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Barriers Encountered by Nurses and Nursing Assistants that Prevent Purposeful Rounding

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Abstract

Purpose: The aim of the study was to identify barriers encountered by registered nurses (RNs) and nursing assistants (NAs) that prevent purposeful rounding.

Background: The literature has shown that purposeful rounding improves patient outcomes and safety. However, few studies show the barriers encountered by nursing staff that hinder the purposeful rounding process.

Methods: A pre-post test design was implemented on a 25-bed oncology, urology medical surgical unit with a staff of 38 RNs, 9 NAs, and 4 Unit Secretaries (US). A pre-implementation needs assessment survey was completed by 55% (21/38) of RNs, 33% (3/9) of NAs, and 100% (4/4) of US. It was followed by an intervention in the form of in-services during huddles and a purposeful rounding checklist. A post-intervention survey was completed by 29% (11/38) of RNs, 56% (5/9) of NAs, and 25% (1/4) of US to evaluate the effectiveness of the intervention.

Results: The pre-intervention survey revealed that 86% (18/21) of RNs, 100% (3/3) of NAs, and 100% (4/4) of US believed better RN-NA communication was needed to do purposeful rounding. The post-intervention survey found that 64% (7/11) of RNs and 60% (3/5) of NAs were more likely to communicate with their RN/NA partner about the patient's comfort and safety needs immediately after a purposeful round.

Recommendations: It is recommended that RN and NA unit champions be designated to role model communication between RNs and NAs during purposeful rounds and that staff use the purposeful rounding checklist in order to improve teamwork and patient care.

Key Words: Checklists, evidence-based practice, purposeful rounding, patient safety, RN-NA communication, unit champions.

Barriers Encountered by Nurses and Nursing Assistants that Prevent Purposeful Rounding

Purpose

The purpose of this quality improvement project was to identify barriers encountered by nurses and nursing assistants that prevent purposeful rounding. The project aimed to implement an intervention to sustain this practice in the hospital setting and improve health care delivery.

Background

Purposeful rounding is defined as a systematic nurse-driven intervention in which a nurse or unlicensed assistive personnel enters a patient's room at regular intervals to anticipate and address the needs of patients (Deitrick, Baker, Paxton, Flores, & Swavely, 2012; Shepard, 2013). These personal needs include pain management, toileting needs, positioning, and assuring that personal items are within reach. Despite the growing use of purposeful rounding in hospitals and the demonstrated benefits to patient safety, quality of care, and patient satisfaction scores, few studies have explored the barriers experienced by nursing staff in the post-implementation phase of this evidence-based practice (Fabry, 2015).

As an evidence-based practice, purposeful rounding prevents patient falls, reduces patient call light use and pressure ulcers, and improves patient satisfaction in the hospital and outpatient settings (Agency for Healthcare Research and Quality, 2015a; Brosey & March, 2015; Ellis, 2013). However, inconsistent purposeful rounding by staff members due to unit-based barriers may limit the safety benefits conferred by this proactive and anticipatory behavior.

Microsystem Setting

The project took place in an urban, Magnet-recognized, non-profit hospital in Northern California. The microsystem was a 25-bed medical-surgical unit that serves gynecology,

oncology, urology, and general surgery patients. Care providers on the unit included registered nurses (RNs), nursing assistants (NAs), and physicians. The unit was supported by a manager, two assistant managers, case managers, physical and occupational therapists, respiratory therapists, social workers, dietitians, laboratory personnel, chaplains, and interpreter services. A flowchart was created to illustrate the current purposeful rounding process on the unit (Appendix A). A delay in the purposeful rounding process can result in unsatisfactory care for patients, decreased comfort or risk to patient safety. For example, if an RN is unable to carry out a purposeful round to assess for pain level or toileting needs then a patient may not receive appropriate pain medication or obtain assistance to the bathroom in a timely manner.

A Strengths Weaknesses Opportunities Threats (SWOT) analysis was conducted to determine the internal and external factors of the unit that may facilitate or threaten the success of this project (Appendix B). The strengths of the project included support from unit management, promotion of patient safety, and the mission, vision, and values of the unit. Weaknesses were the lack of a unit champion, inconsistent education for staff and patients on the purposeful rounding protocol, and perceived lack of time. Opportunities for the project were increased awareness of staff communication and teamwork and improved Press Ganey nurse-sensitive indicator patient satisfaction scores. Threats to the project included competing priorities and multiple unit-focused projects that divided the attention and resources of staff.

Rationale

A needs assessment of the medical-surgical unit revealed several factors that prevented RNs and NAs from doing purposeful rounding. A needs assessment pre-intervention survey was completed by 28 staff members (21 RNs, 3 NAs, and 4 unit secretaries) to determine what

barriers prevented purposeful rounding (Appendix C). This represented a return rate of 55% (21/38) for RNs, 33% (3/9) for NAs, and 100% (4/4) for unit secretaries. Unit secretaries were included in the survey because they assist with many of the call lights that would have been covered by purposeful rounding. For example, they receive calls when patients need pain medication or need assistance to the bathroom. The investigator found that 86% (18/21) of RNs, 100% (3/3) of NAs, and 100% (4/4) of US believed better RN-NA communication was needed to do purposeful rounding (Figure 1).

