. In addition, this intervention has proven to decrease the need for patient initiated call lights and increase patient safety by decreasing patient falls (Brosey & March, 2015; Mitchell et al., 2014; Tzeng, 2011). The nurse call light system and effective nursing hourly rounding with a purpose or "Intentional Rounding" (Harrington, et al., 2013, 523) was crucial to patient communication connection during hospitalization (Tzeng, 2011). The efficiency of the nursing staff's timely response to patient demands per call light requests was favorable to patient's satisfaction (Kalman, 2014) and patient safety (Deitrick et al., 2006; Tzeng & Yin, 2009). These interventions were the pivotal influence to patients receiving high quality care through best practices resulting in improved staff responsiveness to patients needs and increased patient satisfaction scores via HCAHPS surveys.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

The literature review was done to appraise studies to narrow the practice issue to define the current problem at hand (Bonnel & Smith, 2014). The review provided more clarity to the practice issue and revealed what studies had already been completed and published (Zaccagnini & White, 2011). Tracing the flow of the innovation from the research question allowed further findings, validating the relevance, usefulness, and urgency of the project Terry, (2015). Several search engines were accessed during the review.

The literature search through Ovid, CINAHL plus text, Cochrane Database of Systematic Reviews, Internet sources, and Nursing Allied Health Collection was done using the key words hourly rounding, nursing hourly rounding, purposeful or intentional hourly rounding, Studer group hourly rounding, and improving staff responsiveness. The search was limited to years 2006 through 2015. Many articles were found regarding nursing hourly rounding in different capacities including staff's perspectives regarding the usefulness of hourly rounding. All the articles found were used as references for the project. Articles discussing interventions utilized by other facilities for effective practice change were also located. The aim of the literature review was to identify literature related to causes of low HCAHPS scores due to staff responsiveness to patient call light demands.

Specific Literature

A systematic review of 16 articles by Mitchell et al. (2014), synthesized evidence concerning the effect of hourly rounding programs on improving nursing responsiveness. Grading of Recommendations Assessment, Development and Evaluation (GRADE) analysis of evidence using a four-point scale for evidence quality regarding nursing rounds was performed. The articles reviewed used a pre- and post-design. The authors concluded that the evidence was "moderate-strength evidence" (Mitchell, Lavenberg, Trotta, & Umscheid, 2014, p. 465) conveying improvement in patients' perception of nursing responsiveness, decreasing call light usage from 23% to 70% with a median reduction of 54%, (Mitchell et al., 2014, p. 467) and a reduction in patient falls. The systematic review provides additional validation to the project that nursing hourly rounding makes a difference with positive patient outcomes.

Brosey and March (2015) reported that organized nurse rounding is an effective strategic approach to improve patient satisfaction and improve safety. The authors used the Promoting Action on Research Implementation in Health Services (PARIHS) translation model to evaluate the effectiveness of structured hourly nurse rounding on patient satisfaction and clinical outcomes. Their findings revealed an increase of 6.1% to 30.9% in patient satisfaction scores post-implementation of hourly rounding when compared to pre-intervention documentation. However, the HCAHPS domains for responsiveness of staff pre-implementation scores were 49.3% (n = 35) and 48.6% (n = 81) post implementation. The results indicate lower scores post implementation. One-

year post implementation scores revealed and increase to 57.6 percentile (n = 472). Although the study did not show an increase in the nurse responsiveness domain, the authors concluded that unit based champions such as HCAHPS teams are integrated for sustainability and continued staff interest of the practice change. The study provides validation to the project in two of the measurable goals and objectives and the benefits of the HCAHPS team.

Teng and Kim (2014) conducted a quality improvement project regarding the effectiveness of nursing rounds to reduce the use of call lights. The project used a pre- and postimplementation audit strategy adopted from the Joanna Briggs Institute on the Practical Application of Clinical Evidence System (JBI-PACES) and Getting Research Into Practice (GRIP) programs on an oncology unit. The authors concluded that nursing rounds are effective in reducing the frequency of call light use. They further documented an improvement in patient care reporting a 37% reduction in medication issues, 31% reduction in call light usage related to potty needs, and 49% increase in providing comfort measures. The study is beneficial to the project because of the similarities in the activities performed. Direct observation of the staff's current practice was performed to obtain baseline data pre-implementation.

Rondinelli et al. (2012) identified how structures, processes, and outcomes were associated with hourly rounding. The study used a social action research design to collect data related to the implementation of hourly rounding at 11 Southern California hospitals. The Donabedian Model was used to provide the framework for the study.

Interprofessional communication and collaboration among the hospital's project investigators and leads were utilized. Analysis provided evidence of many positive patient care outcomes of nursing hourly rounding, such as a reduction in the number of patient falls, call light usage, satisfaction scores, and efficient nursing practice.

Ford (2010) study over a three-week period, showed a 52% decrease in call light use after implementing the hourly rounding. Other measures were tracked, mainly patient satisfaction showing 92-98%. In addition, the study revealed that nurses reported a less stressful day when performing the structured hourly rounding.

According to the Studer, Robinson, and Cook (2010), hourly rounding effectively decreases call lights by 40%, patient falls were decreased by 50%, skin breakdown was decreased 14%, and patient perception improved by 12 mean points. The 12 mean points refer to an average of all participating units in the study. The authors also note that hospitals that do not rank in the 90th percentile in all domains will receive a penalty from Medicare resulting in a 20% loss of all payments.

Mant, Dunning, and Hutchinson (2012) conducted a systematic review regarding clinical effectiveness of nursing hourly rounding on fall-related incidents on medical-surgical units in acute care settings. The participants were adult patients 18 years or older. Both experimental and epidemiological study designs were considered, inclusive of randomized controlled trials (RCTs), non-randomized controlled trials, quasi-experimental, pre-and post-studies, prospective and retrospective cohort studies, case control studies, and analytical cross-sectional studies. The methodological quality of the

articles used in this review was standardized data extracted tool from a tool of the JBI-MAStARI.

General Literature

Tzeng (2011) conducted an exploratory cross-sectional survey study to determine the perspectives of patients and family visitors about the reasons for and nature of patient-and-family initiated call lights, call light use, and response time to call lights. The results showed that approximately 80% of study participants from the day, evening, and night shifts cumulative indicated that staff's response time to call lights was within three minutes and were satisfied. Additional findings reported that patients expected staff to respond in less than three minutes, but were satisfied overall. Although the study did not investigate nursing hourly rounding specifically, patient call light uses and staff responsiveness to patient demands are significant to this project.

Baker, (2010) documented consistent nurse leader rounding to be an effective evidence-based tool for improving nurse retention as well as patient safety and quality of care. She further notes that the intervention is a foundational strategy that establishes relationships, "harvest wins, identifies areas for process improvement and success, repairs and monitors systems" (p. 162), and ensures that patients are receiving high quality and excellent care. During the interaction with staff or patients, Baker stresses that communicating immediate accolades and concerns will improve satisfaction and reduce any anxiety associated with uncertainties for the patients or staff. The benefits of

this study demonstrate the positive impact that nurse leaders can provide to staff when actively involved in the day-to-day operations of the staff through visibility on the unit.

Theoretical and Conceptual Framework

To facilitate change in practice, The Iowa Evidenced-Based Practice Model (IEBPM) was used for the project (Appendix A). Permission was obtained to utilize the model for this project (Appendix B). The model provided a framework for clarity of the scientific practice process (Polit & Beck, 2008), and offered a step-by-step process guide utilizing an algorithm to assist through the application of care (Titer et al., 1994). Additionally, the model emphasized the essential factors from a holistic view of the infrastructure to guide practice change (Dontje, 2007).

The initial step, which is critical in the process, was identification of the practice question or "triggers" (White & Dudley-Brown, 2012, p. 14) through identification of a practice problem (Melnyk and Fineout-Overholt, 2011). The problem was a lack of hospital reimbursement due to low HCAHPS scores, mainly related to the staff responsiveness to patient call light demands. The hospital implemented the nursing hourly rounding policy several years ago, but staff failed to comply (Wise, personal communication, June 2015). As a result, patient satisfaction scores per the Press Ganey HCAHPS survey declined.

The second step of the model includes stating the question and purpose of the project. The question at-hand is "Will instituting hourly rounding on an inpatient medical-surgical unit improve response time to answer call lights from 64% to 85%,

HCAHPS scores from 42% to 75% and maintain patient falls to less than 3 per 1000 hospital days? The purpose of the project was to show how intentional nursing hourly rounding with a purpose, addressing five Ps, mainly potty needs, pain, positioning, personal needs, and plug-ins, positively impacts patient outcomes.

The third step includes the team formation. The HCAHPS team was reactivated to assist with the project for staff buy-in, sustainability of the project, and outcomes (Hodges & Videto, 2011). Discussion of the relevance of the clinical practice change was explored. Through collaborative efforts, the leadership team and DNP student were in agreement with the hourly rounding intervention on the medical-surgical unit. After exploring many research studies, nursing hourly rounding with a purpose was the practice change for trialing.

Providing relevant and related literature then appraising the data are the fourth and fifth steps of the IMEBP. Many articles were reviewed and found to stipulate that nursing hourly rounding with a purpose, addressing four or five Ps contributes to several benefits. The Ps addressed during the rounding was pain, potty needs, positioning, personal needs, and plug-ins. The benefits will be numerous and should include increased patient satisfaction, safety related to falls, and HCAHPS scores. Other advantages proposed were a decrease in call light usage and skin breakdown (Cairns, 2010; Meade, Bursell, & Ketelsen, 2006). They provided a strong evidence-based foundation for the project. This improvement project looked at the impact on patient

safety, overall HCAHPS scores, and patient response to call light demands on the medical-surgical unit.

