

Purposeful Rounding and Improved Patient Care: An Evaluation of Nurses' and Nursing
Assistants' Perceptions of Purposeful Rounding and Intervention to Improve Practice

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Abstract

Purposeful rounding has gained acceptance in academic literature regarding its clinical benefits in patient optimal outcomes. A Mid-Atlantic regional hospital implemented hourly rounding a few years ago, but it has not been successfully sustained. Hospital administrators desired to improve practice with consistent implementation. The purpose of this project was to implement a structured purposeful rounding intervention on a medical-surgical inpatient unit aimed to improve nurses' and nursing assistants' perceptions of purposeful rounding, thereby decreasing patient fall rates, and improving patient satisfaction. A process improvement initiative was implemented. A baseline organizational assessment was completed on a 30-bed medical-surgical unit of the hospital. The assessment findings led to a focused educational session designed to promote establishment of a structured purposeful rounding that incorporated time management. Due to the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic and census restructuring on the initial host unit, implementation was completed in a comparable unit of same structure staffed by the same personnel. A pre survey involving 24 participants and a post survey involving 29 participants were conducted. A difference between the sample mean of the baseline assessment survey and the sample mean of the post intervention survey was 0.15 for nurse respondents and 0.27 for nursing assistant respondents. A Welch two sample t-test, two-sample $t(50) = 2.1$, $p = .04$ demonstrated a statistically significant difference between the two sample means. A confidence interval and a population mean were not computed due to small sample size. Implications for future consideration include periodic training and formation of a rounding committee to uphold the practice of hourly rounding.

Keywords: Nurses' perception, hourly rounding, patient outcome, nurses, nursing assistants

Purposeful Rounding and Improved Patient Care: An Evaluation of Nurses' and Nursing Assistants' Perceptions of Purposeful Rounding and Intervention to Improve Practice

Patient safety is the hallmark of hospitals' quality performance measures on patient outcomes. When patient safety is compromised, hospitals' performance indicators go down. This causes a ripple effect in which patient satisfaction as well as hospital reimbursement can be negatively impacted. Measures to improve patient outcomes are therefore paramount. Purposeful rounding as evidenced in the literature is one way to improve patient safety, patient satisfaction, and patient outcomes (Brosey & March, 2015; Fabry, 2015; Neville, DiBona, & Mahler, 2016). Purposeful rounding is an intentional checking on of patients by frontline staff in a given interval with the goal of meeting the patients' needs. Purposeful rounding cannot be beneficial without effective and consistent practice. One of the problems that hospitals who have implemented purposeful rounding face is its sustainability due to inconsistent practice (Brosey & March, 2015).

The host organization for this project began a rollout for purposeful rounding in 2017, with implementation on the medical surgical unit occurring in 2018. The rollout was done in an effort to improve patient safety, patient satisfaction, and patient outcomes. However, frontline staff are not consistently embracing this practice to maximize outcomes. Staff perception and perceived barriers preventing consistent purposeful rounding were unclear.

Several factors had hospital administrators of the host organization questioning internal push back regarding purposeful rounding. It was believed that a recent sentinel event at this facility involving a patient fall that resulted in unanticipated patient outcome may have been prevented if consistent purposeful rounding had taken place. Moreover, the hospital's consumer assessment of healthcare providers and systems (HCAHPS) score on the responsiveness of the

hospital staff was at 63%, falling well below the national average of 70%; this key indicator has a direct impact on patient satisfaction (Medicare.gov, 2019). Based on these findings, a needs assessment survey was conducted by the hospital revealing lack of consistency in the organization's implementation of purposeful rounding. As a result, a mandatory and structured purposeful rounding intervention was implemented on a pilot medical surgical unit of the hospital to gain a better understanding of the impact of purposeful rounding.

This capstone project explored the impact of the previously implemented structured purposeful rounding intervention on the perceptions and perceived barriers of nursing assistant and nursing staff on the pilot medical surgical unit of the host hospital.

Overview

Background

Purposeful rounding is the intentional checking-on of patients at hourly or two-hourly intervals with the goal of meeting patients' needs in the areas of positioning, pain management, toileting, and keeping possessions within reach (Brosey & March, 2015; Fabry, 2015; Neville et al., 2016). Through purposeful rounding, the four "Ps" of patient needs - pain, possession, positioning, and potty are proactively met (Brosey & March, 2015; Fabry, 2015; Neville et al., 2016). Purposeful rounding provides different avenues for meeting patient's needs. The benefits of purposeful rounding include increased patient satisfaction, reduced fall rates, increased patient safety, reduced pressure ulcers, decreased anxiety, decreased call bell use, and improved patient outcomes (Brosey & March 2015; Fabry, 2015; Neville et al., 2016). Many health care organizations adopt the practice to enhance quality performance and improve patient outcomes. The sustainability and effectiveness of purposeful rounding relies on provider follow through. To ensure the success of purposeful rounding in acute care settings, nurses and nursing assistants

are expected to not only embrace this patient-centered care strategy but adopt it in their day to day care of patients. Nurses and nursing assistants are important to the success or failure of purposeful rounding because they are at the frontline of patient-care delivery process in acute care hospitals. Hence, the success of this evidence-based practice depends on how well nurses and nursing assistants embrace the practice.

In most hospitals where purposeful rounding has been incorporated in patient care delivery, nurses and nurse assistants have failed to fully embrace the practice. Deitrick, Baker, Paxton, Flores, and Swavely (2012), linked this disconnect to nurses struggling with time management when hourly rounding was introduced. Nurses and nursing assistants' commitment to purposeful rounding is necessary for successful implementation and sustenance. Interventions to aid in eliminating barriers to purposeful rounding based on understanding of nurses' and nursing assistants' perceptions of purposeful rounding are needed to sustain the practice of purposeful rounding.

Problem Statement

Purposeful rounding, previously defined as an intentional checking-on of patients on hourly or two hourly bases to meet their basic needs, is a proactive measure that increases patient safety and patient satisfaction. It also improves patient outcomes, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and nurse satisfaction; it is being utilized in acute care hospitals and facilities because of its proven benefits (Brosey & March 2015; Fabry, 2015; Neville et al., 2016). The successful implementation of this evidence-based initiative in healthcare facilities depends largely on frontline staff (Brosey & March 2015).

Purposeful rounding was needed in the host hospital for the project and was implemented. The practice however was not consistent. Some of the falls and injuries from falls

in the host unit would have been prevented if the patients had been consistently rounded on. A needs assessment survey on purposeful rounding was done by the host hospital to determine if a system change was necessary to improve patient outcomes. The results of the assessment showed that nurses and nursing assistants agreed that purposeful rounding is beneficial to the patients and could enhance a more personalized care. There was, however, no structured purposeful rounding process currently in the pilot unit despite hospital wide implementation of purposeful rounding.

The needs assessment survey was supported by Deitrick et al. (2012) as they recommended comprehensive assessment of adopters of any evidenced-based practice change in any organization for the successful implementation of such a practice change. The needs assessment determined hourly or two-hourly rounding on patients during their hospital stay required greater structure and defined purpose. Based on the pre assessment survey, a structured and well-defined intervention geared towards improving the practice of purposeful rounding was beneficial.

This capstone project explored the following question: On a medical-surgical inpatient unit, how would implementation of a structured purposeful rounding intervention impact nurses' and nursing assistants' perception of purposeful rounding, patient fall rates, and patient satisfaction in a 45-day period?

Purpose Statement

The purpose of this project was to implement a structured purposeful rounding intervention on a medical-surgical inpatient unit aimed to improve nurses' and nursing assistants' perceptions of purposeful rounding, thereby decreasing patient fall rates and improve patient satisfaction.