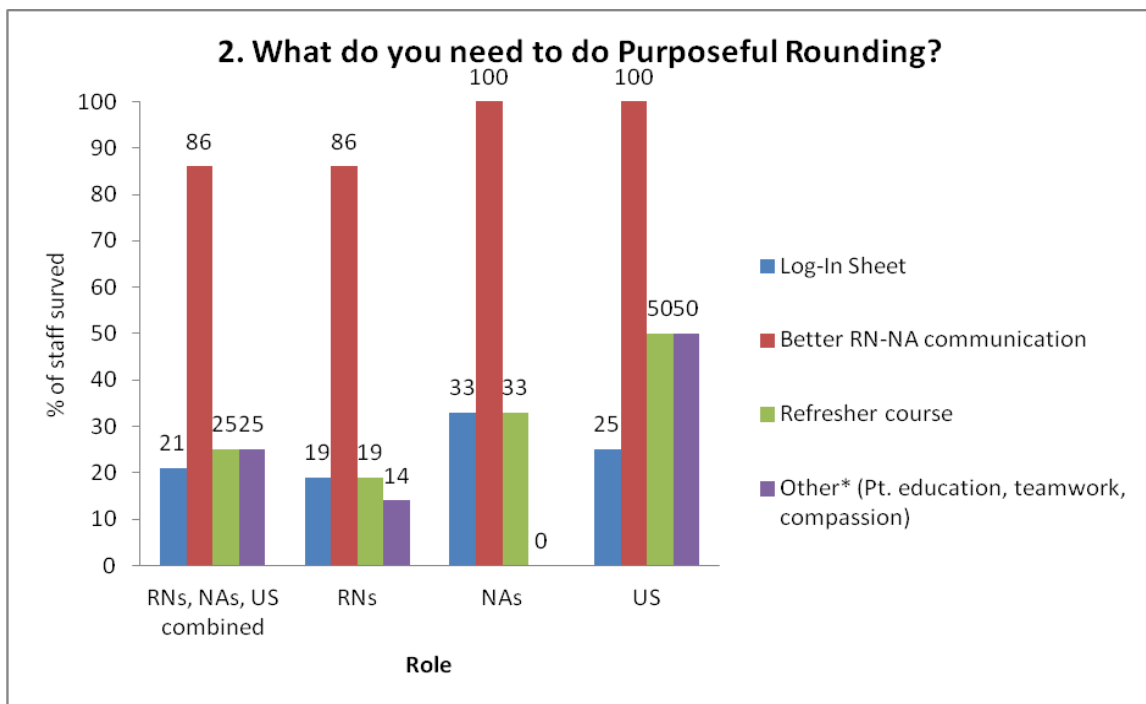


Figure 1. Results of Pre-Intervention Needs Assessment Survey- Question 2. This figure illustrates that 86% (18/21) of RNs, 100% (3/3) of NAs, and 100% (4/4) of unit secretaries (US) believe that better RN-NA communication is needed to do purposeful rounding. The figure also shows that 19% (4/21) of RNs, 33% (1/3) of NAs, and 50% (2/4) of US believed that a refresher course is needed to do purposeful rounding. See Appendix C for complete pre-intervention survey.

The survey also revealed that 25% (7/28) of staff (RNs, NAs, and US combined) believed that there was not enough staff buy-in to sustain purposeful rounding (Figure 2).