Summary

The literature review and theoretical framework were key components to the translation of new knowledge into practice (White & Dudley-Brown, 2012). The literature review gave support that nursing hourly rounding makes a difference in patient safety, HCAHPS scores, patient safety and other variables. The review provided support for the validity and reliability of specific tools and data collection approaches (Zaccagnini & White, 2011). Through research findings, nursing hourly rounding has shown to be an effective evidence-based intervention for positive patient outcomes. Appraising and analyzing current research allowed the project owner to outline "the flow of an idea from the researchable problem to the research question and the theoretical framework (Terry, 2015, p. 48). The Iowa Change model promotes goal directed quality care to patients positively impacting clinical outcomes (Melnyk & Fineout-Overholt, 2011).

Section 3: Methodology

Introduction

Program design is a critical element of any scholarly practice change for advancing patient care (Bonnel & Smith, 2014). The design assists in guiding and enhancing the project for positive patient outcomes (Bonnel & Smith, 2014). To help drive beneficial results and clearly "paint a picture" (Hodges & Videto, 2011, p. 153) when selecting appropriate behaviors for practice change, several elements are essential. The elements consist of measurement of services, resources, activities, demonstrated benefits, and measurable changes (Kettner, Moroney, & Martin, 2013). Section 3 will address the methodology, project design and/or methods, the target population, sampling, data collection, instrument to be utilized, protection of human subjects, data analysis, project evaluation plan and the summary. Lastly, a Gantt chart with timelines was presented regarding activities that assisted in meeting each of the program objectives.

Approach/Methods

The project design was a descriptive comparative one that used the HCAHPS survey and the scatter plot report for the fall rates to evaluate two points: a comparison of the measures of the educational sessions' pre-and post-nursing hourly rounding interventions. A descriptive study is one in which information is collected without altering the environment (Office of Research Integrity [ORI], n.d.). Manipulation did not occur while using the descriptive study (ORI, n.d.), and therefore, natural behaviors and patterns of the group were seen. The outcomes included the overall HCAHPS scores;

staff responsiveness to call light demands, and safety related to falls. Through observation of current practice, and communication with staff, a lack of teamwork, high acuity, and workloads, as well as accountability were identified as essential factors for the inconsistency in staff performing hourly rounding. The scores obtained through Press-Ganey were used.

Population and Sampling

The target population consisted of full, part-time, and per diem nursing staff. While many of the education levels of the front-line staff varies from certifications as nursing assistants, diploma Licensed Practical Nurses (LPNs), associates (ADNs), bachelors (BSN), and masters of science in nursing (MSN), 26 of the nurses are registered nurses. Two Licensed Practical Nurses (LPN) continued to work consistently one day per week on the unit.

A convenience sampling included all full and part-time nursing staff caring for adult patients aged 18 years old and above admitted to the medical-surgical unit who received at least 24 hours of patient care. The sample was representative of nonrandom sampling (Terry, 2015). The DNP student educated any new staff hired during the implementation phase of the project.

Data Collection

Demographics of age, education, years of work experience, and gender were gathered from the nurse manager regarding staff involved in patient care on the medical-

surgical unit. (Appendix C). The patient or his or her representative completed the HCAHPS survey.

Random chart audits consisting of an unstructured participant observational method were used to identify whether the staff performed hourly rounding. The electronic record was formatted to see whether the hourly rounding was performed without accessing other areas of medical record. Permission to access this information was given to the DNP student by the executive and leadership teams of the hospital and medical-surgical unit. The method is used when information of the implementation of specific skills or environment are observed (Terry, 2015). The Cerner electronic power form was reviewed for all patients three times weekly for three months, who were admitted to the unit and received at least 24 hours of patient care. The five Ps are listed on the Cerner power form; staff documented whether the 5Ps were addressed accordingly. The fifth "P" only pertained to patients with plug-ins. Plug-ins is any devices used for patient care such as the Alaris Intravenous pumps, sequential compression hose, and wound vacuums. The DNP student leading the project developed a tool called the 24-Hour Rounding Tracking Form (Appendix D) to be used tri-weekly. The tracking form was an excel spreadsheet displaying all hours required for hourly rounding according to hospital policy. During the tri-weekly chart audit, all hourly rounding performed by the staff for each patient weekly, in a 24-hour period based on the prospective data from the chart was documented on this form, and a percentage was calculated for that 24-hour rounding period. The DNP student received permission from

the leadership and executive teams of the hospital to access the data. The data was de-identified from the electronic medical charts.

Secondly, to measure staff responsiveness to patient call light demands, data was collected by performing random staff observational audits with different nurses to patient call light demands weekly for three 12-hour shifts over four weeks. The number of shifts was determined in consultation by the project designer and the leadership team of the medical-surgical unit. To assist with the correct time in minutes, a device such as a stopwatch was chosen.

A stopwatch was used to monitor the time it took for nursing to respond to the call light and the results were recorded in minutes. Recording time began after the nurse had been adequately informed of the patients' needs. The project planner anonymously recorded the time. Accurate data could not be retrieved from the unit's current call light and monitoring system due to antiquation of the system and malfunctioning lag time. The current system also required multiple repairs that could not be performed due to unavailability of the parts. A forth-coming monitoring system package was evaluated, but downscaled by the company that manages the hospital operations and the budget during the Hospital's annual survey. The new system had the potential to provide the necessary data that would be beneficial to the project.

Patient's perspectives of staff responsiveness to call light demands were measured by comparing the pre- and postintervention HCAHPS survey three months before and three months post education of the nursing hourly rounding intervention. All patients

who are not deceased or transferred to another facility received the HCAHPS survey. The Press-Ganey Corporation mailed the survey out. Preintervention data was already documented due to the monthly assessment of the HCAHPS scores, and was collected from the nurse manager of the unit, who received the report from the Chief Nursing Officer (CNO).

Lastly, the monthly balanced scorecard with a dashboard was used to display the fall rate three months pre-and post-intervention, as well as the national benchmark rates related to falls. This is a common practice of the hospital. A balanced scorecard is a strategic planning and management system that is used extensively to align activities to the vision to improve organizational goals (3 Balanced Scorecard Institute, 1998-2015). The scorecard was obtained from the nurse manager of the medical-surgical unit, as she received the report of the fall rate from the Risk Management department monthly. The fall rate is currently tracked monthly hospital-wide; therefore, the information is readily available. Additionally, three months preintervention data that was collected displays a picture of the unit's current trend regarding fall safety that is specific to the unit. Post-intervention data was also collected over three months post education sessions.

A visual representation of the program design was developed. The design was displayed in a table and was depicted in the document appendices. The document developed included the program's mission statement, goals, objectives, and activities to meet timelines that show a graphical illustration of a schedule of how activities were completed (Appendix E). The two documents provided additional information regarding

other essentials that contributed to the successful planning and implementation of the project.

Instruments

Stopwatch

The project used a stopwatch to monitor the staff's responsiveness to patient call lights demand. The stopwatch is a feature of the iPhone 6 plus located under the "clock" section of the phone. The project facilitator owns the iPhone. The project facilitator ensured that the battery was charged daily for adequate and consistent functioning of the device. A back-up stopwatch available includes the Ultra 310 silent event stopwatch by Bodytronics. The watch is cost effective at $8.95. The device is easy to use, has a simple event timer such as start-stop-reset, times up to 10 hours with 1/100-second resolution and has a three-year warranty (Bodytronics, 2016).

Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)

The HCAHPS survey, also known as "CAHPS" (HCAHPS Fact Sheet, 2015, p. 1) was developed and tested in 2002 by the Center for Medicare and Medicaid Services (CMS) collaboratively with The Agency for Healthcare Research and Quality (AHRQ) (Appendix F). The 32-question HCAHPS survey provides consumers with material that is helpful in providing quality care in a hospital. "The document also standardizes questions for public comparisons" (Ketelsen, Cook, & Kennedy, 2014, p. 6), and is used as a catalyst for quality, linking reimbursement to quality clinical outcomes (Ketelsen, Cook,

& Kennedy, 2014). The survey is mailed to all patients or their legal guardian, with the exclusion of patients who expired or were transferred to other facilities. Twelve domains or categories are tracked and summarized monthly, but only the two domains, mainly the overall hospital rating and staff responsiveness were used in the project. The survey domains are identified in Table 3.

Table 3

HCAHPS Survey Domains

PRESS GANEY® **CAHPS** **Inpatient - 3-West**
The Medical-Surgical Unit

CAHPS				
	Top Box	Top Box	Top Box	Top Box
Rate hospital 0-10				-
Recommend the hospital				-
Cleanliness of hospital environment				-
Quietness of hospital environment				-
Comm w/ Nurses				-
Response of Hosp Staff				-
Comm w/ Doctors				-
Hospital Environment				-
Pain Management				-
Comm About Medicines				-
Discharge Information				-
Care Transitions				-

Monthly, a summary of each domain that reflects the HCAHPS scores are received and reviewed by the patient care representative and the leadership team of the unit. The report, a measurement of care represented through the domains is received from the Press-Ganey Company at the approximately six weeks after the end of the month. Press-Ganey is the nation's leading provider of patient satisfaction surveys with an aim to assist hospitals in delivering accurate, safe, high quality, patient and family

centered care. The measurement of care is displayed through represented through the domains.

The overall rating of the HCAHPS survey represents an average of all score of the nine domains combined (Fact Sheet, 2015). Response time is defined as the interval from the time a call was activated to the time the call was cancelled from the patient's room or the time he or she was informed of the call (Tzeng, 2011). The scores were designed and prepared for use at the hospital level (HCAHPS Fact Sheet, 2016). The project site measures staff response time based on the patient's perspective recorded on the HCAHPS survey tool. Patients' chose from four options: "always, sometimes, usually", and "never" (HCAHPS Survey, n.d.). The selection termed "always" is the preferred rating used by the Center for Medicaid and Medicare Services (CMS) regarding hospital reimbursement (Ehrhardt, personal communication, June 2015).