Outcomes

A more structured purposeful rounding was implemented on the medical surgical unit of the host hospital. Expected project outcomes included improved nurses' and nursing assistants' perceptions of purposeful rounding, a decrease in patient falls on the target unit and improved patient satisfaction. Nursing perceptions were reflected in data obtained using the Nurses' Perception of Patient Rounding Scale (NPPRS) (Neville, 2010). Decreased fall rates were to be reflected in unit specific fall data collected during the 45-day period. Patient satisfaction was to be reflected in improved HCAHPS score on responsiveness of nursing staff.

Review of the Literature

Literature Search Method

A literature search in Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane, Academic Elite, Medline Plus, and Business Elite databases was performed to access data and other relevant research materials for this capstone project. The key terms used in the search were *purposeful rounding*, *hourly rounds*, *intentional rounding*, *patient outcome*, *nurses' perception*, *nurses*, and *nursing assistants*. The search yielded 562 results and 169 results when the search was limited to between year 2014 and year 2019. Google Scholar search engine was also utilized. The phrase used in the Google Scholar search engine was "current evidence on nursing hourly rounding". The search yielded 5,740 results. The search was narrowed down by inclusion criteria of years between 2014 and 2019 and yielded 2,450 results. Furthermore, the inclusion criteria for the articles used in this literature review were any relevance to practice of hourly rounding, any evaluation of nurses' and nursing assistants' perceptions of hourly rounding, and any positive patient outcomes resulting from purposeful rounding.

Literature Findings

Purposeful rounding, which is a nurse-driven intervention to patient care, has been extensively studied in the literature. Brosey and March (2015), Fabry (2015), Forde-Johnston (2014), and Neville et al. (2016) have identified purposeful rounding as an intentional checking-on of patients on an hourly or two hours basis with the intention of providing patients' needs in the areas of pain management, positioning and repositioning, toileting, and environmental needs satisfaction. With the implementation of purposeful rounding and meeting of these patients' needs, patients perceive the care given to them as high quality. As they perceive the care as high quality, they are more satisfied. The available evidence on purposeful rounding shared several themes including benefits, barriers and perceptions, interventions, and overall findings.

Benefits of purposeful rounding. The benefits of purposeful rounding have been extensively studied and discussed in the literature. Fabry (2015) outlined these benefits as: improved patient safety and quality of care, improved patient satisfaction scores, significantly reduced patient falls, decreased pressure ulcer incidence, reduced call light volume, and improved nursing staff satisfaction. Daniels (2016) also confirms improvement in three elements of patient satisfaction namely, effective nurse communication, pain management, and responsiveness of hospital staff to patients' care and needs, as well as a decrease in patient falls. Mitchell, Lavenberg, Trota, and Umscheid (2014) discussed the positive impact of purposeful rounding on patients' perception of nursing responsiveness, patient falls, and call light use after a systematic review on the practice of purposeful rounding. Forde-Johnston (2014) gave statistics on the benefits of intentional rounding as he conducted a literature review on the issue. The evidence from Forde-Johnston analysis showed a reduction in call bell use by 18%, a decrease in

patient fall by 14%, a reduction in pressure ulcer by 14%, and an improved patient experience causing formal patient complaints to drop from monthly average of 4.5 to 1.5 (Forde-Johnston, 2014)

Barriers to purposeful rounding and perceptions of nurses. Despite the benefits of hourly rounding, there are also barriers to its implementation. Neville et al. (2012) identified some of these barriers in their study of nurses' perceptions of patient rounding. Neville et al. (2012) found that nurses saw intentional rounding as more documentation and that hourly rounding amid increased patient acuity is not feasible. Neville et al. (2012) also identified that lack of communication and collaboration between nurses and nursing assistants creates barriers to rounding. Deitrick et al. (2012), linked barriers to intentional and purposeful rounding to improper training on the process of hourly rounding and lack of leadership support. Neville et al. (2012) and Deitrick et al. (2012) tried to identify barriers to successful implementation of hourly rounding in acute care setting. While Neville et al. (2012) studied the perceptions of nurses on intentional rounding and ascertained a lack of communication between nurses and nursing assistants on the practice of intentional rounding, Deitrick et al. (2012) examined it from the perspective of lack of leadership support and proper education on purposeful rounding process. There is insufficient evidence on nursing assistants' perceptions of purposeful rounding. There is also insufficient evidence on how nurses and nursing assistants communicate and collaborate to foster effective purposeful rounding.

Interventions that promote purposeful rounding. Engagement of frontline staff in program design and strong leadership involvement have shown to improve compliance to purposeful rounding (Goldsack, Bergey, Mascioli, & Cunningham, 2015). As one considers leadership involvement, managers' strong engagement and monitoring of compliance to

purposeful rounding not only enhances frontline staff commitment to purposeful rounding but motivates staff especially when the leaders themselves engage in leadership rounds. Creation of unit champions to facilitate the process of purposeful rounding has also been linked to better diffusion of the process (Goldsack, Bergey, Mascioli, & Cunningham, 2015).

Summary of findings and rationale for project. A comprehensive review of the literature suggests that purposeful rounding is an evidence-based practice that promotes patient safety, improves patient satisfaction, and promises positive patient outcomes. Despite its benefits, successful implementation and continued practice of purposeful rounding is non-sustaining in some organizations. Studies have been done to investigate reasons for its setbacks. Unfavorable nurses' perceptions, lack of communication between nurses and nursing assistants regarding how to engage in purposeful rounding, inadequate education on the process of purposeful rounding, and lack of leadership support have been blamed. Nursing assistants' perceptions of purposeful rounding have not been well documented in the literature (Deitrick et al., 2012; Neville et al., 2012). Furthermore, knowledge on how to promote collaboration between nurses and nursing assistants for successful implementation of purposeful rounding is insufficient.

Based on the findings of the literature, one aim of this project was to build on the hospital's practice of purposeful rounding by implementing a structured purposeful rounding intervention on a medical-surgical unit. A checklist was provided which would enable nurses and nursing assistants to have similar knowledge on the process of purposeful rounding and engage in a more structured rounding.

Theoretical Framework

Rogers' theory of diffusion of innovations was the theoretical framework chosen for this project. The reason for its adoption was because of concepts it promoted which guided practice change and quality improvement initiatives (Rogers, 1983). Rogers identified five perceived attributes of innovation by which the rate of adoption of innovation can be measured. The attributes were relative advantage, compatibility, complexity, trialability, and observability (Rogers, 1983). Rogers also identified four variables that affected the rate of adoption in addition to the five attributes. These variables were innovation decision, communication channels used in disseminating the innovation, the social system embracing the innovation, and efforts by the change agents (Rogers, 1983).

Furthermore, the rate of adoption was heightened when decision making was streamlined, communication channel was brought to the level of adopters, norms of the social system was put into consideration, and consistent and sustaining efforts of the change agents were in place (Fabry, 2015; Rogers, 1995). According to Rogers (1983), for the rate of diffusion of an innovation to increase, the adopters of the innovation must perceive the innovation to be compatible with the needs of the organization, simple in application, have relative advantage over existing practice, applicable, and observable. Because the attributes may be perceived differently by different people, it was imperative to elicit the favorable attributes from the adopters before measuring them (Rogers, 1983).

Nurses' and nursing assistants' perceptions of purposeful rounding would be augmented positively by providing a detailed rationale for purposeful rounding. Rogers theory supported observability (Rogers, 1995). A checklist was provided to the frontline staff as a reference to the

content of purposeful rounding. Rogers theory further supported consistent and sustaining efforts of the change agents (Rogers, 1995). Unit champions for purposeful rounding were formed that would enable frontline staff take charge of purposeful rounding. The image of the variables and attributes determining the rate of adoption of innovations are shown in figure 1 (see Appendix A).