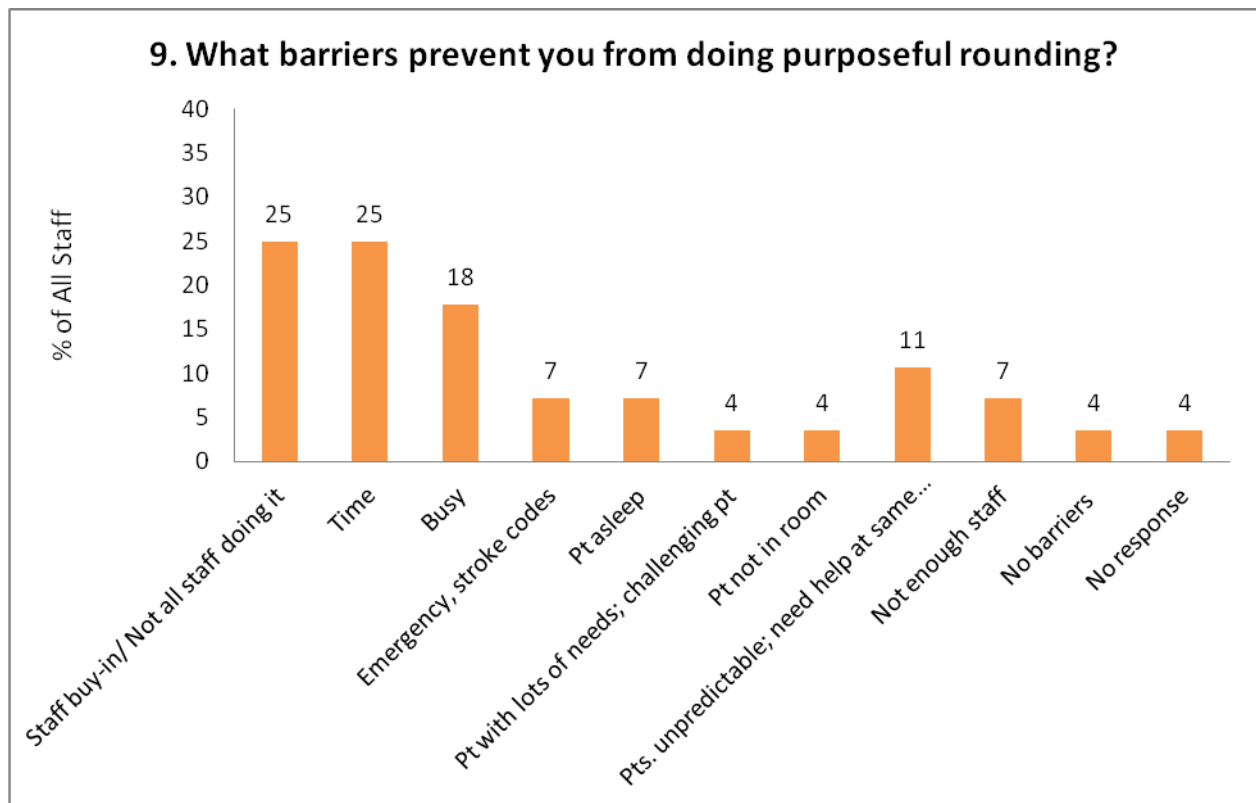


Figure 2. Findings of Pre-Intervention Survey- Question 9. A total of 28 staff members (21 RNs, 3 NAs, and 4 US) returned the pre-intervention survey for a return rate of 55% (21/38) for RNs, 33% (3/9) for NAs, and 100% (4/4) for unit secretaries. This figure shows that 25% (7/28) of staff believed that not enough staff buy-in was a barrier to purposeful rounding while 25% (7/28) believed that time was a barrier to purposeful rounding, and 18% (5/28) believed that a busy shift was a barrier. See Appendix C for complete pre-intervention survey. RNs= registered nurses. NAs = nursing assistants. US= unit secretary.

A root cause analysis (RCA) using a fishbone diagram was completed to identify the barriers to purposeful rounding (Appendix D). The needs assessment surveys on purposeful rounding, informal interviews with staff, and observations on the unit were the methods of data collection used to accomplish the RCA. The major categories that caused inconsistent purposeful rounding included unit processes, patient factors, staff factors, and environmental factors.

The primary unit-focused goals for 2015 are to reduce the amount of avoidable calls by 50%; improve Press Ganey “Likelihood to Recommend” patient satisfaction scores by 5 percentile points, from 88.42 to 93.42%; and maintain Press Ganey “Nurse Sensitive Indicator” patient satisfaction scores at or above the 75th percentile benchmark. The unit also has a goal to reduce falls annually from 14 (recorded in 2014) to less than 8 in the year 2015. As of November 2015, the unit has experienced 17 falls, which indicates that this last goal was not accomplished.

After researching the Inpatient Nurse Dashboard on the unit, the investigator found that toileting (77.1%) and pain management (81.5%) were the lowest of all the Nurse Sensitive Indicator patient satisfaction scores. Patient satisfaction scores for toileting needs and pain management fell below the 75th percentile for 4 months during the period of August 2014 to August 2015 (see Appendix E for toileting and Appendix F for pain management). The unit protocol for purposeful rounding prompts staff to proactively ask patients about the 4 P’s while they are in the patient’s room. The 4 P’s are pain level, positioning, personal needs (such as toileting, hydration, oral, and nutritional needs), and prevention of falls. This proactive, systematic, evidence-based behavior helps assure that the comfort and safety needs of patients, such as pain management, toileting needs, positioning and fall prevention are met throughout the shift. By identifying and addressing the barriers to purposeful rounding, it is expected that patient satisfaction scores will increase and that falls will decrease.

Clinical Leadership Theme

The clinical nurse leader (CNL) role was created in 2003 to address the fragmentation of patient care, and the growing number of medical errors and adverse events in our health care system. This project utilizes the CNL roles of outcomes manager, educator, and systems analyst and highlights the CNL competencies in quality improvement and safety (AACN, 2013). As an outcomes manager, the CNL assumes responsibility for the evaluation and improvement of patient care outcomes, such as improved satisfaction scores and the reduction of falls. The CNL fills the role of educator in order to explain the process of purposeful rounding and its benefits in patient care to staff and patients. Lastly, as a systems analyst, the CNL anticipates risk for a cohort of patients at the microsystem level.