Scorecard

The balanced scorecard with the dashboard was used to track the monthly fall rate. A balanced scorecard is a useful and relevant tool to direct attention and resources to facilitate improvement in rehabilitation and hospital settings where health information infrastructure is substandard (Khorshidi, Mastaneh, & Javidkar, 2013). In addition, the balanced scorecard also measures, describes, and improves performance (Khorshidi, Mastaneh, & Javidkar, 2013). Monthly, the Director of the Risk Management department of the hospital updates the fall rate for all units, and distributes the results to

the CNO, directors, and nurse mangers. The data for the scorecard were extracted from the report received from the Risk Manager.

Protection of Human Subjects

The practice change improvement project was not implemented until approval was received from the Institutional Review Board of the Hospital (IRB) and from Walden University. The project planner submitted a request to the IRB of the hospital to determine that the project complied with Department of Health/Humans Services (DHHS) regulations and is exempt from IRB review. A role of the IRB is to implement and "monitor the principles promulgated in the Common Rule at all institutons receiving federal dollars" (Bonnel & Smith, 2014, p. 152). The Common Rule set the guidelines required, if any, for the project to be executed (Bonnel & Smith, 2014).

To ensure data integrity, the information was kept in a locked cabinet within the program's planner mentor's office that has been designated and allotted to the project planner. The computer was password protected and kept in a locked private office. The protection of human subjects is paramount. According to the "*Code of Ethics for Nurses with Interpretive Statements"* (Zaccagnini & White, 2011, p. 11), nurses have a moral responsibility to protect human rights. Patient information reported by the nursing staff is via electronic documentation and will be protected by username and password login. Each staff member was assigned a username and password for daily operations of the facility.

When conducting research, the IRB conducts a review of the project to foster a complete, scholarly and fair review that is ordinarily conducted in institutions (Grove, Burns, & Gray, 2013). Informed consent from the subjects is not required for this type of improvement project. However, patients did sign a general consent form at time of admission, which grants the hospital permission to conduct research if needed (TRMC website, 2016). The intervention, hourly rounding, is a hospital policy that was neglected by the staff. The data collected is routine patient care and was kept according to hospital policy and procedures. All current and new hires of the nursing staff were required to participate in the QI project.

Projected Benefits

The project answered the question **"**will instituting nursing hourly rounding on an adult inpatient medical-surgical unit improve staff responsiveness to patients from 64% to 85%, overall HCAHPS scores from 42% to 75%, and patient falls to less than 3 per 1000 hospital days" over three months post implementation of the nursing education? Answering this question in a favorable manner has provided the evidence for clinical decision-making. In addition, the project has transformed practice to reflect that high quality; individualized care was being delivered to patients.

Risks

The information collected during the QI project involved data from the electronic file and the HCAHPS survey. However, names were not mentioned. The data collected does not violate the HIPPA rights of patients. Staff performed routine patient care

according to hospital policies and procedures. Therefore, there was no risk or harm to the human subjects.

Data Analysis

The data analysis strategy based on the research design requires descriptive examination of pre-and post-changes in staff responsiveness to patient call lights, overall HCAHPS scores, and the fall rate. Specifically, the data collected compared changes in study metrics as a result of hourly rounding training sessions. Descriptive analysis was used to examine and analyze the data pre-and post-implementation of the educational sessions provided for the project. Pre-and post-data is illustrated using charts, graphs and tables for comparison. Five variables were analyzed: 1) observed level of responsiveness to patient call light demands, 2) hospital staff response to patient call lights per the HCAHPS survey, 3) overall HCAHPS rating for the medical-surgical unit, 4) patient safety related to falls, and 5) hourly rounding. Baseline or pre-intervention data was compared retrospectively to post education training.

Nursing hourly rounding was analyzed by using descriptive statistics. Level of responsiveness to patient call light demands was analyzed by using descriptive statistics. The results are displayed with a two-dimensional bar graph: horizontal representing the X-axis and vertical dimensions representing the Y-axis, to display the frequency information (Pilot, 2010). The categories pre-and post-teaching, hospital policy, and the national standard of response time to patient call light demands are displayed along the horizontal axis. Time in minutes, representing percentages is displayed on the vertical Y-

axis. The bars are drawn to the height that indicates the relative frequency for each category. The widths and distance are equal and not touching each other. The exact percentages are documented at the top of the bars (Pilot, 2010).

The overall HCAHPS rating are also analyzed using a bar graph to compare three months pre-and post-educational training. The vertical Y-axis displays the percentages of the relative frequency. The horizontal X-axis represents the months of the year the survey was completed. Monthly, the Press-Ganey survey company, mails out surveys to 100% of the patients who receive care at the facility except for those who expire or transfer to another facility during discharge. The results are summarized based on the nine domains and specific unit for which patient care was provided. Survey scores for three months pre-implementation was obtained from the Hospital's customer service representative for review pre-intervention. Post-intervention survey results conducted by Press-Ganey on behalf of the hospital were compared to the pre-intervention survey results to determine the success of the pilot, effectiveness of the EBP, and need for modification of either the implementation process of the practice protocol. (Melnyk & Fineout-Overholt, 2011). Post implementation data was collected for three months. The purpose of displaying the three-month trends analysis was to see what occurred over a specific time frame. The results are represented in a bar graph for pre-and post-comparisons. The data helps to take advantage of potential opportunities manifested in the analysis.

The fall rates were analyzed using a scattered plot diagram to demonstrate the relationship between the measurements of two variables (Pilot, 2010). The two measurements are the number of patient hospital days and the number of falls per those days. The horizontal axis shows the months of the year and the vertical axis exhibits the number of patient days pre-and post-educational training. Pre-and post-implementation analysis also include three months data and is displayed using a graph for comparison to determine the effectiveness of the intervention. The practice maintained consistency in the data analysis process of all elements to be analyzed.

Monthly, the nurse manager reports the number of fall occurrences to the risk manager of the hospital. A special formula was used to calculate the fall rate per 1000 hospital days. Afterwards, the rate was reported as data and annotated on the balanced score and given to the leadership team of the unit. The variable was analyzed by using a chart to compare pre-and post-implementation data.

Project Evaluation Plan

Program evaluation is a continuous process that is essential to evidence-based health program (Gard, Flannigan, & Cluskey, 2004). Ongoing evaluation of the program with evidence integrated into quality improvement programs are needed to foster incorporation of the practice into daily care (Melnyk & Fineout-Overholt, 2011).

The Iowa Model of Evidenced-Based Practice was used to evaluate the effectiveness of the project. The model is well known for research utilization and promoting quality care (Melnyk & Fineout-Overholt, 2011). The step-by-step problem-

solving algorithm was used to evaluate the effectiveness of the project. Each area of the algorithm was compared to the specified criteria set for the model. The Iowa Model of Evidence-Based Practice guided the project planner in making decisions about the day-to-day practices of the project. The comparison of the pre-and post-pilot data determined the outcomes of the program, effectiveness of the evidence-base intervention, and the need for "modification of either the implementation process or the practice protocol (Melnyk & Fineout-Overholt, 2011). The results are appropriate; therefore, recommendations were made to the leadership team to implement the practice house-wide.

Improving staff responsiveness to patients call light demands from 64% to 85%, overall HCAHPS scores from 42% to 75%, and maintaining patient falls to less than 3 per 1000 hospital days indicates the effectiveness of the intervention. The recommendation has prompted consideration of rollout and integration of the practice throughout the remaining units of the hospital done. The translation of the practice change has been facilitated through leadership support, education, and continuous monitoring of outcomes (Davier et al., 2006; Gifford et al., 2006; Gifford et al., 2007; Greenhalgh, Robert, Bate, et al., 2005; World Health Organization, 2007). If the practice change is unacceptable for adoption and rollout, quality improvement monitoring has been recommended to the management team to ensure high-quality patient care (Melnyk & Fineout-Overholt, 2011).

Summary

Program evaluation is an ongoing process that is essential to outcomes. The evaluation is necessary for measuring the degree to which the outcomes were or were not met (Zaccagnini & White, 2011). The Iowa model of evidenced-based practice is a compatible fit for the program to best demonstrate the outcomes (Zaccagnini & White, 2011). Timelines provided a visual representation to assist with sensible completion of the process (Melnyk & Fineout-Overholt, 2011). Outcomes of the project correlated with results documented in recent literature and evidence-based projects.

Effective hourly rounding has proven to increase patient satisfaction, improve patient care and HCAHPS scores, improve patient safety related to falls, and improve pressure ulcers, to name a few (Brosey & March, 2015; Chua & Neo, 2014). Long term implications for not addressing hourly rounding could result in a decline in patient care, decrease in patient safety related to falls, increase in pressure ulcers, and decrease in patient satisfaction and HCAHPS scores. Unfortunately, these results can profoundly add to the lack of reimbursement from Center of Medicare/Medicaid Services (CMS) and other regulating agencies. Of course, lack of funds means no increase in staff salary. The staff shortage will continue resulting in the frequent hiring of many agency nurses, which can cause other problems. Agency nurses are not vested into the institution and pose more disadvantages than advantages to staffing (Castle, 2009). The inconsistency can have a profound effect in quality patient-centered care. If not addressed, altered practices will produce inconsistent results and dissatisfaction including

increased staff shortages. With favorable results, the recommendation by the project planner will further advance progress in providing high quality care to patients.

Section 4: Findings, Discussion, and Implications

Introduction

The purpose of this quality improvement project was to show how intentional nursing hourly rounding with a purpose, addressing the five Ps of potty needs, pain, positioning, personal needs, and plug-ins, positively impacts patient outcomes (Popovich & Drew, 2014). Section four presents the results of the comparison of the pre-and post-educational sessions regarding the hourly rounding intervention. Nursing hourly rounding with a purpose has shown to provide an increase in patient satisfaction. The evidence-based intervention was a pivotal influence in patients' perception of high quality individualized care. Section four discusses the findings of the DNP project, the results in the context of the literature and conceptual model, implications for practice, social change, project strengths, limitations, and analysis of self as a scholar, practitioner, and a developer, and proposed future professional development of the project.