Organizational Assessment

This project was carried out on a medical surgical unit within a 285-bed acute care community hospital located in the Mid-Atlantic region of the United States of America. This host hospital implemented hourly rounding practice throughout the entire facility in the fall of 2017, through the leadership of the director of nursing practice and outcomes. The aim was to improve patient safety, patient satisfaction, overall patient outcomes, and to improve HCAHPS scores. Though hourly rounding had been implemented, it was not diffused and failed to produce the intended outcomes. The hospital called on action committees such as the hand-off communication committee and fall prevention committee, that are co-managed by the hospital's leadership and frontline staff to examine the issue. The hand-off and the fall prevention committees were tasked to rejuvenate purposeful rounding in all the units through the leadership of the director of nursing practice and outcomes. It was not clear what the pushbacks to diffusion of purposeful rounding in this organization were. A needs assessment survey was conducted on a medical surgical unit of the hospital to evaluate nurses' and nursing assistants' perceptions of purposeful rounding. The medical surgical unit was chosen because of high rates of falls and injuries from falls in the identified unit. An unanticipated patient outcome occurred on that unit in which there was no clear accountability as to the last time the patient was rounded upon.

The host hospital identified the medical surgical unit as the most beneficial location for implementation of this capstone project. The nurses and nursing assistants were receptive to any intervention that would enhance patient safety. The nurse manager of the medical surgical unit was supportive of the project and was ready to offer any assistance needed. The director of nursing practice and outcomes was the primary point of contact for this project. The leadership and management of the host hospital supported educational growth and performance improvement initiatives by frontline staff. In the “recommendation for practice” portion of the assessment survey, frontline staff indicated the need for coaching on the process of hourly rounding. Despite the frontline staff’s reception to project implementation, a potential barrier to the project was staff participation in a survey during project implementation and completion of the education in the target unit due to the unit being converted to a “patient under investigation” unit amidst severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic. There were no anticipated unfavorable consequences as a result of the capstone project.

Methodology

Setting

The capstone project was carried out on a medical surgical unit in a community hospital situated in Mid-Atlantic region of the United States of America. The 30-bed unit provided care for the surgical patient as well as medical patients with acute and chronic illnesses. The unit staff was comprised of 56 nurses, 15 nursing assistants, 9 administrative assistants, a clinical educator, a unit clinical coordinator, and a manager.

Sampling

The participants included registered nurses and nursing assistants who work on the target medical surgical unit. The participants comprised of both dayshift and nightshift staff. Exclusion criteria included non-nursing staff on the medical surgical unit and non-nursing staff employed in other areas of the hospital.

Implementation Procedures

Implementation of the educational session began in a comparable unit of the pre-surveyed unit because the pre-surveyed unit became a “patient under investigation” (PUI) unit due to SARS-CoV-2 pandemic. When the pre-surveyed unit became a PUI unit, it was impossible to do purposeful hourly rounding in the unit. The frontline nursing and nursing assistant staff in the comparable unit were recruited in the educational session implementation to allow successful results. The education on the structured rounding process lasted for two weeks. This was done during huddles on both shifts.

The education session was combined with hands-on implementation of the process of structured purposeful rounding for two weeks instead of four weeks due to SARS-CoV-2 pandemic. The nursing and nursing assistant staff were made to use the rounding checklist provided, to aid rounding process and to ensure uniformity of practice. The hourly rounding cue and the checklist were placed permanently on each computer in each patient room as reminder for the staff on how to complete structured purposeful rounding.

Nurses’ and nursing assistants’ perceptions of purposeful rounding were evaluated post implementation. This was done using the Nurses’ perception of Patient Rounding Scale (NPPRS) survey tool. The survey tools which contained no personal identifiers were placed in a box in the nurses’ station. The staff were asked to place the completed survey in a locked-up box and the

box was secured in the charge nurse office to protect data integrity. Participating staff were given a week instead of two weeks to complete a post participation survey due to the SARS-CoV-2 pandemic.

The evaluation of the hospital consumer assessment of healthcare providers and systems HCAHPS scores on nursing staff responsiveness pre and post intervention, was not included in the implementation process due to SARS-CoV-2 pandemic. Similarly, the fall rate evaluation, pre and post implementation, was not done because the report's data may have been affected by SARS-CoV-2 pandemic.

Intervention

The focus of the structured purposeful rounding intervention was to build a consistent and positive practice culture. The focus was not on purposeful rounding documentation in an electronic medical record but on actual practice of the process. Education about structured, proactive, and purposeful rounding was provided to nurses and nursing assistants in the unit during huddles (see Appendix B). The educational session took place every day during each shift for 10 minutes. Dayshift education session began at 0750 and ended at 0800. Nightshift education session began at 1950 and ended at 2000. The educational session took place at the designated time periods daily for two weeks. The purpose of the educational session was to coach the participants on the process of structured purposeful rounding and was provided by the lead investigator. The educational content also included the benefits of purposeful rounding. A checklist (see Appendix C) for the rounding process was provided and explained to the staff. Communication on purposeful rounding responsibilities between nurses and nursing assistants was established. The educational materials were displayed on an educational poster on the unit.

Structured purposeful rounding enhanced by use of a checklist was implemented for a period of two weeks.

Measurement Instrument(s)

In order to measure the outcomes of this Capstone Project the following instruments were to be used: NPPRS survey tool, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores on patient satisfaction, and the unit's Fall Rate Monthly Data.

The NPPRS survey evaluated nurses' and nursing assistants' perceptions of purposeful rounding on the unit (Neville, 2010). The NPPRS survey tool was a 42-item questionnaire in a 5-point Likert format ranging from strongly disagree (1) to strongly agree (5) that was developed by Dr. Neville in 2010 (Neville et al., 2010). The tool was also divided into subscales namely, communication, patient benefits, and nurse benefits (Neville et al., 2016). The reliability of the tool was determined by computing coefficient alphas. The Cronbach's α for the total NPPRS was 0.91. The Cronbach's α for the communication subscale was 0.79. The Cronbach's α for the nurse benefits subscale was 0.84. The Cronbach's α for the patient benefits subscale was 0.85 (Neville, DiBona, & Mahler, 2016). Face validity of the tool was established by staff nurses evaluating the tool for content (Neville et al., 2012). Content validity of the tool was established by expert opinion and factor analysis using varimax rotation. The varimax rotation resulted in three subscales of communication, patient benefits, and nurse benefits (Neville et al., 2012).

Permission to use the NPPRS tool was sought and obtained from the author Dr. Neville.

The unit Press-Ganey Patient Satisfaction Reports and the unit Fall Rate Data were not obtained as originally planned as part of the project due to SARS-CoV-2 pandemic.

Data Collection Procedures

Data collection involved evaluation of nurses' and nursing assistants' perception of purposeful rounding using the NPPRS. The post intervention survey as well as organization preassessment survey were obtained.

Data from HCAHPS scores on patient satisfaction in the month preceding the structured purposeful rounding intervention and the month when the intervention took place were not collected due to SARS-CoV-2 pandemic. Similarly, the internal fall rate data for the month preceding the intervention and month in which the structured purposeful rounding intervention took place were not obtained due to SARS-CoV-2 pandemic.

Ethical Considerations/Protection of Human Subjects

Institutional Review Board (IRB) approval was obtained prior to initiating the capstone project. The IRB approval was sought from both the host organization and the affiliate institution for the capstone project. Permission for capstone project implementation was obtained from the nursing leadership of the host organization which included the director of nursing practice and outcomes and the nurse manager of the medical-surgical unit.

The population of interest for this project were nurses and nursing assistants working in the target unit of the hospital. One of the risks that the project population was to face was breach of confidentiality. Confidentiality was protected by not using any personal identifiers such as name and date of birth during survey process. Another risk that the population was to face was perceiving unfavorable action towards their work performance if they failed to fully participate in the implementation process. The project was for quality improvement and did not attract corrective action.

There was no conflict of interest personally or professionally for the capstone project coordinator. However, it should be known that this project coordinator was a registered nurse that worked in the target unit. Employment status did not affect the project or cause bias in any way, as no supervisory responsibilities of participating staff exist. This capstone project served as a quality improvement initiative to determine if adding greater structure to a pre-existing purposeful rounding policy would impact nursing perceptions, fall rates and patient satisfaction. The capstone project coordinator and mentor both completed the required Collaborative Institutional Training Initiative (CITI) training.