By identifying and addressing barriers to purposeful rounding, the CNL enhances an evidence-based process that anticipates the comfort and safety needs of patients, which in turn, decreases patient falls, improves pain management, and decreases the risk of hospital acquired pressure ulcers (Halm, 2009). The Master's Essential # 3 of the CNL competencies states that the CNL will use evidence to design and direct system improvements that address trends in safety and quality. According to the Master's Essential # 4, the CNL leads change initiatives to decrease discrepancies between actual practices and identified standards of care (AACN, 2013). The purpose of this project is to identify barriers to purposeful rounding in order to reconcile the differences in how purposeful rounding is practiced by RNs and NAs on the unit and the way purposeful rounding is defined in the literature.

Literature Review

Search Strategies

CINAHL, PubMed, Cochrane, and Google Scholar were the search engines used to obtain journal publications from the years 2012 to 2015. Key search words were *hourly rounding, purposeful rounding, intentional rounding, comfort care rounds, barriers to hourly rounding, and patient safety*. Different terminologies of purposeful rounding are used in the literature and clinical practice and are reflected in the search words.

Summary of Evidence

In a cross sectional study of six inpatient units, Fabry (2015) found that only 25% of the 52 registered nurses (RNs) in the study felt a sense of ownership of the purposeful rounding initiative. Although 94% of the RNs agreed that a patient's pain, position, and personal needs were being addressed during a purposeful round, only 55% felt that rounding improved pain management. The findings emphasized how frontline staff will be more open to adopting an innovation, such as purposeful rounding, if they feel like a part of the implementation stage and are active participants in the decision-making process. If the innovation is in line with the staff's values, it is more likely to be adopted. It was noted that only 43.3% of the nursing staff in the study felt that there was continued support and resources available to them after implementation of purposeful rounding. Fabry (2015) suggested designating a staff champion to provide educational and emotional support for the nursing staff and sustain the rounding process.

An ethnographic study of two inpatient units by Deitrick, Baker, Paxton, Flores, and Swavely (2012) also found that nursing staff desired a designated purposeful rounding resource person to improve the rounding process. In agreement with Fabry (2015), Deitrick et al. (2012) found that staff members wanted proof that purposeful rounding would provide benefits for their patients. The researchers also noted that most of the nursing staff could not verbalize the purpose

or logic behind purposeful rounding which may hinder acceptance of this nurse-driven intervention into the unit culture. An in-service for staff was strongly recommended to educate the team on the benefits of purposeful rounding for both patients and staff members (Deitrick et al., 2012). This increases clarity about the purpose of doing purposeful rounding, and explains why this initiative was implemented.

A quasi-experimental study of two medical-surgical units by Olrich, Kalman, and Nigolian (2012) found that purposeful rounding decreased fall rates by 23%. Like Fabry (2015), Olrich et al (2012) emphasized the need for a purposeful rounding resource person or “champion” to ensure rounding is performed consistently on all shifts. Without consistent support of a staff champion, ingraining purposeful rounding into the unit culture becomes difficult. The aforementioned studies highlight the need to generate data on the benefits of purposeful rounding for patients and distribute them to staff. This serves as a positive reinforcement to round hourly on patients (Deitrick et al., 2012; Fabry, 2015; Olrich et al., 2012).

A study on a 24-bed medical-surgical unit by Brosey and March (2015) revealed that a 20-minute education session on nurse hourly rounding provided for each staff member increased hourly rounding compliance from 48.6% to 69.4% in the first month of implementation. The education session was composed of a review of the evidence, working definition of structured hourly nurse rounding, review of historical performance indicators, and goals for improvement on the unit. However, the increase in purposeful rounding compliance was not sustained decreasing to 44.3% and 59.2% in the next two months, respectively. In agreement with Fabry (2015) and Olrich et al. (2012), Brosey and March (2015) recommend a unit-based rounding champion to stimulate enthusiasm and sustain the purposeful rounding process among the nursing staff.

Halm (2009) conducted a clinical evidence review on the effects of hourly rounding on care outcomes. This review paper emphasized three barriers and the corresponding solutions to sustain hourly rounding. First, hourly rounding is an autonomous intervention that remains controversial among nursing staff due to the formal scripting written in the hourly rounding protocol. As a result, some staff members feel that addressing the 4 P's of hourly rounding (pain, potty, positioning, personal belongings) is too rehearsed, thus removing individual ownership of the rounding process. To overcome this barrier, Halm (2009) recommends customizing the 4 P's to the most essential needs of the unit's patient population and for the staff to use their own authentic voice when communicating with patients in the room regarding the 4 P's.

A second barrier is the perceived lack of support for nursing staff. A solution is to view hourly rounding as an interdisciplinary intervention in order to provide support for nursing staff. For example, physical therapists may address the 4 P's while ambulating the patient to the bathroom and assessing their transfer capabilities and gait. The third barrier is hourly rounding documentation. According to Halm (2009), logs of rounds assist with monitoring and accountability of the rounding process, but may increase opposition from staff and decrease adherence. An alternative is to write patients' responses during rounds on the white board located in each room such as positioning preferences and pain level goals. This allows visible communication of patient needs between patients and the nursing team staff for future rounds.