Summary and Evaluation of Findings

The goal of the project was to increase the staff's responsiveness to patients' call light demands, maintain the hospital's fall rate below the national benchmark through the National Database of Nursing Indicators (NDNQI), and increase the overall HCAHPS survey scores. The aim was to evaluate and compare the pre-and post-educational sessions to determine if there was increased use of nursing hourly rounding. The targeted audience was the nursing staff on the medical-surgical unit in a rural hospital. The practice-focused question used to guide the project was: Will instituting hourly rounding

on an adult inpatient medical-surgical unit improve staff responsiveness to patients from 64% to 85%, overall HCAHPS scores from 42% to 75%, and maintain patient falls to less than 3 per 1000 hospital days over three months postimplementation of the nursing education sessions? To answer the practice-focused questions, the following objectives were identified:

1. To implement the Iowa Model of Evidence-Based Practice (IMEBP) approach using problem-solving steps to promote quality patient-centered care on a medical-surgical unit (Zaccagnini & White, 2011).
2. To perform a pre-and post-comparison of the education sessions provided to staff regarding hospital policies and procedures for nursing hourly rounding.
3. To evaluate the effectiveness of the QI project for practice change on the medical-surgical unit.
4. To evaluate patient safety regarding falls pre-and post-educational sessions per the scorecard maintained by the Nurse Manager.

The first objective was to implement the Iowa Model of Evidence-Based Practice (IMEBP) approach using problem-solving steps to promote quality patient-centered care on a medical-surgical unit (Zaccagnini & White, 2011). The IMEBP was implemented to guide the development of the project. In the initial step, the practice question was identified out of the practice problem. Multiple consultations were held with the leadership team of the unit to discuss the most urgent practice need. Results revealed lack of reimbursement to the hospital due to low HCAHPS survey scores and

performance. Although scores were low throughout the facility, the lowest scores were identified on the medical-surgical unit. Therefore, the quality improvement project was initiated first on this unit.

The practice of hourly rounding and how it increased patient satisfaction, thereby positively contributing increased HCAHPS survey scores was a priority for the organization because there was a lack of revenue for the hospital that resulted in loss of wage increases for the staff during the fiscal years 2013-2014, 2014-2015. An evaluation of the project site's risk management data consisting of the past and current HCAHPS scores on the medical-surgical unit was reviewed for fiscal years October 1, 2013-September 30, 2014, 2014-2015 and current scores for 2015-2016. Internal and external benchmarking data was also evaluated. Due to the urgency of the topic within the organization, a team was formed to assist the DNP student with the quality improvement project.

Step two of the model was the team formation. The unit had previously organized a HCAHPS team, but it was inactive due to staff shortages and staff turnover. The Nurse Manager reactivated the team to include an information technician, administrative assistant, two CNAs and two registered nurses, one of which was the Nurse Manager. Through informal team meetings, the team helped to identify the staff's perspective for the low HCAHPS scores. During the initial meeting, the purpose of the project and current literature discussed regarding the successful outcomes of hourly rounding were discussed by the DNP student. The team agreed that the hourly rounding tool needed to

be reassigned to the staff members electronic task list for integration into the daily routines of the staff. The process was necessary so that the clinical staff could record the data required to address the 5 Ps of potty, pain, positioning, readjustment of personal items, and plug-ins. The process provided a way to obtain the data and information necessary to the outcomes of the project (Kettner, Moroney, & Martin, 2013). The task was discussed with the upper leadership of the medical-surgical unit, the Director of the Department, and the Information Technology Manager. After several months of deliberation, the hourly rounding intervention was reassigned to all nursing staff.

During several staff meetings, and one-on-one teaching by the DNP student for new employees, the project was introduced to the staff. A PowerPoint Presentation was used to discuss the project, its purpose, background information, and its objectives with the staff. Staffs were receptive to the project and verbalized agreement to participate in the project. Their greatest concern was implementing ways to increase revenue for consistent staff wages increases and patient safety.

Step three included the assembling of the literature findings and review. Many articles published within the past 3-5 years were located through several search engines by the DNP student. The articles revealed recent evidence-based information relevant for the project. All the literature was used to help validate the benefits of this project. Project outcomes were selected in collaboration with the leadership team of the medical-surgical unit. The hourly rounding intervention was reassigned to the task list for the nursing staff. The staff was instructed to execute the assignment per the standard hospital

policy. Previously the nursing staff were given a cue card to remind them of the communication required to convey to the patient about hourly rounding. The nurses rounded every other hour on the even hour and the CNAs rounded on the odd hour. Hourly rounding began at 07:00 a.m. and continued until 10:00 p.m. daily. Afterward, the staff rounded every other hour and documented the results per the Cerner electronic documentation system.

The second objective was to perform a pre-and post-comparison of the education sessions provided to staff regarding hospital policies and procedures for nursing hourly rounding. The goal of the objective was to change staff behavior to influence practice change for hourly rounding. Staff were previously re-educated regarding the hospital policy for nursing hourly rounding. To determine whether staff rounded hourly, random chart audits were performed. The electronic power form was reviewed three times weekly for patients who were admitted to the unit and received at least 24 hours of patient care. The data was manually annotated on the 24-hour Rounding tracking form that was developed by the DNP student (Appendix D). The tracking form is an excel spreadsheet that displayed all hours required for hourly rounding according to the hospital policy. During the tri-weekly chart audit, hourly rounding performed by the staff for each patient weekly, in a 24-hour period based on the retrospective data from the chart was documented on this form by placing a “y” for yes and an “x” for no. A percentage was calculated for that 24-hour rounding period on the tracking form for each patient. A cumulative percentage rate was also performed for each day of the tri-weekly audit for a

weekly rate to determine the monthly average of hourly rounding over three months. A descriptive analysis was performed with each week's percentages times four weeks over three months.

Pre-intervention (education) data showed 0% for staff hourly rounding. The data retrieved from the tri-weekly chart audit for nursing hourly rounding yields the following results: month one results range from 75.8-87.64% with a mean of 81.46% and median of 81.20%. Month two values range from 70.41-88.15% with a mean of 78.51% and a median of 77.74%. Month three data ranges from 74.98-80.15% with a mean of 77.54% and a median of 77.51%. The cumulative percentages for the three months were 79.17%. The data reflected positive practice changes on the unit (Table 4).

Table 4

Descriptive Analysis for Hourly Rounding

	Preintervention n = 12		Postintervention n = 12
Month	Week	%	%
1	1	0.00	83.00
1	2	0.00	87.64
1	3	0.00	79.40
1	4	0.00	75.80
Mean		0.00	81.46
Median		0.00	81.20
2	1	0.00	79.20
2	2	0.00	88.15
2	3	0.00	76.28
2	4	0.00	70.41
Mean		0.00	78.51
Median		0.00	77.74
3	1	0.00	78.63
3	2	0.00	80.15
3	3	0.00	76.40
3	4	0.00	74.98
Mean		0.00	77.54
Median		0.00	77.51
Cumulative		0.00	79.17

The third objective evaluated the effectiveness of the QI project for practice change on the medical-surgical unit by the improved work flow, quality of care provided through consistent hourly rounding, and patient satisfaction metrics that were compared (Krepper, Vallejo, Smith, Myers, 2012). Staff responsiveness was measured by performing random staff observational audits with different nurses to patient call light demands weekly for three 12-hour shifts for four weeks. During the three 12-hour shifts, staff responsiveness ranged from three to five minutes averaging four minutes for the first week. Week two staff responsiveness ranged from two to five minutes with an average response time of 3.6 minutes, three to six minutes for week three with an average response time of 4.6 minutes, and three to ten minutes for week four with an average of 5.6 minutes (Figure 1). Results of the pre-intervention observation of staff responsiveness varied from 3-20 minutes. A stopwatch was used to monitor the staff's response to patient call lights demand. The stopwatch was a feature of the iPhone 6 plus located under the "clock" section of the phone.

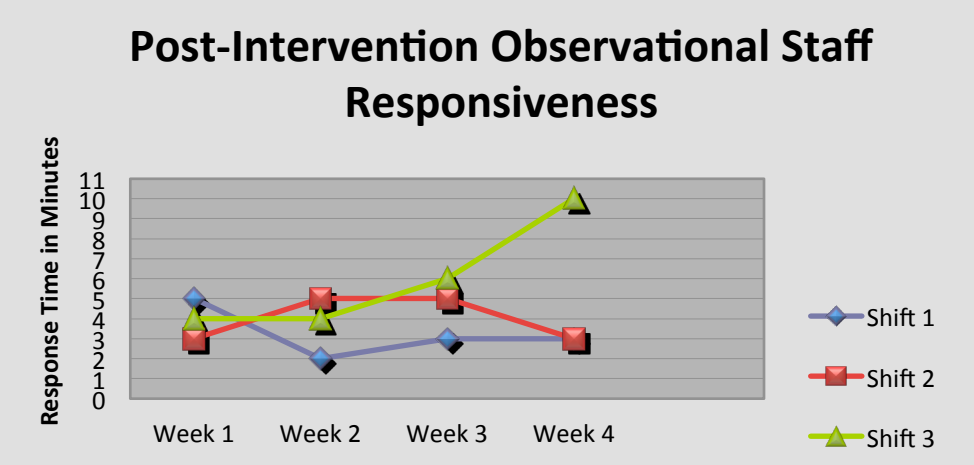

Figure 1. Postintervention observational staff responsiveness.

Although staff's response time did not consistently meet the guidelines of the hospital's policy of three minutes or less, staff improved patient response time of twenty to three minutes pre-intervention to an average time of 4.3 seconds. The delay in response time of the staff correlated with an increase in the nurse-patient ratio. During week four, the staff ratio was one nurse to seven patients and one CNA to 10 patients. Other delays included the increase in patients who were placed on contact precautions with staff required to apply gowns and before entering the patients' room.

The patients' perspectives of staff responsiveness to call light demands were measured by comparing the pre- and postintervention HCAHPS survey three months before and three months post education of the nursing hourly rounding intervention (Figure 2). The HCAHPS scores for the consecutive months one, two, and three were 54%, 78%, and 76% respectively. However, intermittent survey scores for the response of staff to patient call light demands ranged from 21-85%. The Press-Ganey Corporation mailed out the 32-question survey to all patients admitted to and discharged from the medical-surgical unit. Preintervention data for staff responsiveness to patients' demands was already documented due to the monthly assessment of the HCAHPS scores, and was collected from the nurse manager of the unit, who received the report from the Chief Nursing Officer (CNO).