Informed consent of the participants was sought during the survey. Voluntary participation in survey served as informed consent. The survey included explanation of the intent of the project and establishing voluntary participation. The survey contained no personal identifiers.

Data integrity was ensured during implementation process. Data collected was secured in a locked box until data analysis. Access to the data was given to the Nebraska Methodist College institutional statistician and a private statistician only for assistance with data analysis. The data was void of identifying demographics.

Data Analysis

Data was collected from a pre-organizational assessment survey using NPPRS and a post-intervention survey also using NPPRS. The pre-organizational assessment survey yielded 20 registered nurse respondents, and 4 nursing assistant respondents. In the post-intervention survey, 24 registered nurses and 5 nursing assistants responded. The NPPRS was categorized into three subscales namely, communication, nurses' benefits, and patient benefits (Neville, 2010). A quantitative data analysis was employed using Excel. A descriptive statistic of the 42

questions contained in the NPPRS was obtained pre and post intervention. Data editing was done due to missing data during the survey using listwise deletion leaving only questions with complete responses from all the respondents. A descriptive statistic was subsequently run on the edited data. Furthermore, descriptive statistics were run on the three categories/subscales of the NPPRS survey tool, including communication, nurses' benefits, and patients' benefits. In order to investigate the desired outcome of this capstone project to "improved nurses' and nursing assistants' perceptions of purposeful rounding", a Welch two sample t-test was run.

Results

Baseline organizational assessment of the frontline staff on their perception of hourly rounding using the NPPRS prompted an educational session on the benefits and process of structured hourly rounding. The educational session was combined with hands-on implementation of the structured process. After the education and hands-on implementation, the perceptions of the frontline staff on hourly rounding was again evaluated using the same NPPRS. As mentioned previously, the NPPRS was categorized into communication, nurse benefit, and patient benefit subscales (Neville, 2010). The results of the baseline organizational survey and post intervention survey were narrated according to those subscales.

Communication Subscale

Table 1 showed average responses on communication subscale questions of the NPPRS from all the nurses who participated in the pre organizational assessment. The mean value of this subscale was 3.35. The communication subscale questions assessed the nurses' perceptions of the benefits of hourly rounding in improving communication between the frontline staff and patients. Table 2 showed similar responses but post educational intervention. The mean value of

the communication subscale post intervention was 3.46. Table 3 went on further to show the comparison of the nurses' response pre and post educational session. The difference in mean value of the communication subscale before intervention and after intervention was 0.11. This showed an increase in mean scores post intervention.

There was demonstrated improvement in responses of the nurses after they were taught structured process and after the process was implemented (see Figure 1). Questions 7, 31, and 36 were expected to attract lower number on the Likert scale if the perceptions of frontline staff were in favor of hourly rounding (Neville, 2010). Figure 1 demonstrated a lower mean score on the questions 7, 31, and 36 post intervention.

Table 1

Communication subscale questions on NPPRS - Average responses from all RN participants during baseline organizational assessment

Respondent RN	Q 4	Q 7	Q 17	Q 25	Q 28	Q 31	Q 32	Q 35	Q 36	Q 38	Q 39	Q 40	Q 41	Q 42	Totals
Pre-Assessment Avg response	3.8	2.3	4.1	2.3	1.6	1.8	4.1	3.9	1.8	4.0	3.8	4.5	4.1	4.5	3.3486842 11

Note. NPPRS, Nurses' perception of patient rounding scale, RN, Registered nurse, Q, question.

Table 2

Communication subscale questions on NPPRS - Average responses from all RN participants during post intervention assessment

Respondent RN	Q 4	Q 7	Q 17	Q 25	Q 28	Q 31	Q 32	Q 35	Q 36	Q 38	Q 39	Q 40	Q 41	Q 42	Totals
Post-Intervention Avg response	4.29	1.92	4.33	2.54	1.83	1.63	4.25	4.17	1.79	4.29	4.08	4.39	4.43	4.52	3.4623 4472

Note. NPPRS, Nurses' perception of patient rounding scale, RN, Registered nurse, Q, question.

Table 3

Communication subscale questions on NPPRS - Change in average responses from all RN participants

Respon dent RN	Q 4	Q 7	Q 17	Q 25	Q 28	Q 31	Q 32	Q 35	Q 36	Q 38	Q 39	Q 40	Q 41	Q 42	Totals
Pre- Assessm ent Avg respons e	3. 8	2. 3	4. 1	2. 35	1. 63	1. 8	4. 15	3. 9	1. 8	4. 05	3. 85	4. 55	4. 1	4. 5	3.34868 4211
Post- interven tion Avg respons e	4. 29	1. 92	4. 33	2. 54	1. 83	1. 63	4. 25	4. 17	1. 79	4. 29	4. 08	4. 39	4. 43	4. 52	3.46234 472
Change in Avg respons e	0. 49	- 0. 38	0. 23	0. 19	0. 20	- 0. 18	0. 1	0. 27	- 0. 01	0. 24	0. 23	- 0. 16	0. 33	0. 02	0.11366 051

Note. NPPRS, Nurses' perception of patient rounding scale, RN, Registered nurse, Q, question.

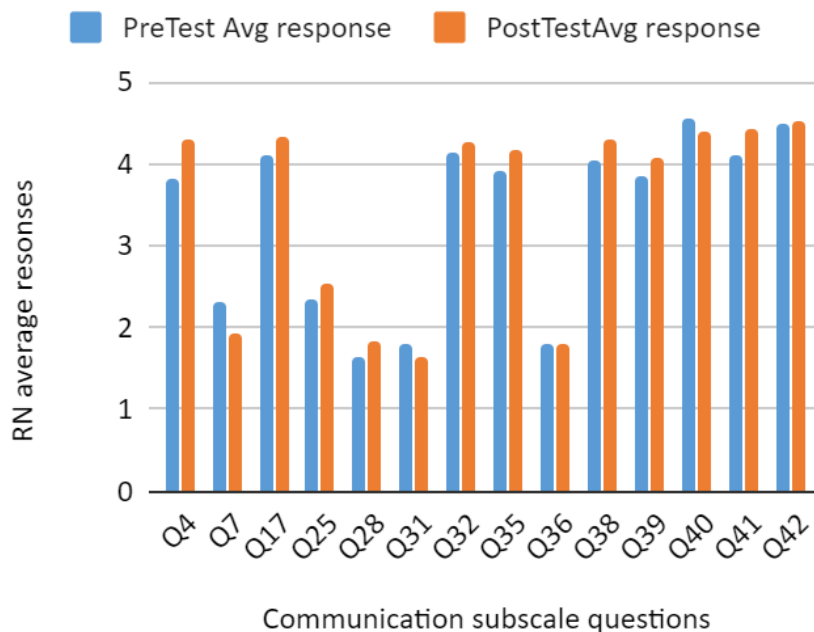


Figure 1. RN responses on the communication subscale questions of the NPPRS. Blue indicated baseline assessment survey and orange indicated post-intervention survey.

Note. Q, questions on the nurses' perceptions of patient rounding scales, NPPRS, RN, registered nurse.

The average responses of nursing assistants on the communication subscale questions of the NPPRS were similar to that of the registered nurses. Table 4 showed a mean score of 3.46 of pre intervention responses of nursing assistants on the communication subscale of the NPPRS. Post intervention, the mean value of the responses of nursing assistants on communication subscale was 3.39. Nursing assistants selected higher numbers on the Likert scale for positive questions and significantly lower numbers on the Likert scale for the negative questions as shown in table 4 and figure 2. Hence the mean score of nursing assistants' responses on communication subscale, post intervention, was 3.39. This yielded a negative mean value of -0.07 for the change in response between pre and post intervention. The difference in mean score for question 7 was -1.93. The difference in mean score for question 31 was -2.00. The difference in mean score for question 36 was -0.80 (see Figure 2). These mean values reflected favorable perceptions of benefits of hourly rounding on communication between frontline staff and their patients (Neville et al., 2012; Neville et al., 2016).