A review of hourly rounding literature by Shepard (2013) found that barriers to successful implementation of hourly rounding were lack of staff buy-in, inadequate time management, and unexpected interruptions. According to the author, seasoned nurses who have been in practice for several years may hold the perception that hourly rounding is a new intervention that is unnecessary to meet the basic care needs of patients. These nurses represent

informal leaders and mentors for other nurses and may inculcate similar values to the rest of unit staff regarding hourly rounding. Thus, it is worthwhile to gain buy-in from seasoned nurses by showing them the evidence that hourly rounding benefits patients (Shepard, 2013). Unexpected interruptions, such as phone calls from physicians or laboratory, can be addressed through team nursing. Team nursing is defined as a nurse-led care team, consisting of the RN, vocational nurse, NA, and other staff members who care for a group of patients together. The additional team members allow for alternating rounding schedules which results in more consistent hourly rounding throughout the work shift.

A 30-day pilot study of two medical-surgical units by Goldsack, Meredith, Mascioli, & Cunningham (2015) showed that the inclusion of unit champions, frontline staff, and nursing leadership at the outset of hourly rounding implementation resulted in a larger decrease in the patient fall rate and call bell use in comparison to a medical surgical unit that did not engage leadership or frontline staff. Patient fall rate was measured as number of falls per 1,000 patient days. On the medical-surgical unit that engaged frontline staff and utilized a unit champion for the hourly rounding implementation (Unit 1), the 1-year baseline mean fall rate fell from 3.9 to 2.5 falls/1,000 patient days. The second unit (Unit 2), which did not engage frontline staff through unit champions nor had leadership involved, experienced a decrease of 2.6 to 2.5 falls/1,000 patient days during the pilot study.

Goldsack et al. (2015) found that 94% (17/18) of staff from Unit 1 believed that hourly rounding either had a positive or strongly positive impact on patient care overall compared to 25% (5/20) of staff on Unit 2. The researchers found that 89% (16/18) of staff on unit 2 believed hourly rounding is an effective fall-prevention strategy compared to 50% (10/20) on Unit 2. These findings suggest that staff perception towards hourly rounding and its impact on patient

care is more positive when frontline staff and leadership are engaged in the hourly rounding implementation.

Theoretical Direction

The Theory of Planned Behavior (TPB) by Icek Ajzen helps to guide the purpose of identifying barriers encountered by nurses and nursing assistants that prevent purposeful rounding. TPB predicts an individual's intention to engage in specific behavior, such as purposeful rounding, at a specific time and place. Behavioral intent is the key component of this model. Behavioral intentions are influenced by an individual's attitude about the likelihood a behavior, such as doing a purposeful round, will have the expected outcomes and the subjective evaluation of the risks and benefits of that outcome (Boston University, 2013). The model distinguishes between three types of beliefs- behavioral, normative, and control beliefs (Figure 3). Behavioral beliefs are determined by whether the person has a favorable or unfavorable view of the behavior. Normative beliefs refer to whether most people in the cultural group approve or disapprove the behavior. Control beliefs refer to what makes the behavior easy or difficult to perform. These three beliefs influence the intention (motivation) and ability (behavioral control) of a person to perform a particular behavior. In this project, the behavior is purposeful rounding by nurses and nursing assistants.

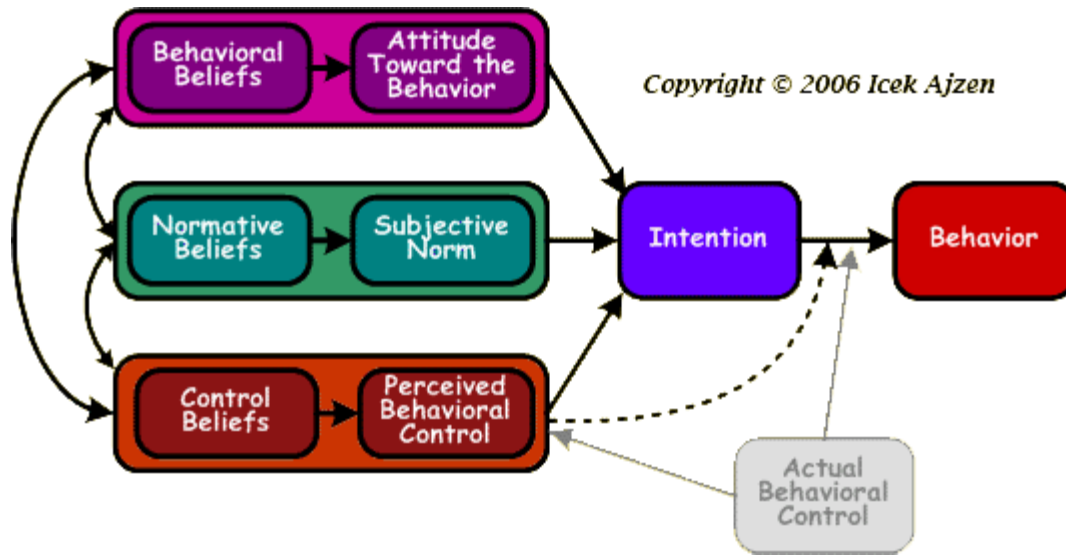


Figure 3. Theory of Planned Behavior. Retrieved from Boston University School of Public Health (2013).