Post-intervention results of the HCAHPS survey scores for the overall rating category for the medical-surgical unit in months one, two, and three were 46%, 87%, and

69% respectively. The average score of the HCAHPS survey rating for the overall rating for the three months evaluated was 67.3%. In comparison to the pre-intervention data of 42% that contributed to the loss of reimbursements to the hospital, the data reflect a 25.3%- increase in the HCAHPS survey scores for overall rating.

The overall hospital rating for all units of the hospital showed an increase of 1% from the previous year of 68%. The overall hospital rating for the medical-surgical unit for the three months analyzed revealed an average rate of 67.3%, which is an approximate 4% decline than the previous fiscal year. In comparison to the national benchmark, there is an 11% reduction from fiscal year 2014. Although correlational statistics were not run as a part of this project, there appears to be a direct association between change in knowledge and behavior between the overall HCAHPS rating and responsiveness of the hospital staff for the three months evaluated (Figure 2). The correlation indicates that monthly, as the response of hospital staff to patient call light demands increased, so did the overall rating for the medical-surgical unit with the same corresponding months.

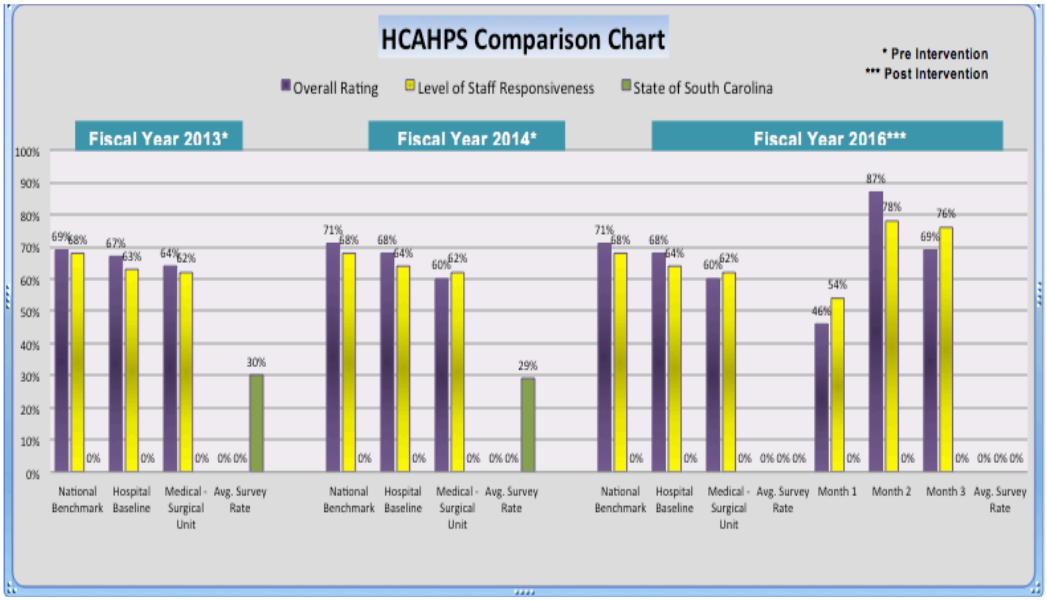

Figure 2. HCAHPS comparison chart.

The pre-and post-comparisons of the staff's level of responsiveness intervention (observational) to patient call light demands in minutes, HCAHPS response rate, overall HCAHPS rating for the medical-surgical unit, safety related to falls, and hourly rounding are displayed in Table 5. The hospital policy requires that call lights be answered within three minutes. The post-intervention observational staff responsiveness results revealed a time of 4.42 minutes, reflecting a 15.58-minute improvement in staff response time. The results indicate that the evidence is clinically relevant. The HCAHPS survey representing the patients' perspective of the staff response time shows a 4% increase, which is not statistically significant. The overall HCAHPS rating three months post intervention shows an increase of 25.33% when compared to pre-intervention data. Safety related to patients' fall rate shows a significant decrease of 3.8 for fiscal year 2015 to less than 1.4 for the months evaluated. Lastly, the results for hourly rounding correspond to the

literature that the practice of hourly rounding is significant in clinical practice (Mitchell et al., 2014)

Table 5

Descriptive Analysis/Mean Comparisons of Pre-Post Indicators of Purposeful Hourly Rounding

Measures	Pre Training Mean	Post Training Mean	p Value
Level of Responsiveness Interval (Observational)	20 minutes	4.42 minutes	.000*
HCAHPS Responsiveness	64%	69.33%	.051
Overall HCAHPS Score (3 months)	42%	67.33%	.363
Safety (Fall Rate	2	0.467	.190
Hourly Rounding	0%	79.17%	.000*

*represents p value statistically significant

The fourth objective was to evaluate patient safety regarding falls. The pre-and post-educational sessions per the scorecard maintained by the Nurse Manager regarding fall rates were measured by comparing the fall rates pre-and post-educational sessions. The fall rate was maintained below the benchmark of 3.5 per 1000 hospital days. The fall rates were zero for months one and two, and month three had a fall rate of one. Data from the chart audits validating the percentage of hourly rounding correlated with the decrease in the fall rate. For the three months evaluated for staff hourly rounding and the fall rate, the fall rate findings were significantly lower than the pre-intervention data. The preintervention rate of falls ranged from 1.2-3.8 per 1000 hospital days. The post-

intervention fall rate ranged from 0-1.4 per 1000 hospital days. (Table 6 and Figure 3). The findings are lower than the national benchmark results, which were 3.5 per 1000 hospital days.

Table 6

Balanced Scorecard with Fall Rate for Medical-Surgical Unit

	Pre-Intervention			Post-Intervention		
Month	October	November	December	January	February	March
Fall Rate Benchmark (BM) 3.5	3.5	3.5	3.5	3.5	3.5	3.5
# of Falls	3	1	1	0	0	1
Patient Days	799	769	778	700	672	716
Fall Rate FY 2015 = (2.8)	3.8	1.3	1.2	0	0	1.4

(Risk Management Data Form, 2016)

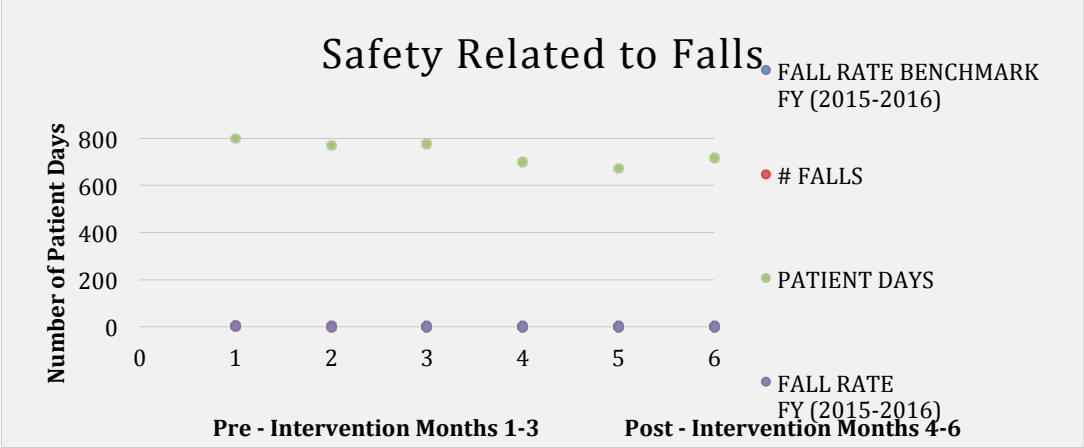

Figure 3. Line graph for fall rate three months pre- and post-intervention.

Implications

Policy

Quality improvement initiatives are a driving force for translation of practice change in the healthcare arena (Weston & Roberts, 2013). They infuse the flow of nursing care provided to patients (Hughes, 2008). The goal of the quality improvement initiative was to increase staff responsiveness to patients' call light demands, increase overall HCAHPS scores, and maintain the fall rate related to safety on the medical-surgical unit. Understanding the importance of utilizing policy and quality improvement practice models such as the Iowa Model to Evidence-Based Practice to Promote Quality Care to enhance positive patient outcomes must continue to be integrated for practice initiatives. The project site's policy for nursing hourly rounding has specific and rigorous standards related to implementation and documentation of when hourly rounding is performed. Adhering to the current hospital policy will help to decrease patient call light usage, increase access to patients' demands, contribute to a safer environment related to falls for the hospitalized population, and increase recompense for the facility.

Practice

A major outcome for this project was observing the nursing staff work together as a team when hourly rounding or responding to patient call light demands, to compensate for high acuity and staff shortage. Staff buy-in for the QI mission surpassed the expectation of the program facilitator, thereby providing the evidence of how leadership involvement, robust realignment of educational sessions with follow-through, and

continuous practice adjustments, can accentuate nursing practice (Rondinelli, Ecker, & Crawford, 2012). The results of the project indicate that when the stakeholders are an integral part of the planning, and continuous education of that plan is conveyed, implementation and compliance of the process will yield positive outcomes. The pinnacle of the nursing practice concedes care that was safe, effective, and efficient (Stevens, 2013)

Research

While research utilizes a methodology to generate new knowledge based on theory with less focus on protocols and policy making, the evidence generated from the studies is critical to QI projects that use a systematic approach to improve patient outcomes (Connor, 2014; White & Dudley-Brown, 2011). The evidence-based intervention used for this quality improvement initiative suggests that implementation of protocols with refinement makes a difference in the staff's workflow and acceptance of the standards of care (Baker, et al. 2014). Re-defining the meaning of hourly rounding and its participants, not limiting it to the nursing staff, can provide additional beneficial aspects of the development of the intervention. Additionally, utilizing models such as The Iowa Model for Evidence-Based Practice to promote quality care should also be used, and ensuring that the main stakeholders are an integral part of the project from start to completion for buy-in and investment. Perpetual assessments and evaluations of the hourly rounding intervention is a necessity for the advancement and improvement of patient care.