Table 4

Communication subscale questions on NPPRS - Change in average responses from all NA participants

Respondent NA	Q4	Q 7	Q 17	Q 25	Q 28	Q 31	Q 32	Q 35	Q 36	Q 38	Q 39	Q 40	Q 41	Q 42	Totals
Pre-Assessment Avg response	3.5	3.33	4.5	2.25	2.25	3	3.33	4	2	4.5	3.75	3.75	3.75	4.5	3.458333333
Post-intervention Avg response	5	1.4	4.8	1.4	1	1	4	4.4	1.2	4.6	4.6	4.6	4.6	4.8	3.385714286
Change in Avg response	1.5	-1.93	0.3	-0.85	-1.25	-2	0.67	0.4	-0.8	0.1	0.85	0.85	0.85	0.3	-0.072619048

NPPRS, Nurses' perception of patient rounding scale; NA, Nursing assistant, Q, question.

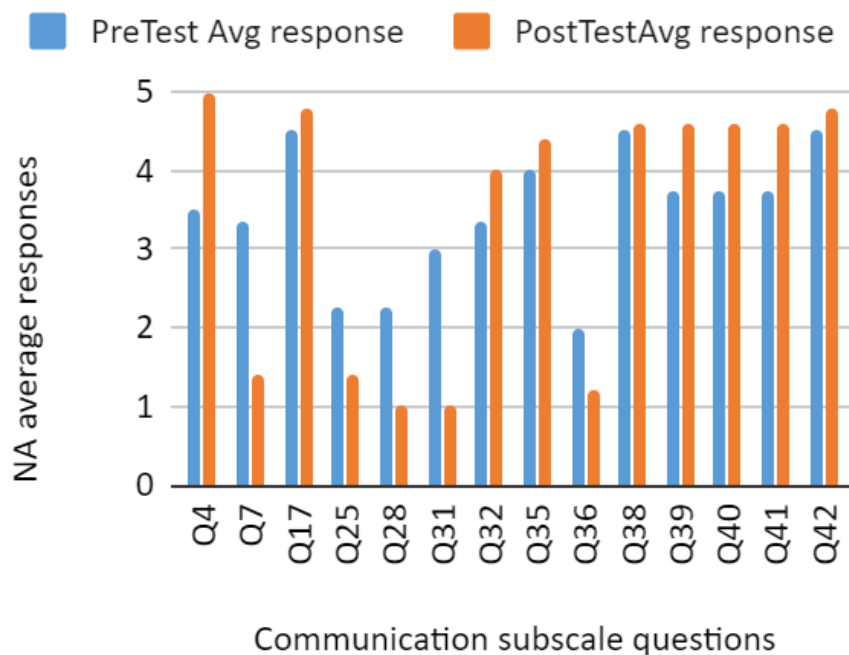


Figure 2. NA responses on the communication subscale questions of the NPPRS. Blue indicated baseline assessment survey and orange indicated post-intervention survey.

Note. Q, questions on the nurses' perceptions of patient rounding scales, NPPRS, NA, nursing assistant.

Nurse Benefits Subscale

Perception of frontline staff on nurse benefits from hourly rounding was also explored and is contained in the NPPRS (Neville, 2010). The nurse benefits subscale questions assessed the nurses' perceptions of the benefits of hourly rounding in enhancing nurse satisfaction and effecting better management of patient care by nurses (Neville, 2010). Table 5 showed the mean values of nurses' responses on the nurse benefits of hourly rounding. The mean value of the baseline organizational assessment survey was 3.59. The mean value of the post intervention survey was 3.78. The difference in mean values between baseline organizational survey and post intervention survey was 0.18. Furthermore, for question 3, the mean value for nurses' responses pre intervention was 3.5 and the mean value after intervention was 3.13 (see Figure 3). This question 3 which asked: Call bell use has not decreased through the use of

rounding (Neville, 2010), was a negative question in which a low Likert scale was preferred to indicate positive perception of nurse benefits of purposeful hourly rounding (Neville et al., 2012; Neville et al., 2016). The mean value for question 19 was 3.70 before education and structured hourly rounding intervention and 3.25 after the intervention (see Figure 3).

Table 5

Nurse Benefit subscale questions on NPPRS - Change in average responses from all RN participants

Respondent RN	Q2	Q3	Q5	Q6	Q8	Q11	Q12	Q15	Q19	Q34	Totals
Pre-Assessment Avg response	4.21	3.5	3.63	3.2	2.65	3.25	4.4	3.63	3.7	3.75	3.592368421
Post-intervention Avg response	4.5	3.13	4.21	3.46	2.79	3.58	4.54	4.25	3.25	4.04	3.775
Change in Avg response	0.29	-0.38	0.58	0.26	0.14	0.33	0.14	0.62	-0.45	0.29	0.182631579

NPPRS, Nurses' perception of patient rounding scale; RN, Registered nurse

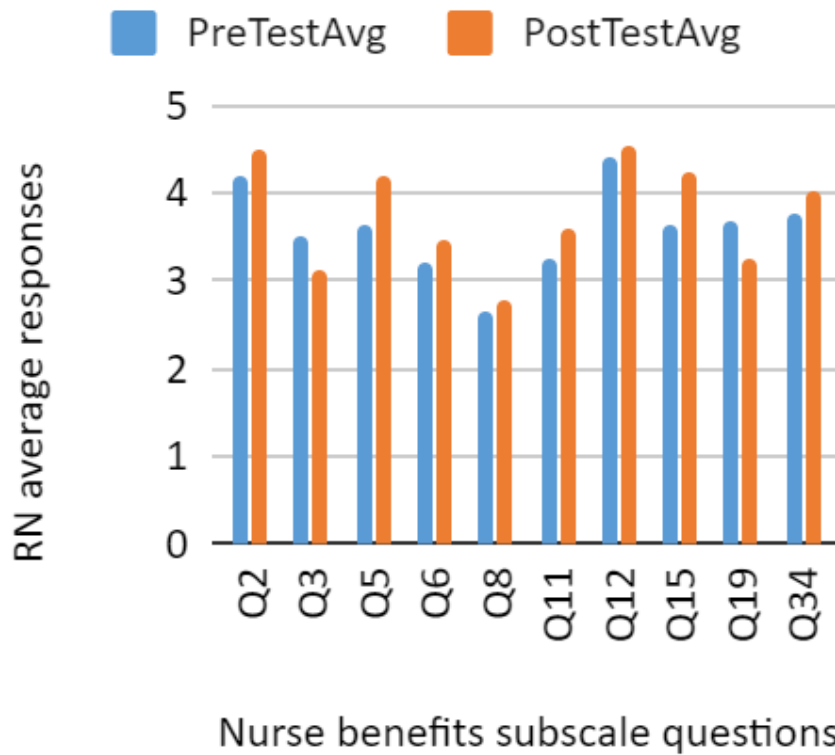


Figure 3. RN responses on the nurse benefit subscale questions of the NPPRS. Blue indicated baseline assessment survey and orange indicated post-intervention survey.

Note. Q, questions on the nurses' perceptions of patient rounding scales, NPPRS, RN, registered nurse.

Questions 2, 5, 6, 11, 12, 15, and 34 all had increases in nurse response scores following post intervention and all established awareness of the benefits that purposeful rounding fostered on the nurses.

Nursing assistants also had positive impact from a structured purposeful rounding. Table 6 showed a mean of 3.55 of the nurse benefits questions during baseline organizational survey and a mean of 3.96 of the nurse benefits questions after education and practice of structured hourly rounding. A difference in mean between pre intervention and post intervention was 0.41. This showed an increase in mean value following intervention.