As illustrated by Figure 3, behavioral beliefs lead to the attitude towards a certain behavior, like purposeful rounding. The attitude entails consideration of the outcomes of performing the behavior. For example, a nurse or nursing assistant may have an attitude of wanting to do purposeful rounding if it results in better management of the patient's pain and if rounding prevents falls. Normative beliefs lead to the subjective norm. The subjective norm refers to whether most people in the group approve or disapprove a behavior. It relates to the person's belief of how peers and people of importance think he or she should engage in the behavior. For example, a nurse or nursing assistant may be more likely to do purposeful rounding if nursing colleagues and unit management perceive purposeful rounding as a necessary part of high quality and safe patient care. The control beliefs result in perceived behavioral control. Perceived behavioral control refers to the person's perception of the ease or difficulty of performing the behavior. In this project, if the RN-NA communication barrier can be addressed through interventions, like an in-service, purposeful rounding checklist and unit champion who

can role model interdisciplinary communication, staff may acquire the needed skills for consistent purposeful rounding more readily and perceive purposeful rounding as a useful behavior that can be achieved through teamwork.

Stakeholders

The key stakeholder of this project is the patient. Other stakeholders are family members; the nursing team such as the RNs, NAs, and unit secretaries; physicians; unit management; the hospital system; Centers for Medicare and Medicaid Services (CMS); insurance companies; hospital donors; and the Joint Commission.

Methods

The investigator used a pre-post test design to accomplish the following objectives: 1. To identify the barriers experienced by RNs and NAs that hinder purposeful rounding through a needs assessment survey, 2. To implement an appropriate intervention based on the responses from the survey, and 3. To evaluate the effectiveness of the intervention in addressing barriers to purposeful rounding by re-surveying staff.

Pre-Implementation Surveys

The pre-implementation needs assessment survey was distributed to 38 RNs, 9 NAs, and 4 Unit Secretaries (US). There was a return rate of 55% (21/21) for RNs, 33% (3/9) for NAs, and 100% (4/4) for US. The survey was adapted from a study by Fabry (2015), which explored the frontline staff perception of purposeful rounding. It had 10 questions on purposeful rounding that explored the purposeful rounding definition, benefits of purposeful rounding and barriers that prevent purposeful rounding (Appendix C). Paper copies of the survey were distributed during change of shift and morning huddles in order to capture both night shift and day shift nursing

staff and were collected for a three week period. Signage to raise awareness of the survey were placed throughout the unit, and the manager, assistant manager, and unit secretary assisted in encouraging staff members to complete the survey.

A Gantt Chart was designed by the investigator as a roadmap for the three-month improvement strategy and to track the progress of the project (Appendix G). The completed tasks are highlighted in green and the tasks in progress are in blue. The columns represent the action items, team members responsible for the action items, and the month and week that the tasks were completed.

Intervention

The needs assessment survey revealed that better RN-NA communication was needed to do purposeful rounding. Thus, the investigator created a purposeful rounding checklist with an emphasis on RN-NA communication and presented it at in-services on enhanced communication. According to a process improvement study by Pape et al. (2005), a protocol checklist can help reduce errors and distractions and serve as reminders during busy times, when excess input (information overload) can affect the working memory.

The in-services were done at 2 morning huddles and 2 evening huddles with 4 to 5 RNs, 2 to 3 NAs and 1 US attending each huddle. The in-services were carried out over a 1 week period on alternating morning and evening huddles to avoid repeating the in-service to staff who worked consecutive days. An infographic poster during the in-services was used as a visual aid (Appendix H). It showed the mission and vision of the unit, results of the pre-intervention survey results, and the benefits of purposeful rounding to patient care. The poster illustrated the use of a competency checklist (Appendix I) to increase communication between RNs and NAs before and

after the purposeful rounding process. Hard copies of the checklist were passed out to RNs and NAs during the in-services.

The investigator collaborated on the communication in-services with a CNL student colleague who carried out a separate project on teamwork and communication for RNs and NAs. Saldana (2015) substantiated the need for improved communication between RNs and NAs through a teamwork perception survey. The findings of the teamwork perception survey demonstrated a great difference in perception between RNs and NAs regarding discussion of patient treatment and care (Saldana, 2015).

The purposeful rounding competency checklist was adapted from the hospital's C-I-CARE Script (2014) and an hourly rounding education tool by Studer Group (2007). The checklist created by the investigator allows RNs and NAs to self-assess strengths and weaknesses regarding the steps of purposeful rounding using the C-I-CARE model (Appendix I). Significantly, it prompts the RNs and NAs to communicate with each other regarding the purposeful rounding schedule and the patients' responses to the 4 P's.

Post-Intervention Surveys

Paper copies of the post-intervention survey were distributed to the 38 RNs, 9 NAs, and 4 US on the unit after the 1 week period of in-services (Appendix J). The survey consisted of 4 multiple choice questions regarding RN-NA communication during purposeful rounding and 1 yes/no question about the resources for purposeful rounding. There was a return rate of 29% (11/38) for RNs, 56 % (5/9) for NAs, and 25% (1/4) for US. The manager and assistant manager also helped the investigator distribute electronic copies of the in-service poster and post-

intervention survey through an email listserv. The post-intervention surveys were collected for a 10-day period.