Social Change

Social change occurred by increasing the percentage of nursing hourly rounding by staff. Because of the hourly rounding, HCAHPS survey scores reflected an increase in the areas of the overall rating and responsiveness of staff to patients. Observations of current practice post educational sessions also revealed faster responses of staff to patients' call light demands. Lastly, the safety rate regarding falls was maintained below the national benchmark. A culture change was observed among the staff regarding the compliance of hourly rounding. Before the educational sessions were provided regarding the necessity and benefits of the project, staff displayed insouciant behavior and were non-compliant in performing the intervention. According to Grant (2011), "disruption" (p. 169) is essential to interject a culture change. He further adds that the leadership must acknowledge their responsibility in grooming staff for the "disruption of change and consider the many ways in which progress towards an improvement, even one that brings many benefits, impacts on individual lives and improves the experience of care" (p. 169). Teamwork was notably cultivated and staff embraced the intervention with professionalism. There were some days the staff had intermittent scores of 100% hourly rounding on a given shift.

Project Strengths and Limitations

Strengths

The strengths of this QI project are multifaceted. Staff performance for hourly rounding and responding to patients' call light demands was record-breaking for

this unit. Before the initiation of the project, staff exhibited a lag time of up to 20 minutes when responding to patients' demands. The project helped to clearly define the necessity for rapid response and the unquestionable impact on patient satisfaction. Another strength was that the project helped to make staff aware of how patient satisfaction is connected to reimbursement. Staff also commented on the culture change that exuberated during the implementation phase. Creating a culture that promoted high quality patient care through consistent hourly rounding contributed to the positive outcome of the project (AACN, 2006). Applying the evidence-based research findings to nursing practice will contribute to patient centered care (Woods, 2011).

Limitations

One limitation of this quality improvement project is related to the hourly rounding of only the nursing staff. Throughout the shifts, physical and occupational therapists enter the patient rooms to provide care. Limiting hourly rounding to only the nursing staff prevents the cohesiveness of a collaborative effort for all departments to collectively contribute to the high quality care of the patient. A second limitation was the time frame of the project (Bonnel & Smith, 2014). To adequately evaluate the effectiveness of hourly rounding, data should be collected at 3, 6, and 12-month intervals. Afterwards, a 6-12-month evaluation of hourly rounding and observational staff responsiveness to patients' call light demands coupled with the HCAHPS survey scores should be performed for sustainability.

Another limitation was defining the intervention as "hourly rounding" versus patient rounding. Although the words are sometimes used interchangeably, rounding can go beyond addressing the 5Ps to providing holistic care for the patient (McLeod & Tetzlaff, 2015). Updating the hospital policy to include that nursing hourly rounding interventions provided to patients inclusive of medication administration, physical assessment, and care provided by other disciplines can provide benefits to increasing patient satisfaction.

Recommendations for Remediation of Limitations in Future Work

To remedy the limitations posed by this project, policies and protocols must be revised to all disciplines and care rendered to patients as an integral part of hourly rounding. Staff must be held accountable for not complying with the hospital's policies and procedures. Leadership must be engaged and provide frequent and effective communication to staff regarding the plan, purpose, and progress of any quality improvement for patient-centered care. The data clearly shows that when leadership is engaged with practice change and there is active staff involvement from the main stakeholders in the planning phase, staff participation is surmountable.

Analysis of Self

As Scholar

As a clinical scholar for the improvement project, evidence was generated through practice to guide improvements in the quality of health care, outcomes, and systems (AACN, 2006; AACN, 2015). Through this process, the DNP scholar is better equipped

to effectively disseminate findings to positively impact patient-centered care. Because of the process, the DNP professional is now prepared to coach, mentor, and guide bedside or other advance practice nurses in obtaining positive patient outcomes to their fullest potentials utilizing the DNP Essentials. Adhering to the systematic process from start to finish has significantly impacted how future endeavors will be embraced. Time involved in completion of the project was underestimated. However, the empowerment of knowledge gained will be beneficial for future clinical decision-making. The translation of the findings into practice is relevant to current trends in nursing practice and brings face value to the DNP Essentials outlined by the AACN.

As Practitioner

The development and process for executing the quality improvement project has equipped the DNP practitioner "to serve as an expert in nursing practice" (Zaccagnini & White, 2011, p. 441). The expertise in nursing practice is linked to three entities: research, evidence-based knowledge, and quality improvement. The execution and completion of this innovative program in a rural setting has provided additional clarity and practical understanding of the importance of staying abreast of new knowledge through research findings for integration into nursing practice for improving patient outcomes using EB interventions.

Giving back and investing into the multigenerational nursing professionals will provide the guidance warranted by clinicians for clinical decision-making in a rapidly changing profession. Investment of continuing education and components of progressive

nursing practice is essential for patient centered care (Zaccagnini & White, 2011). The role of practitioner has without a doubt enhanced the skills of mentoring, educating, role modeling, and providing leadership to other nursing professionals. Implementing evidence-based interventions, then dissecting the outcomes has given mastery knowledge for the future of population health.

As Project Developer

Implementing change then translating it into practice is complex. Yet with proper mentoring and guidance, the process yields increased understanding and appreciation for scientific approach and knowledge acquired. The knowledge gained from the planning, implementation, and evaluation of this quality improvement project has equipped the planner with maturity and patience for future projects. As project developer, a critical component identified was creating a timeline. Timelines are essential for project planning. A Gantt chart was used to assist with projected timelines to help stay on track, convey the plan clearly to the staff and leadership teams, and for the progression of the project. Each component of the proposal was listed with the best time of support. Revisions of the chart were made as needed due to unforeseen circumstances. Those circumstances consisted of staff turnover, which required the appointment of a new champion for the unit-based HCAHPS team.

What Does This Project Mean for Future Professional Development?

Sustainability of the intervention will contribute to staff's future professional development. The process will require a complete culture change for the staff with

consistent leadership monitoring and effective communication of expectations with rationales. Because nursing hourly rounding is a proven evidence-based intervention with surmountable documented patient outcomes, the leadership team of the unit must hold staff accountable for non-compliance to its own policy. In the event of consistent workflow, stability of staff retention, revision to how staff assignments are made, and leadership involvement, the metrics will continue to show improvement, thereby contributing to better reimbursement from CMS and other regulating entities.

From a facilitator's perspective, lessons learned from this process include the importance of purpose, planning, persistency and consistency. These elements have enhanced, contributed to, and produced finer writing and leadership skills for project planning knowledge, problem solving, and self-accountability. Other attributes include the development of interpersonal skills from an executive and staff level. The attributes have shown to be critically beneficial to future professional development of the DNP student at the academic and practice setting levels. Quality improvement projects are envisioned to impact and enlighten practice issues (Zaccagnini & White, 2011). When remaining focused and consistent in meeting the established timelines, positive outcomes will be the result.

Summary and Conclusion

Nursing hourly rounding is an evidence-based intervention that has proven to yield positive patient outcomes in the practice arena. Application of the research and findings to nursing practice can positively impact patient satisfaction and outcomes

(Woods, 2011). Quality improvement projects that are evidence-based driven and patient-centered will assist with goals to improve the patient experiences through best practice and address patient priorities for optimal care (Woods, 2011). Because the nursing discipline comprises such a large part of the healthcare workforce, it is imperative that nursing staff at all levels is empowered to discern and apply the necessary interventions as needed.

Section 5: Scholarly Product

Introduction

The scholarly product was designed to implement an evidenced-based quality improvement project to obtain significant outcomes to positively impact practice change for optimum patient care (Melnyk & Fineout-Overholt, 2011). "Translation of research into practice (TRIP) is a multifaceted, systematic process of promoting adoption of evidence-based practices in delivery of health care services that goes beyond dissemination of EB guidelines" (LoBiondo-Wood & Haber, 2014, p. 419). The findings of the project require dissemination of the knowledge obtained to the most suitable audience for translation of the change (White & Dudley, 2012). Providing feedback to the main stakeholders is critical to professional growth and development for future endeavors. A PowerPoint Presentation is appropriate for distribution of results to the staff and leadership teams. The systematic approach will provide a structured method and clearly define steps for communicating the outcomes.

Dissemination of the scholarly product results' will be shared during the research conference via poster given by the local chapter and professional organization of Sigma Theta Tau Nursing Honor Society (Appendix G). The poster will be displayed in the medical-surgical unit where the project was conducted. Posting the results in the department can be used as an educational teaching tool for professional growth and development. Staff can view how consistency, perseverance, and collaboration can positively impact patient care. Poster presentations are a tool used for presenting

evidence-based information for professional participants (Melnyk & Fineout-Overholt, 2011). Submission for publications through educational and research journals will also be sought to impact a broader community for practice change (Zaccagnini & White, 2011).

Project Summary and Evaluation

The success of the quality improvement project implemented was measured by outcomes (Morganti, Lovejoy, Haviland, Haas, & Farley, 2012). To effectively measure the outcomes, an evaluation of the QI project must be done. The summative evaluation method was utilized for program evaluation. The method provides information on project efficacy conducted post completion of the program design (MIT, n.d.).

Although all metric goals were not met, the nursing staff and program planner had the opportunity to experience a positive impact for participating in an evidence-based process. The workflow regarding hourly rounding, staff responsiveness to patient call light demands, and safety regarding patient falls showed significant progress. Translation and sustainability of this practice change is paramount for the expansion of high quality patient-centered care (White & Dudley-Brown, 2011). Compliance of practice interventions by the nursing staff contributes to the quality of care that patients receive. The Agency for Healthcare Research and Quality (AHRQ) validates that this is a barrier that must be confronted to ensure excellence health care (White & Dudley-Brown, 2011). As nursing continues to evolve, patients continue to age, and new knowledge and

findings are integrated into practice, the systematic approach involving key players will augment the success of any QI project and positively impact social change.

