



NURSE-LEADER COLLABORATIVE IMPROVEMENT PROJECT: IMPROVING PATIENT EXPERIENCE IN THE EMERGENCY DEPARTMENT

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CE Earn Up to 8.0 Hours. See page 232.

Contribution to Emergency Nursing Practice

- The purpose of this practice improvement project was to improve patient experience in the ED setting.
- The primary outcome of this practice improvement project was that hourly bedside and daily leader rounding improved ED patient experience.
- For emergency nursing practice, key implications from this project are that rounding proactively meets patients' needs and improves quality of care and patient satisfaction.

Abstract

Introduction: Studies show that nurse rounding is an effective means to increase patient satisfaction and quality of care and decrease patient-safety events. There is evidence to support that daily leader rounding improves patients' hospital experience as well. Patients' experience increased confidence in their care providers, and leaders are able to address service concerns proactively. Furthermore, recent studies have addressed patient satisfaction in the ED setting as having an impact on patients' perceptions of the health care institution as a whole. Our objective was to demonstrate the effect of

hourly nursing rounds and daily leader rounds on the ED patient experience.

Methods: We used a pre- and postintervention evaluation of Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) survey scores. Two groups of stakeholders developed standard work for rounding. The leader group and the bedside nursing care groups used the evidence cited in this article to create their standard processes.

Results: During the 2-month pilot period, patient experience scores—as measured by 5 survey questions—all improved. Results will continue to be tracked monthly and reported to all stakeholders in real time to help hardwire the process change.

Discussion: Through collaboration and a participative approach, nurses and leaders used the current evidence from scholarly nursing literature as well as Lewin's theory of change to guide a successful approach to rounding and improving patients' experiences when receiving emergency care.

Key words: Rounding; Nurse leader; Emergency department; Patient experience; Patient satisfaction

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Introduction

In 2006, the Center for Medicare and Medicaid Services (CMS) implemented the Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) survey. By July of 2007, hospitals subject to the Inpatient Prospective Payment System (IPPS) were required to report HCAHPS survey data publicly on the Hospital Compare website (www.hospitalcompare.hhs.gov) to receive their full annual IPPS payment from the Centers for Medicare and Medicaid Services (CMS). Because the HCAHPS survey is an indicator of overall patient satisfaction and quality-of-care delivery, and its scores affect reimbursement, hospital leaders are focused on strategies to achieve top scores.^{1,2} The survey includes

composite topics such as nurse communication, physician communication, responsiveness of hospital staff, pain management, communication about medications, and discharge information. It also addresses cleanliness and quietness of the hospital environment, overall rating of the hospital, and willingness to recommend.²

At an urban community emergency department in Missouri, HCAHPS survey scores were a concern. An evidence-based process improvement project was initiated by 2 MSN students, with a focus on rounding. With the guidance of these 2 process owners, 1 group of stakeholders focused on creating standard work for nursing staff (nurses, paramedics, and patient-care technicians) rounding at the bedside, whereas the other focused on creating standard work for the leadership team rounding in the emergency department. Process owners collaborated with key stakeholders to receive input as well as to achieve maximum buy-in. The groups of stakeholders chose to address 5 HCAHPS survey questions on which the emergency department was performing poorly: responsiveness to concerns and complaints during hospitalization (6th percentile), degree to which hospital staff worked as a team (12th percentile), likelihood to recommend (9th percentile), overall rating (8th percentile), staff identifying themselves to patients (9th percentile).