Table 6

Nurse Benefit subscale questions on NPPRS - Change in average responses from all NA

participants

Respondent NA	Q2	Q3	Q5	Q6	Q8	Q11	Q12	Q15	Q19	Q34	Totals
Pre-Assessment Avg response	4.5	3.75	3.75	3	3.5	2.33	4.5	3.5	3	3.67	3.55
Post-intervention Avg response	4.8	2.75	4.6	4.8	2	3.2	4.2	4.2	4.5	4.5	3.955
Change in Avg response	0.3	-1	0.85	1.8	-1.5	0.87	-0.3	0.7	1.5	0.83	0.405

NPPRS, Nurses' perception of patient rounding scale; NA, Nursing assistant

Patient Benefit Subscale

The last subscale was the patient benefit subscale. The patient benefit subscale questions assessed the frontline staff perceptions of hourly rounding as means of improving patient satisfaction and patient outcomes (Neville, 2010). Table 7 showed that the mean score of baseline organizational survey response was lower than the mean score of survey responses obtained after a structured hourly rounding was established through education and demonstration. The mean value of the nurses' responses before educational intervention and structured process was 3.59. The mean scores after intervention was 3.78. The difference in mean scores of nurses' perception of hourly rounding benefits related to improved patient outcomes was 0.18. This could mean that nurses perceived that hourly rounding could mean more positive impact on patient outcomes. Question 18 yielded a negative mean difference (see Figure 4). The mean responses for question 18 was 2.55 before intervention and 2.17 after intervention. The lower mean score after intervention favored improved perception since the question was a negative question.

Table 7

Patient Benefit subscale questions on NPPRS - Change in average responses from all RN participants

Respondent RN	Q10	Q14	Q18	Q21	Q22	Q24	Q27	Totals
Pre-Assessment Avg response	4.1	3.74	2.55	3.7	3.58	3.75	3.74	3.593233083
Post-intervention Avg response	4.25	3.96	2.17	4.08	3.63	4.13	4.21	3.775621118
Change in Avg response	0.15	0.22	-0.38	0.38	0.05	0.38	0.47	0.182388035

NPPRS, Nurses' perception of patient rounding scale; RN, Registered nurse

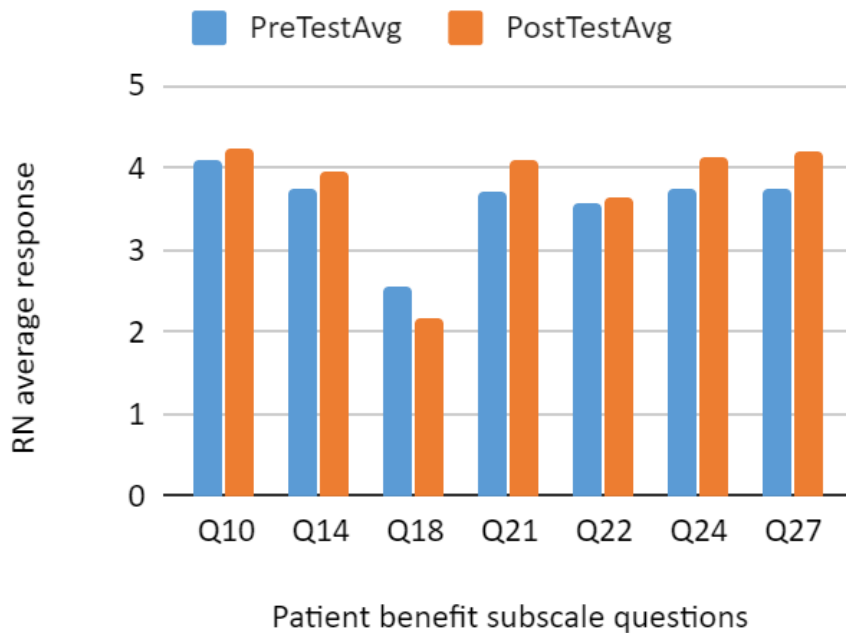


Figure 4. RN responses on the patient benefit subscale questions of the NPPRS. Blue indicated baseline assessment survey and orange indicated post-intervention survey.

Note. Q, questions on the nurses' perceptions of patient rounding scales, NPPRS, RN, registered nurse

For nursing assistants, the mean value of their responses to the survey questions on patient benefits was 3.33 before intervention as shown in table 8. After intervention, the mean value of nursing assistants' responses on patient benefits was 4.09. The difference in the mean values pre and post intervention, was 0.76. This demonstrated improved perception of purposeful hourly rounding by nursing assistants after educational intervention and demonstration. Similarly, the mean scores on the individual questions increased after the intervention (see Figure 5).

Table 8

Patient Benefit subscale questions on NPPRS - Change in average responses from all NA participants

Respondent NA	Q10	Q14	Q18	Q21	Q22	Q24	Q27	totals
Pre-Assessment Avg response	3.33	3	2	3.75	3.25	4.25	3.75	3.333333333
Post-intervention Avg response	4.6	4.6	2	4.6	3.6	4.6	4.6	4.085714286
Change in Avg response	1.27	1.6	0	0.85	0.35	0.35	0.85	0.752380952

NPPRS, Nurses' perception of patient rounding scale; NA, Nursing assistant

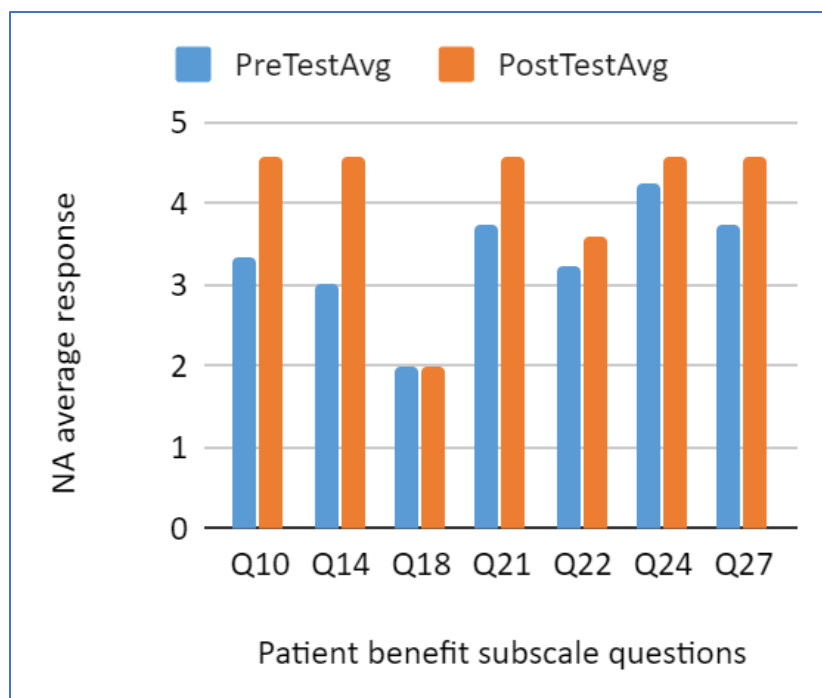


Figure 5. NA responses on the patient benefit subscale questions of the NPPRS. Blue indicated baseline assessment survey and orange indicated post-intervention survey.

Note. Q, questions on the nurses' perceptions of patient rounding scales, NPPRS, NA, nursing assistant.

During the data analysis, a Welch Two Sample *t*-test was also run to establish any equality in the two sample means. The two samples were the baseline organizational assessment survey participants and the post intervention survey participants. The baseline participants were 20 nurses and 4 nursing assistants. The post intervention participants were 24 nurses and 5 nursing assistants.

The Welch Two Sample *t*-test, two-sample $t(50) = 2.1$, $p = .04$ demonstrated statistically significant differences between the two groups. A negative *t* value, -2.1384 resulted showing increase in sample mean. The impact of educating the staff on benefits of hourly rounding and introducing them to a structured process was a positive result on their perceptions of hourly rounding which demonstrated a meaningful indication for possible improvement in practice.