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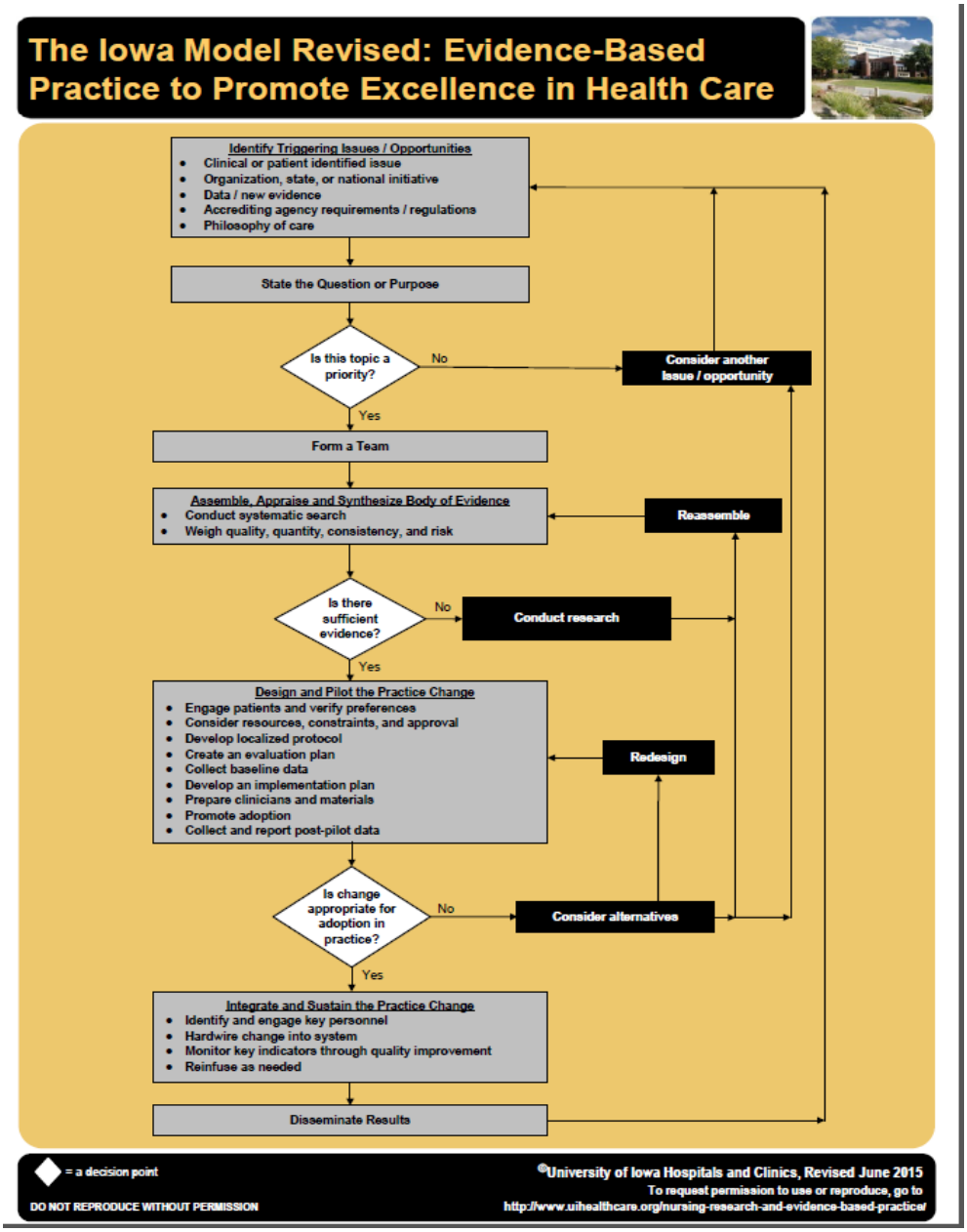
Appendix A: The Iowa Model



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Appendix B: The Iowa Evidence-Based Model Permission Letter

UNIVERSITY OF IOWA HOSPITALS & CLINICS
University of Iowa Health Care

Department of Nursing Services and Patient Care
Nursing Research, Evidence-Based Practice and Quality
200 Hawkins Drive, RM T100 GH
Iowa City, IA 52242
319-384-9098; 319-356-4348 (fax)
www.uihealthcare.com

February 8, 2017

Lucretia Wilson
DNP Student

Dear Ms. Wilson:

As requested, you have permission to use and reproduce the *2015 Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Healthcare Care* in your capstone project.

If you wish to use the Iowa Model in a publication, please be sure to inform the editor that copyright of the 2015 *Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care* **will be retained** by the University of Iowa Hospitals and Clinics.

In written material, please add the following statement: Used/Reprinted with permission from the University of Iowa Hospitals and Clinics, Copyright 2015. For permission to use or reproduce, please contact the University of Iowa Hospitals and Clinics.

Citation: The Iowa Model Collaborative (In press). The Iowa Model-Revised: Development and validation. *Worldviews on Evidence-Based Nursing.*

If you have any questions, please feel free to contact me at 319-384-9098 or kimberly-jordan@uiowa.edu. Thank you.

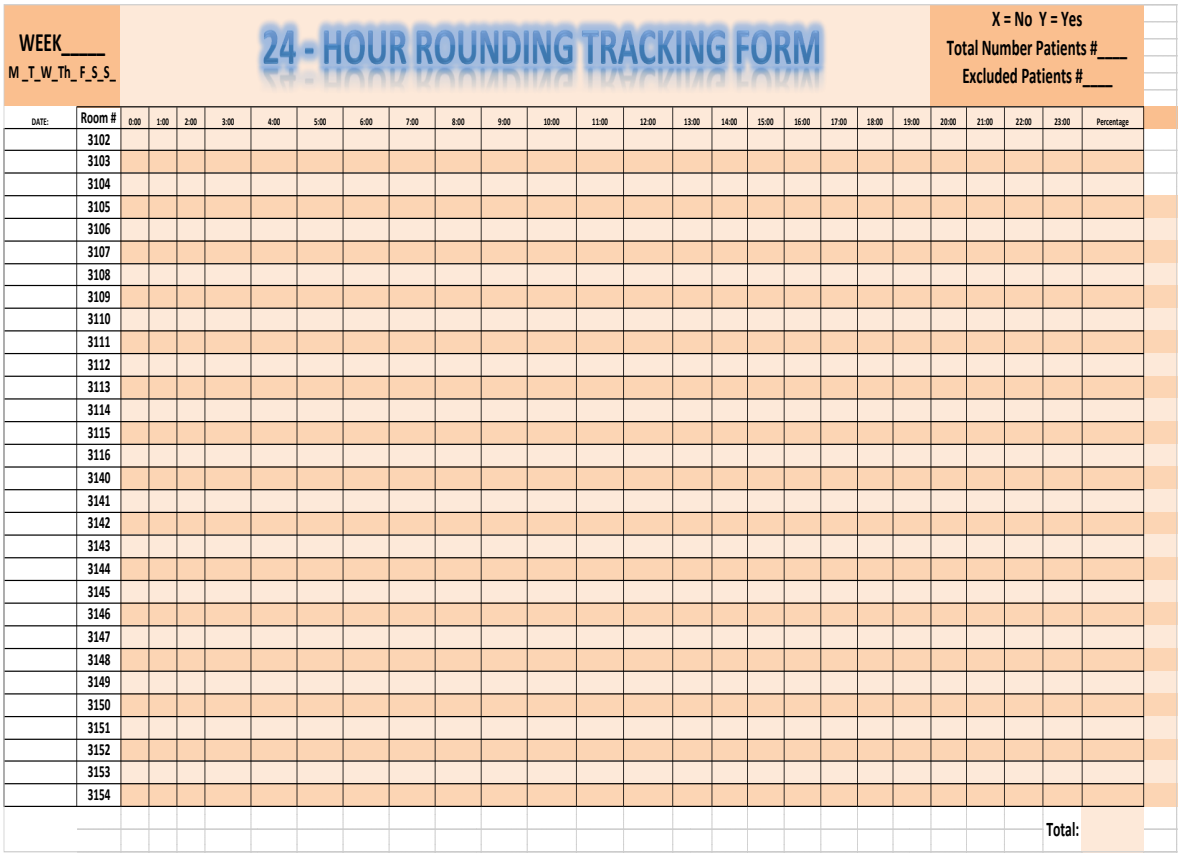
Sincerely,

Kimberly Jordan
Administrative Services Coordinator
Office of Nursing Research, Evidence-Based Practice and Quality
Department of Nursing Services and Patient Care

Appendix C: Staff Demographic Chart

Nurses n=26	CNAs n=16	Administrative Assistants n=5	Education Level of Nurses	Age in Years	Staff's Years of Experience
24 RNs	All certified	3-day shift	2 Diplomas	unknown	1-35
2 LPNs	5-night shift	2-night shift	11 BSNs		
2 Males	11-day shift		11 ADNs		
24 Females			2 MSNs		