OUTCOMES ASSOCIATED WITH NURSE HOURLY ROUNDING

“Hourly Rounding” is a phrase trademarked by the Studer Group, established by Quint Studer, health care leader, teacher, and author. The Studer Group conducted a study of 14 hospitals and 27 nursing units that included telemetry, surgical, and medical-surgical units.³ The Studer Group initially examined the primary reasons patients use call lights and measured the average time taken to respond to call lights. The data revealed that patients primarily use call lights for bathroom assistance (15%), IV or pump alarms (15%), pain medication (10%), to request a nurse (9%), and positioning assistance (4%) as well as accidental hits of the call light (13%) and other miscellaneous reasons (13%).³ Based on the findings of this study, the Studer Group recommended purposeful hourly rounding to include the following components: (1) Greet patient and identify yourself to decrease anxiety; perform any scheduled tasks; (2) address the 4 Ps: potty/personal care, pain/need for intervention, position/mobility and personal items within reach; (3) before leaving the patient, ask if there is anything more the staff member can do for the patient, indicating that there is time; (4) advise the patient when a staff member will return; and (5) document the round in the medical record.⁴⁻⁷

Studer’s study³ was able to demonstrate a decrease in call lights by 37.8%, a decrease in falls of 50%, a decrease in skin breakdown of 14%, and an increase in patient satisfaction by 12 mean points. Other researchers have reported similar findings. Olrich et al demonstrated a 23% reduction in falls.⁶ Call-light use showed mixed results during their study, with only 1 week displaying a statistically significant decrease in use. Finally, patient satisfaction, although slightly increased, was not significant ($P = 0.383$). That said, the anecdotal evidence gathered revealed that patients perceived the nursing staff to be more attentive.⁶ Other authors acknowledge improvements in call-light use and patient satisfaction⁸⁻¹⁰ and a decrease in patient safety events such as falls and skin breakdown.^{4,11,12}

LEADER ROUNDING IMPACT

Although nurse hourly rounding has shown increases in patient satisfaction and decreases in call-light use and patient safety events, leader rounding is also being explored as a way to increase patient satisfaction as well as staff engagement.¹ The Studer Group suggested that daily rounding by nurse leaders would have a positive effect on patient quality, safety, and satisfaction when added to hourly nurse rounding.^{3,13} There is a benefit to leader rounding because managers and other leaders are able to address service concerns proactively, before it is necessary to apply service recovery measures.¹⁴ Leaders rounding have increased visibility and gain the trust and respect of ED staff working at the bedside. It is a good way for leaders to connect directly to patients on the unit as well as with their care providers.^{1,14,15} Rather than focusing on physiologic needs, leaders can focus on service needs, recognition of staff caring for patients, and address concerns in real time.^{1,2,15} Interestingly, following leader rounding, many patients reported greater confidence in their care providers¹³ as well as perceiving that leaders spent a greater amount of time with them on rounds than they actually had.¹⁶

ED PATIENT EXPERIENCE

When being evaluated and treated in the emergency department, many patients and families report a feeling of powerlessness and lack of control.¹⁷ Some patients and families feel abandoned, waiting without communication or information for long stretches of time. Many say they feel unsupported by the medical personnel providing care to himself, herself, or a loved one.¹⁷ One hermeneutical phenomenological study examined the experiences of patients, family members, and emergency nurses.¹⁸ Not surprisingly, Cypress found that

patients coming to the emergency department greatly valued the critical thinking ability of their nurses and other care providers.¹⁸ Another concern overwhelmingly identified by patients and families was communication. Patients and families emphasized the need for continuous communication about their conditions, wait times, meanings of test results, and staff members identifying themselves to patients. Finally, patients and families want to feel cared about, which is often tied to the communication they are receiving or not receiving from emergency staff. Patients and families want to feel that they are the focus of concern and not be in the middle of conversations among coworkers regarding weekend plans or other unrelated topics.¹⁸

Knowing the perceptions of patients and families receiving care in the emergency department validates the need for clear, respectful communication. Communication by nurses and doctors is addressed in several of the HCAHPS survey questions, and is correlated with patient experience scores. Kirk and Kane looked at the implementation of hourly rounds at an emergency department in England, focusing on nurse perceptions and implementation challenges.⁵ Nurses perceived patients and families as partners in their care¹⁸ as well as placing great importance on the physiologic needs and stability of their patients.^{5,18} Nurses acknowledged the need for hourly rounding to improve care of patients, as well as safety, in that a decline in clinical status could be recognized earlier. However, many emergency nurses felt a need to customize the way rounds were conducted to account for ED crowding and high-acuity events.⁵