Discussion

Outcomes

Nurses' and nursing assistants' perceptions of purposeful rounding. Improved nurses' and nursing assistants' perceptions of hourly rounding after implementation of a structured purposeful rounding was supported by the results obtained. When agents of change perceive the need for a change, a change is more likely to be diffused and sustained (Rogers, 1983). The purpose of this project was to improve the frontline perceptions of hourly rounding through education and demonstration of a structured hourly rounding process. The sample mean responses on the benefits of purposeful hourly rounding, communication, nurse benefits, and patient benefits increased post intervention for both nurses and nursing assistants. The difference in mean responses of nurses on communication was 0.11. This demonstrated that educating nurses and introducing structure to the hourly rounding process influenced positively, their perceptions of hourly rounding as a tool to improve communication with the patients under their care. The difference in mean responses of nursing assistants was -0.07. Nursing assistants selected higher numbers on the Likert scale for positive questions and significantly lower numbers on the Likert scale for the negative questions. On nurse benefits, the difference in mean responses of nurses was 0.18 and that of nursing assistants was 0.41. These numbers demonstrated that both nurses and nursing assistants perceived that hourly rounding could enhance their care of patients positively, especially after the educational intervention. Furthermore, the difference in mean responses of nurses on the patient benefits was 0.18 and that of nursing assistants was 0.75 demonstrating again, improved frontline perceptions of hourly rounding. The Welch two sample t-test, two-sample $t(50) = 2.1, p = .04$ demonstrated statistically significant differences between the pre sample and post sample mean. However, it

was difficult to calculate the population mean from the sample mean because one of the criteria for estimating a confidence interval which was sample size of greater than 30 was not met.

Decrease in patient falls on the target unit. One of the outcomes was originally to investigate patient fall rate on the target unit before education on and implementation of the structured hourly rounding and patient fall rates post intervention. It was with regrets that due to the SARS-CoV-2 pandemic; the fall rates data were not collected. It was impossible to collect such data when the unit became a biocontainment unit. Moreover, the baseline assessment was done in one medical-surgical unit and the intervention was done in a comparable unit. Therefore, true indication of improvement was difficult to ascertain. Despite inability to collect data, frontline staff confirmed verbally during education session, that fall rate in the unit decreased when they rounded frequently on their patients.

Improved patient satisfaction. Likewise, data from HCAHPS scores on patient satisfaction in the month preceding the structured purposeful rounding intervention and the month when the intervention took place were not collected due to SARS-CoV-2 pandemic. There was evidence in the literature that consistent hourly rounding can decrease fall rates, pressure ulcer injury, call light use and increase patient satisfaction and nurse satisfaction (Daniels, 2016; Fabry, 2015; Mitchell et al., 2014). Unfortunately, it was not proven in this project.

Limitations

The project had some limitations that might hinder the generalizability of the findings. These included timeframe for the completion of the project, sample size, change of target units, and SARS-CoV-2 pandemic. The project implementation period was supposed to last for four weeks but it was rather cut down to two weeks due to SARS-CoV-2 pandemic. The target unit was converted to biocontainment unit SARS-CoV-2 pandemic and could no longer support

hourly rounding. Consequently, the project implementation was moved to a sister unit for completion. This made the survey participants post implementation, to be different from the survey participants before the implementation. The sample size for both the baseline survey and post intervention survey were less than 30. This made the computation of confidence interval and population mean impossible. This in turn might limit the generalizability of the findings to the target population.

If this study were to be repeated, a larger sample size and longer duration for implementation would be sought and hopefully, there would not be any pandemic such as this.

Plan for Sustainability

One of the reasons for implementing this process improvement project was to promote sustainability of the rounding practice in the target unit. Hence during the project implementation, a rounding checklist was created that enabled the frontline staff follow the structured rounding process. The checklist was also placed in each patient room for future reference. An hourly rounding cues were also constructed as a visual for the structured process and placed in each patient room. A poster board on purposeful rounding was created for the unit and placed at the nurses' station. A unit practice council (UPC) was already in place that oversaw the unit's daily practices. A collaboration was sought with them to maintain the practice of purposeful rounding through the use of champions. The manager confirmed an existence of a unit champion for hourly rounding and encouraged collaboration with them. The UPC chair was encouraged to incorporate an agenda for hourly rounding in the councils' routine agenda to enable sustainability of the structured rounding process. The manager was encouraged to monitor the progress of the purposeful rounding process consistently through the UPC.

Implication for Practice

The findings from this project included that education about a process and structure to any process were needed for that process to thrive. The implication was that unit managers needed to form unit hourly rounding committee that would include both the registered nurses and nursing assistants. The rounding committee needed to enforce structured rounding process set up in the unit. The unit rounding committee needed to meet periodically in a consistent manner to discuss the progress of the practice, to maintain the structure to the practice, and to input any ideas that would constantly rejuvenate the practice.

The project ignited the hourly rounding for sustainability and so must be disseminated to practitioners and stakeholders. One of the methods for delivering the findings would be knowledge dissemination during organizational leadership daily huddle. Another method would be dissemination of project findings to the frontline staff during unit meeting or daily huddle. Dissemination through a professional body would also be sought.

Opportunities for system improvement and practice change would be conscious effort to enquire about perceptions of frontline staff in any practice change initiatives and to provide training and education that the adopters of the change would attune to. The adopters of the change or innovation should be made change agents through committee groups.

A future research suggestion would be how to use improved perception of practice to engage frontline staff in sustaining such practice.

Conclusion

Hourly rounding as a practice to improve patient outcomes has received tremendous support in literature, stating its numerous benefits. But the gap between the practice and its sustainability in clinical setting is still left to be closed.

In this project an organizational assessment was implemented to establish ways to close the gap between practice of hourly rounding and its sustainability. During that inquiry, input was elicited from the frontline staff as to a way forward to sustaining the practice of hourly rounding. The staff gave their candid perception of the practice through survey using a validated tool. Some of the staff recommended a structure to the process that was sustainable. To that note, a purpose was established for this project which was to implement a structured purposeful rounding intervention in a medical-surgical unit of the organization, that would improve nurses' and nursing assistants' perceptions of the practice. That was to eventually create sustainability and improve patient outcomes. During the intervention process, frontline staff were educated on the benefits of hourly rounding and on structured hourly rounding process that enabled clustering of patient care on the hours of rounding. Through that process staff deciphered that time management could be achieved through the process of purposeful hourly rounding. It could be concluded that the intervention improved the frontline staff's perceptions of hourly rounding process, reflected in a statistically significant mean difference in the sampled participants.