Results

Pre-Intervention Survey

The investigator found that nearly all of the RNs who returned the pre-intervention surveys believed that purposeful rounding benefited their patients (Figure 4).

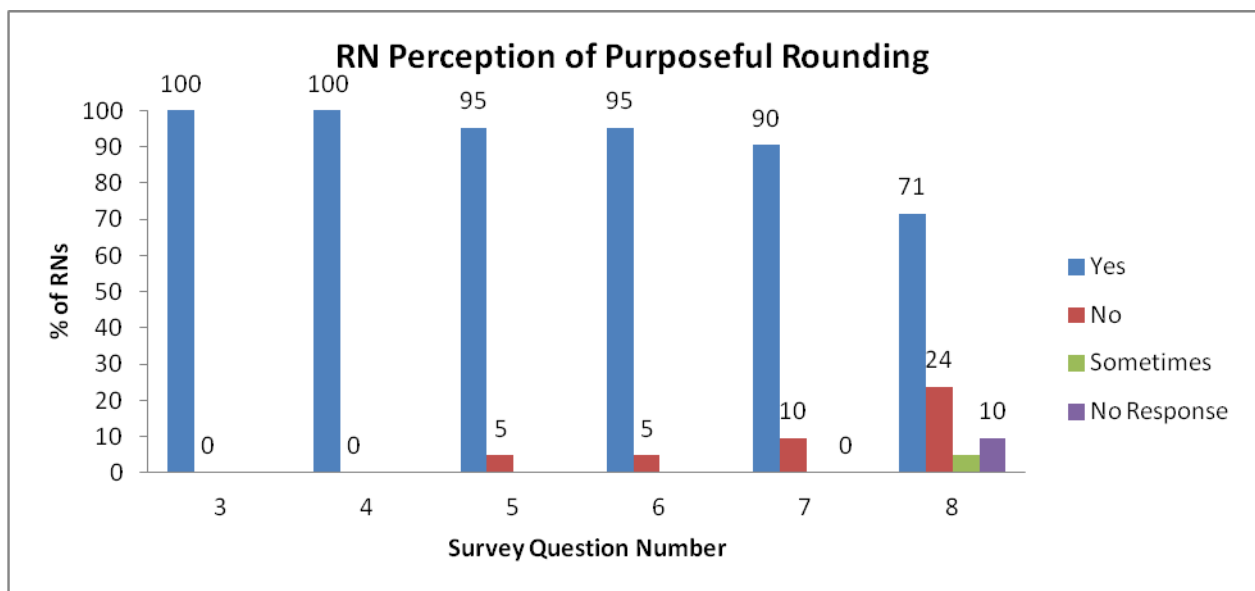


Figure 4. Registered nurse (RN) Responses to Pre-Intervention Survey. This figure illustrates that 100% (21/21) of RNs who returned the survey believed that the benefits of purposeful rounding for patient care were clearly communicated (question 3), 100% (21/21) believed that purposeful rounding contributed to better management of patient's pain (question 4), 95% (20/21) believed it prevented falls (question 5), and 95% (20/21) believed it prevented hospital acquired pressure ulcers (questions 6). Of the RNs surveyed, 90% (19/21) felt ownership of the rounding process (question 7) and 71% (15/21) felt that there was continued support and

resources to do purposeful rounding (question 8). Please see Appendix C for complete pre-intervention survey.

The pre-intervention surveys returned by the NAs indicate that 100% (3/3) of NAs who returned the surveys believed that purposeful rounding benefited patients by improving pain management, preventing falls, and preventing hospital-acquired pressure ulcers (Figure 5).