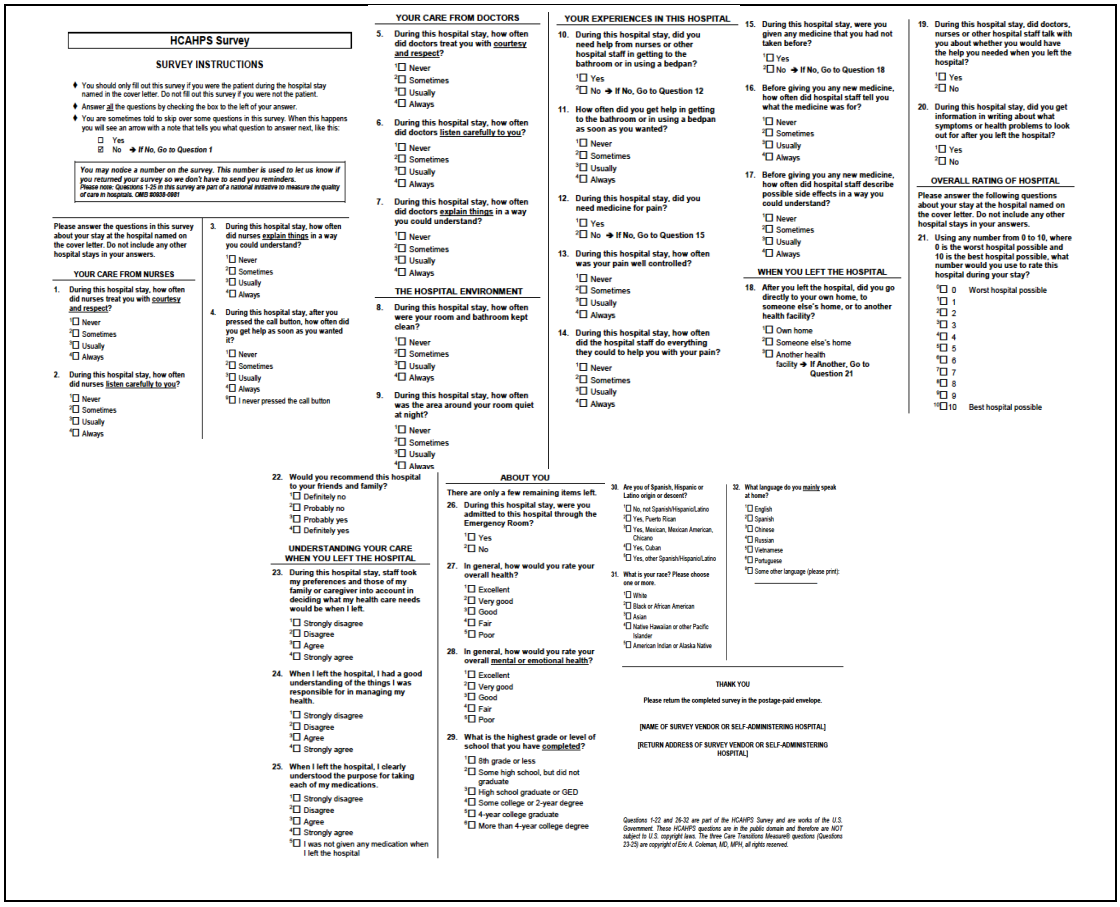
Appendix D: 24-Hour Rounding Tracking Tool



Appendix E: Mission Statement/Goals/Objectives/Activities

MISSION STATEMENT
To promote patient and family centered care on the medical-surgical unit within a rural hospital that fosters teamwork, while maintaining best evidence-based practice for increased patient satisfaction
GOALS
1. Improve staff response time to call lights from 64% - 85% 2. Increase overall HCAHPS scores from 42% -75% **3.** Maintain patient falls to less than 3 per 1000 hospital days
OBJECTIVES
Implement the Iowa Model of Evidence-Based Practice (IMEBP) approach using problem-solving steps to promote quality patient-centered care on a medical-surgical unit Provide at least two in-services to re-educate staff regarding hospital protocol for hourly rounding with inclusion of integral components of EBP Evaluate the effectiveness of the QI project for practice change of the medical-surgical unit three months post-intervention with recommendations for integration throughout the facility Compare pre-and post-intervention HCAHPS scores
Activities
Meet with Mentor and Nurse Manager of project unit Meet with HCAHPS team on unit to finalize their role in project Obtain HCAHPS scores from Hospital Customer Service Representative and review the last three months prior to implementing intervention. Conduct two staff educational sessions regarding details of the QI project to include current policy for nursing hourly rounding addressing the five Ps and time line Complete DNP Project Proposal Obtain IRB and approval to implement project Implement QI project with staff addressing 5Ps Compare pre-& post intervention HCAHPs scores, staff responsiveness to patient call light demands, and patient safety related to falls Evaluate effectiveness of program intervention for practice change Review results of project with Nurse Manager and schedule meetings to disseminate results with staff, managerial team on unit, and executive team. Recommendation or modifications for practice change throughout facility if objectives were met/unmet

Appendix F: HCAHPS



HCAHPS Survey

SURVEY INSTRUCTIONS

- You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- Answer all the questions by checking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☐ Yes
☑ No → *If No, Go to Question 1*

You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders. Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB 0938-0981

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

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
   1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
2. During this hospital stay, how often did nurses listen carefully to you?
   1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
3. During this hospital stay, how often did nurses explain things in a way you could understand?
   1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
   1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always 5☐ I never pressed the call button

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
   1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
6. During this hospital stay, how often did doctors listen carefully to you?
   1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
7. During this hospital stay, how often did doctors explain things in a way you could understand?
   1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always

THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?
   1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
9. During this hospital stay, how often was the area around your room quiet at night?
   1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
    1☐ Yes 2☐ No → **If No, Go to Question 12**
11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
    1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
12. During this hospital stay, did you need medicine for pain?
    1☐ Yes 2☐ No → **If No, Go to Question 15**
13. During this hospital stay, how often was your pain well controlled?
    1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
    1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
15. During this hospital stay, were you given any medicine that you had not taken before?
    1☐ Yes 2☐ No → **If No, Go to Question 18**
16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
    1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always
17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
    1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?
    1☐ Own home 2☐ Someone else's home 3☐ Another health facility → **If Another, Go to Question 21**
19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
    1☐ Yes 2☐ No
20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
    1☐ Yes 2☐ No

OVERALL RATING OF HOSPITAL

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

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
    0☐ 0 Worst hospital possible 1☐ 1 2☐ 2 3☐ 3 4☐ 4 5☐ 5 6☐ 6 7☐ 7 8☐ 8 9☐ 9 10☐ 10 Best hospital possible

22. Would you recommend this hospital to your friends and family?
    1☐ Definitely no 2☐ Probably no 3☐ Probably yes 4☐ Definitely yes

UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL

23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
    1☐ Strongly disagree 2☐ Disagree 3☐ Agree 4☐ Strongly agree
24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
    1☐ Strongly disagree 2☐ Disagree 3☐ Agree 4☐ Strongly agree
25. When I left the hospital, I clearly understood the purpose for taking each of my medications.
    1☐ Strongly disagree 2☐ Disagree 3☐ Agree 4☐ Strongly agree 5☐ I was not given any medication when I left the hospital

ABOUT YOU

There are only a few remaining items left.

26. During this hospital stay, were you admitted to this hospital through the Emergency Room?
    1☐ Yes 2☐ No
27. In general, how would you rate your overall health?
    1☐ Excellent 2☐ Very good 3☐ Good 4☐ Fair 5☐ Poor
28. In general, how would you rate your overall mental or emotional health?
    1☐ Excellent 2☐ Very good 3☐ Good 4☐ Fair 5☐ Poor
29. What is the highest grade or level of school that you have completed?
    1☐ 8th grade or less 2☐ Some high school, but did not graduate 3☐ High school graduate or GED 4☐ Some college or 2-year degree 5☐ 4-year college graduate 6☐ More than 4-year college degree
30. Are you of Spanish, Hispanic or Latino origin or descent?
    1☐ No, not Spanish/Hispanic/Latino 2☐ Yes, Puerto Rican 3☐ Yes, Mexican, Mexican American, Chicano 4☐ Yes, Cuban 5☐ Yes, other Spanish/Hispanic/Latino
31. What is your race? Please choose one or more.
    1☐ White 2☐ Black or African American 3☐ Asian 4☐ Native Hawaiian or other Pacific Islander 5☐ American Indian or Alaska Native
32. What language do you mainly speak at home?
    1☐ English 2☐ Spanish 3☐ Chinese 4☐ Russian 5☐ Vietnamese 6☐ Portuguese 7☐ Some other language (please print):

THANK YOU

Please return the completed survey in the postage-paid envelope.

[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

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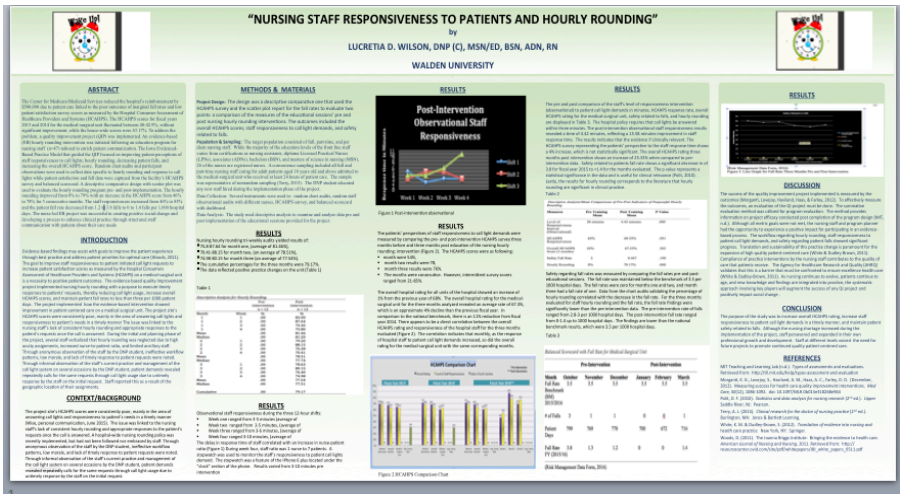
(HCAHPS, 2016) http://www.hcahpsonline.org/home.aspx

Appendix G: Dissemination Poster Presentation



"NURSING STAFF RESPONSIVENESS TO PATIENTS AND HOURLY ROUNDING"

by

LUCRETIA D. WILSON, DNP (C), MSN/ED, BSN, ADN, RN

WALDEN UNIVERSITY

ABSTRACT

INTRODUCTION

CONTEXT/BACKGROUND

METHODS & MATERIALS

RESULTS

Post-Intervention Observational Staff Responsiveness

RESULTS

RESULTS

DISCUSSION

CONCLUSION

REFERENCES