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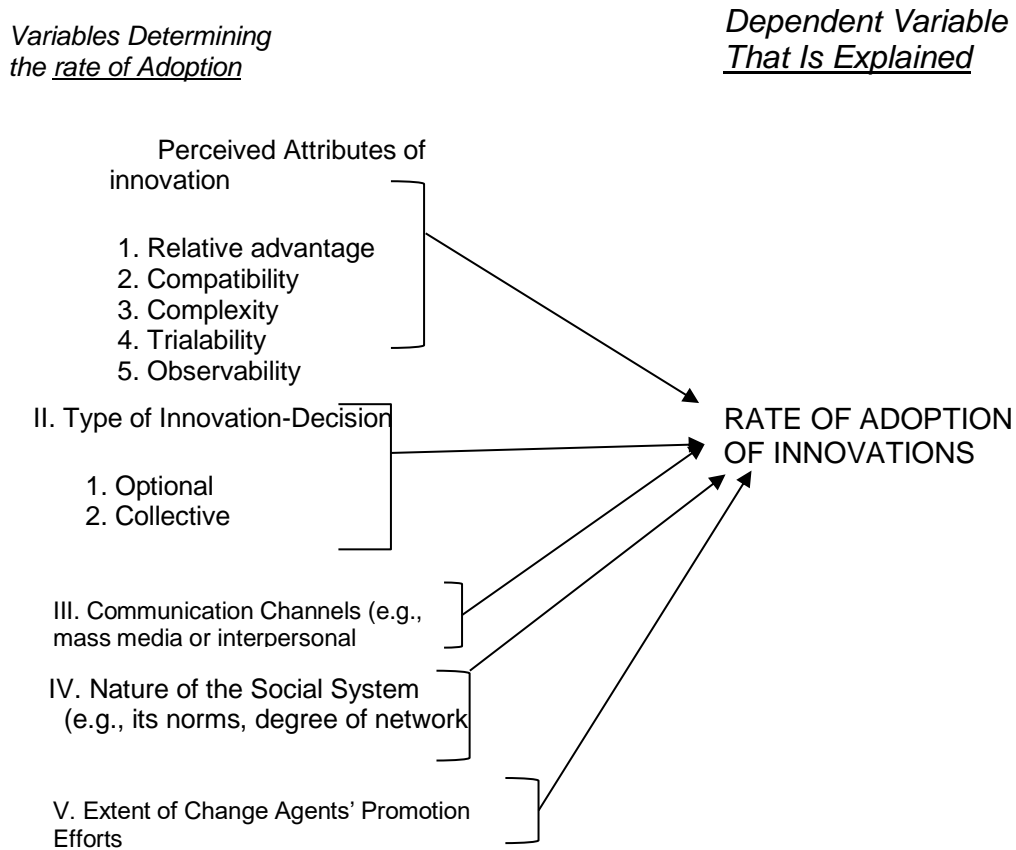
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Appendices

Appendix A

Figure 1. Variables Determining the Rate of Adoption of Innovation



Appendix B

Education Tool

A Quality Improvement Educational tool on Purposeful Rounding Presented by Bernadine Ihediohanma

Definition of Purposeful Hourly Rounding

Purposeful rounding is the intentional checking-on of patients at hourly or two-hourly intervals with the goal of meeting patients' needs in the areas of positioning, pain management, toileting, and possessions within reach (Brosey & March, 2015; Fabry, 2015; Neville et al., 2016).

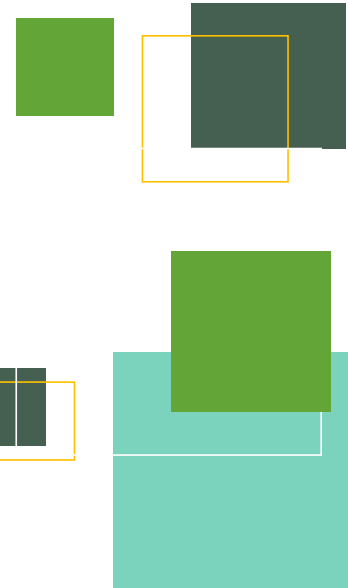
Benefits of Purposeful Rounding

- Increased patient satisfaction
- Reduced fall rates
- Increased patient safety
- Reduced pressure ulcers
- Decreased anxiety
- Decreased call bell use
- Improved patient outcomes (Brosey & March, 2015; Fabry, 2015; Neville et al., 2016)



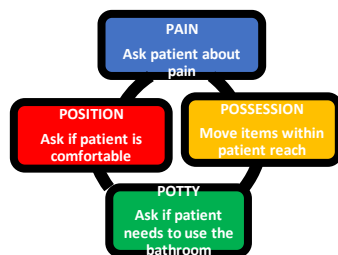
Educational Aim

The aim of this educational tool is to establish a long lasting and structured purposeful rounding in the unit.



Elements of Structured and Purposeful Hourly Rounding

Hourly Rounding Visual Cues



Purposeful rounding checklist

To be done every 1-2 hours on days and night

INTRODUCTION

Knock prior to entering. Manage up your skill and that of your co-worker. Use key phrase “We will provide excellent care”

UPDATE WHITE BOARD

Write care team names on white board and update plan of care.

ADDRESS THE 4 P’S

POTTY

May I take you to the bathroom now?

PERFORM SCHEDULED TASKS

Integrate rounding with ordered treatments

Complete nursing care such as vital signs

Administer scheduled medications

Educate patient on rounding, pain medication, plan of care/goals.

CLOSING (Before you leave the patient’s room)

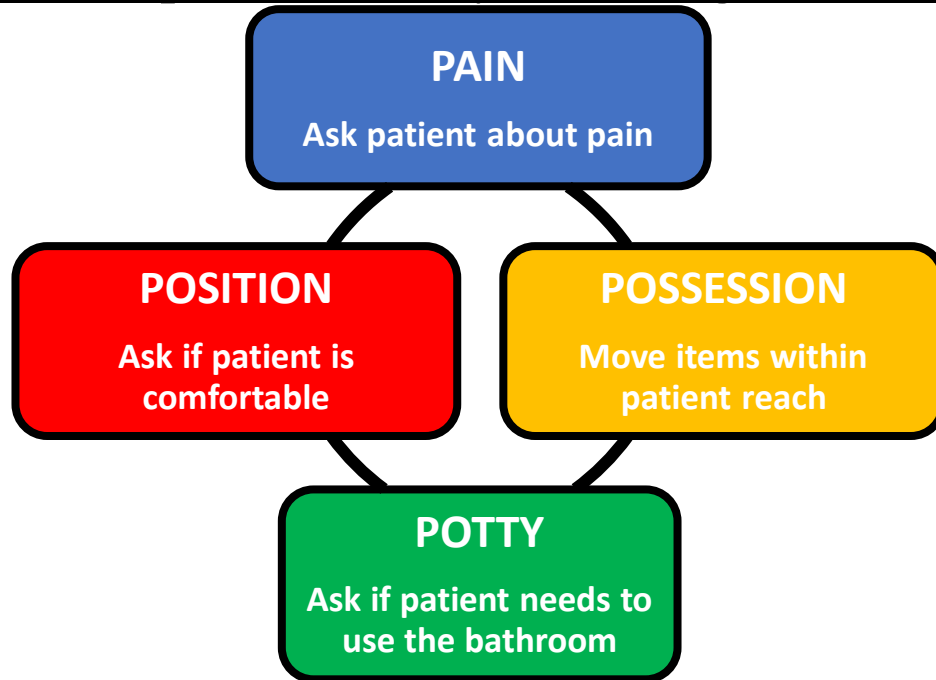
We will round again about an hour or two.

Is there anything else I can do for you? I have the time.

Write the time of your rounding on the white board.

https://health.mo.gov/d ata.interventionmica/index_4.html#top

4 'P's of Purposeful Hourly Rounding Visual Cues



Purposeful rounding:

- Increases patient satisfaction
- Reduces fall rates
- Reduces the use of call lights
- Reduces hospital acquired pressure ulcers (HAPU)

Appendix C

Purposeful Rounding Checklist

To be done at least every 2 hours on days and nights

INTRODUCTION

Knock on door prior to entering-ask permission.

Manage up your skill or that of your co-worker.

Use eye contact.

Use key words “excellent” care.

UPDATE WHITE BOARD

Place name on white board.

Update plan of care/goals for patient.

ADDRESS THE 4 P’S PAIN, POSITION, POTTY, AND POSSESSION

May I take you to the bathroom now?

How is your pain?

Are you comfortable?

Move items within reach (i.e. table, call light, trash can, cellphone, water, etc.).

PERFORM SCHEDULED TASKS

Complete MD ordered treatments, procedures (if applicable).

Complete nursing care as needed.

Administer scheduled medications (for nurses only).

Educate patient on rounding, pain medication, plan of care/goals (for nurses only).

CLOSING

We will round again about an hour or two.

Is there anything else I can do for you? I have the time.

Write the time of your rounding on the white board.

Adapted from: https://health.mo.gov/data/interventionmica/index_4.html#top

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