Methods

STUDY DESIGN AND POPULATION

This study represents a pre- and postevaluation of an evidence-based intervention with the goal of increasing the HCAHPS scores of ED patients, focusing on the following 5 HCAHPS survey questions: (1) Response to concerns/complaints during your stay; (2) degree to which hospital staff worked as a team; (3) staff identified themselves to patients; (4) overall rating of institution; (5) likelihood to recommend. The setting was an urban community hospital emergency department. The hospital is not designated a trauma center but is a level I ST-elevation myocardial infarction (STEMI) center and a level II stroke center. The emergency department has 34 rooms and sees approximately 178 patients a day. There is 1 nurse manager, 3 assistant nurse managers to cover all shifts, and multiple charge nurses. Above the unit-level management, is a director of the emergency department and a chief nursing officer (CNO).

TABLE 1

Forces surrounding hourly and leader rounding in the emergency department

Driving Forces	Restraining Forces
<ul style="list-style-type: none"> • HCAHPS scores too low • Chief nursing officer request • Value-based purchasing: increased patient satisfaction scores = increased reimbursement 	<ul style="list-style-type: none"> • Busy emergency department • Nursing staff skepticism • Busy leader schedules

PROJECT STEPS VIEWED THROUGH A THEORETICAL FRAMEWORK

During the months of September and October 2017, process owners met weekly with their teams of stakeholders. The CNO led the process of developing standard rounding with the leadership stakeholders in the emergency department. The director of the emergency department was the process owner for the nursing staff rounding process. Each group began with review of the baseline data before the practice change. Each group reviewed the scholarly literature and, based on the evidence, created standard workflow for the leaders and nursing staff.

Using Kurt Lewin's Force Field Analysis and Planned Change Theory,¹⁹ the process leaders and their teams were able to devise plans for their rounding interventions and timeline for implementation. A force field analysis refers to assessing whether an environment or team is ready for the change. One must consider the driving forces and restraining forces surrounding the change and whether there is enough drive to overcome any resistance, accomplish the change, and establish the new behavior (Table 1).

Given the strength of the driving forces, they were ready to begin the practice change. Lewin's Planned Change Theory is broken into 3 phases: unfreezing, change, and refreezing. This practice change project represents each phase of this theory.

Unfreezing

During this phase, stakeholders involved in the change gained an understanding of the need for the change and decreased the resistance to the change. The stakeholders were able to understand the gap that existed between current practice and desired practice and outcomes. Process owners identified stakeholders in each group. The leaders included

TABLE 2

Standard work for leader rounds

	Leader rounding process	Key points/rationale
1.	Review new admit and discharge list to prioritize rounding on patients and families	Prepares leader to make best use of their time
2.	Speak with direct care RN before entering patient room	Understand any issues or patient needs Validate the work of the bedside RN Establish trust and respect Gain feedback on the process of hourly rounding
3.	<p>“Good morning, my name is _____, manager/ director/ administrator. I am visiting our patients to ensure that we are providing exceptional care.</p> <ul style="list-style-type: none"> • Are we meeting this commitment? • Have we been checking on you every hour? • Are we responding to your call light in a timely manner? • I see that _____ is your RN today. He/she is one of our finest nurses. You are in excellent hands.” 	<p>Build relationship with patient/family If possible, sit at bedside at eye level. It makes the visit more personal and signals to the patient when you stand, the visit is ending Refer to the whiteboard and ensure the patient can read the information from the bed Managing up staff improves patient confidence in the organization and their caregiver Keep visit to 5 minutes or less</p>
4.	“Is there anything else I can get you before I leave the room? I have the time.”	Reaffirms your commitment to exceptional care
5.	<p>Immediately seek out direct care RN and provide feedback from the patient Example: “Thank you for your commitment to rounding hourly on your patient, Ms. _____ in room _____. She noted that she never needed to use her call light.”</p>	<p>Reinforces the desired behavior and recognizes the nurse’s success and hard work Creates trust, satisfaction and sense of pride in work</p>

the director of the emergency department, the nurse manager, assistant nurse manager, and will include the charge nurses in the future, once the standard work is identified and trialed. The bedside rounding group included nursing staff (nurses, paramedics, and patient-care technicians) involved in the unit practice council. Each group met weekly for 6 weeks during September and October 2017 to review HCAHPS data and to identify elements of current practice as well as to review best practices for improving patient experience scores. Once standard work was established (Tables 2 and 3) for each group, the pilot implementation was planned for November and December 2017. During the pilot phase, the leadership team agreed to trial their standard work during a 1- to 2-hour period on the day shift. After the pilot phase, charge nurses would round on the evening and night shifts as well. The unit practice council assisted with communicating baseline HCAHPS scores and best-practice information to the nurses, technicians, and

paramedics in the emergency department during the last 2 weeks of October, so they would be prepared for the project implementation and have time to clarify any questions or concerns.

Change

Once the standard work was established (Tables 2 and 3) and the timeline expectation set with the ED nursing and leadership staff, implementation was set for November 2017. During the implementation phase, the process owners and teams conducted random audits and were available to offer support and feedback to the nurse leaders and bedside providers. According to Lewin’s Planned Change Theory, the Change phase involves revised policies and objectives, leading to the implementation of new processes. The affected workforce should understand the driving forces

TABLE 3

Standard work for hourly patient rounding in the emergency department

Hourly rounding process	Key points/rationale
1. Establish expectation of hourly rounds upon first meeting patient. "A member of the nursing team will make rounds hourly while you are here to make sure you are comfortable, have assistance to the bathroom if you need, and to assist you with any other needs. We want to provide you with exceptional care."	This will establish the expectation that the patient will see a nursing staff member at least hourly and provide reassurance, possibly alleviating some anxiety.
2. Hourly, check the 4 Ps: Pain: Rate pain, see if intervention needed Potty/personal care: Does the patient need assistance to the bathroom? Do we need to measure or sample stool or urine? Positioning: Is the patient in a comfortable position or need help adjusting? Personal items: Can the patient reach their personal items and call light?	This should proactively meet patient needs, decrease falls or other events and decrease random calls. Improves nursing efficiency by decreasing call lights
3. Before leaving patient room, ask: "Is there anything else I can do for you before I leave? I have the time."	Reassures patient they are important and that you are available to them. (Patient centeredness)

and need for the change. There must be proper training and support for the implementation of the change.

Refreezing

During this phase, Lewin states that changes are implemented and monitored, adjusted as needed, and reinforced so that the change becomes permanent. The process owners and teams continued audits and feedback throughout the month of December 2017.

Results

The implementation of hourly rounding was to start at the beginning of November 2017, although some staff began as soon as they were informed of the change in practice. This may be responsible for a small increase in scores at the beginning of the implementation phase. HCAHPS scores were pulled weekly during the implementation phase and showed a marked increase from baseline (Table 4). Six leaders shared the responsibility of making daily rounds on all patients in ED beds during a prescribed period during the day shift. As charge nurses become involved in leader rounds in the future, all shifts will be addressed. Seventy-five nurses, 25 paramedics, and 6 patient-care technicians were educated about and performed hourly rounds on their patients in the emergency department, averaging 175 patients daily.

Audits occurred on all shifts through observation so that real-time feedback and adjustment of behaviors could take place. Compliance was approximately 60% initially, improving to over 90% after 1 to 2 weeks.

Discussion

The project's results were very promising during the months of November and December 2017. However, the flu season of 2017 to 2018, especially in January 2018, presented major challenges to this and other Missouri hospitals. Missouri saw more flu cases than anywhere in the nation, and emergency departments were stretched beyond capacity, requiring split-second decision making and rapid development of temporary solutions to decompress the department. Because of this stress, the bedside care providers' focus on hourly rounding was derailed in January and February 2018. It was hoped that the emergency department would regroup after flu season and begin to focus on rounding again. However, in light of a change in CNO and the MSN students who owned the process not being present any longer, the project stalled. The manager of the emergency department states that the staff and leadership continue to round and monitor the HCAHPS scores, but that many competing priorities and the lack of feedback from the original process owners may have contributed to the decline in scores post-intervention. Interestingly, the

TABLE 4

Baseline HCAHPS scores compared with intervention and postintervention scores

HCAHPS Survey Question	Baseline Percentile Rank	Planning Phase Percentile Rank (Unfreezing)		Implementation Phase Percentile Rank (Change)		Postimplementation Phase Percentile Rank (Refreezing)			
		Sept 2017	Oct	Nov	Dec	Jan 2018	Feb	Mar	Apr
Response to concerns/complaints during stay	6	4	1	33	57	1	5	3	21
Degree to which hospital staff worked as a team	12	3	2	45	53	5	12	17	22
Likelihood of recommending	9	1	1	17	45	8	5	8	15
Staff identified themselves	9	28	25	55	75	8	40	99	99
Overall rating of institution	8	14	17	15	75	6	9	16	20

scores for “staff identified themselves,” a metric directly impacted by nursing staff, increased to the 99th percentile.

The Emergency Department Unit Practice Council worked collaboratively with their process owner and the ED director and expressed appreciation of the opportunity, stating that they perceived more camaraderie and recognition from their leaders. Furthermore, bedside-care providers said that seeing the leaders visible during the day hours was difficult at first but created a more collegial and supportive environment.

Although not sustained, this project showed that with the right collaborative focus, patient experience scores could be affected directly in real time with a focus on rounding. Using the standard work proved effective and needs to be considered in larger, longer-term studies.

LIMITATIONS/RECOMMENDATIONS

This project demonstrated the potential positive effects of rounding by nurses and nurse leaders in the ED setting. Because it was a short-term MSN student project, there is a potential for lack of adherence to the new practice unless individuals take on the mantle of responsibility after the process owners step away. There is also the limitation of trialing this work in a single environment. Long-term evaluation of HCAHPS scores and continued practice of the standard work will potentially reveal that these best practices have ongoing impact on patient experience in the emergency department.

Because this project represents the work of 2 groups of stakeholders, it is difficult to determine if the improvement in scores can be attributed to 1 group or the other. It does potentially support the collaboration between the leadership team and those at the bedside providing care. This combination of efforts should be replicated on a larger scale to provide

validity for this approach. There are no studies available in which both leader rounding and bedside hourly rounding were implemented simultaneously. Through continued monitoring of these processes in this Missouri hospital, we are optimistic that there will be continued success.

Implications for Emergency Nursing

Emergency nurses and other nursing staff such as patient care technicians and paramedics can influence patient experience directly in the emergency department. The implementation of hourly bedside rounding in collaboration with daily leadership rounding has an impact on patients' experience of care as well as the potential to decrease safety events and improve quality of care and outcomes.

Patients in the emergency department often feel particularly vulnerable and powerless. Remember this: The emergency nurse, paramedic, or technician can alleviate much of this stress through hourly rounding and proactively meeting patient needs. Addressing needs proactively with rounding improves timely communication, patient safety, and satisfaction. Furthermore, by improving patients' experiences while they are receiving care in the emergency department, the perception of and loyalty to the overall organization is improved. This is important to the hospital's reputation and improves reimbursement.

Conclusion

This evidence-based process improvement project met its goal of increasing patient experience scores in this emergency department. Through collaboration and a participative approach, nurses and leaders successfully used the current

evidence from scholarly nursing literature as well as Lewin's theory of change to improve ED patient experience while receiving emergency care. Continued efforts by all stakeholders are necessary to sustain this change and valuable practice.

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