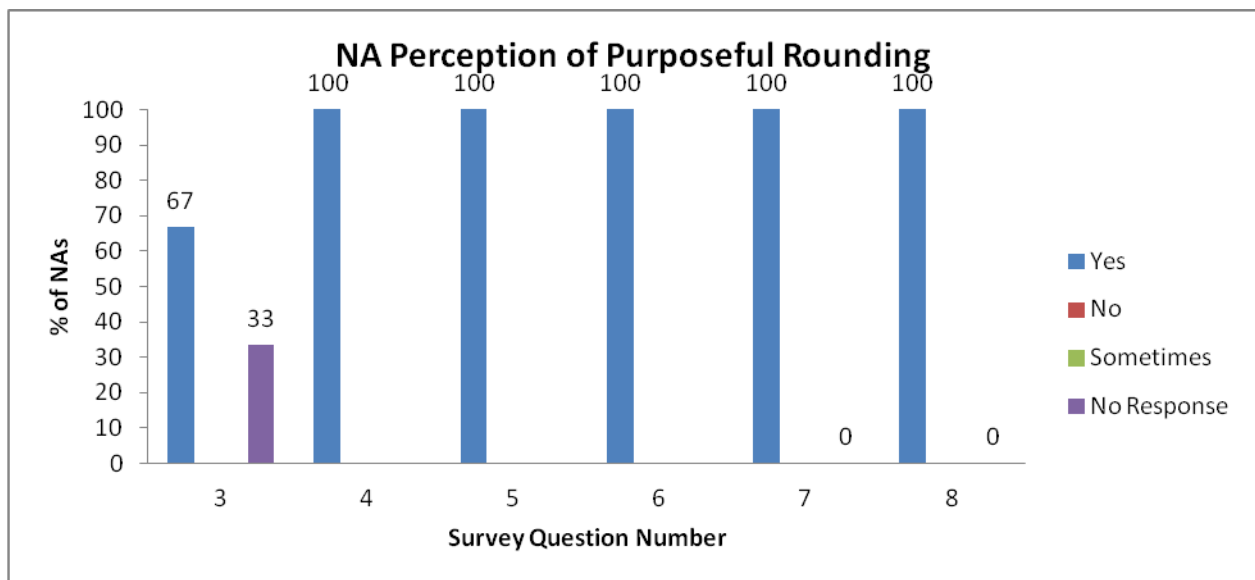


Figure 5. Nursing assistant (NA) Responses to Pre-Intervention Survey. This figure illustrates that 67% (2/3) of NAs who returned the survey believed that the benefits of purposeful rounding for patient care were clearly communicated (question 3), 100% (3/3) believed that purposeful rounding contributed to better management of patient's pain (question 4), 100% (3/3) believed it prevented falls (question 5), and 100% (3/3) believed it prevented hospital acquired pressure ulcers (question 6). Of the NAs surveyed, 100% (3/3) felt ownership of the rounding process (question 7) and 100% (3/3) felt that there was continued support and resources to do purposeful rounding (question 8). Please see Appendix C for the complete pre-intervention survey.

Post-Intervention Survey

The investigator found that 55% (6/11) of RNs and 80% (4/5) of NAs who completed the post-intervention survey would do purposeful rounding more often after the communication in-service (Figure 6). Sixty five percent (11/17) of the staff (RNs, NAs, and US combined) who returned the surveys said that they will do purposeful rounding more often after the in-service.

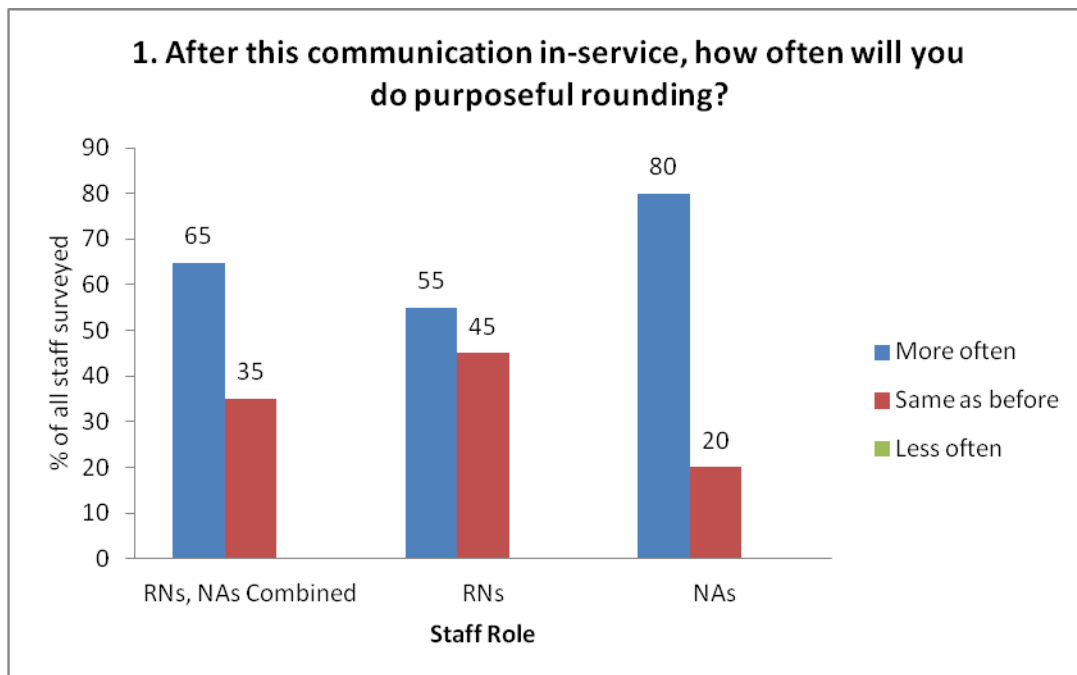


Figure 6. Results to Post-Intervention Survey Question 1. This figure illustrates that 55% (6/11) of RNs and 80% (4/5) of NAs who returned the survey will do purposeful rounding more often following the in-service (See Appendix J for post-intervention survey).

The investigator found that 73% (8/11) of RNs (Figure 7) and 60% (3/5) of NAs (Figure 8) were more likely to communicate with their RN/NA partners about the purposeful rounding schedule following the in-service. For question 4 of the survey, 82% (9/11) of RNs (Figure 4)

and 20% (1/5) of NAs (Figure 5) were more likely to communicate with their RN/NA partner about areas to improve on regarding teamwork following the in-service.

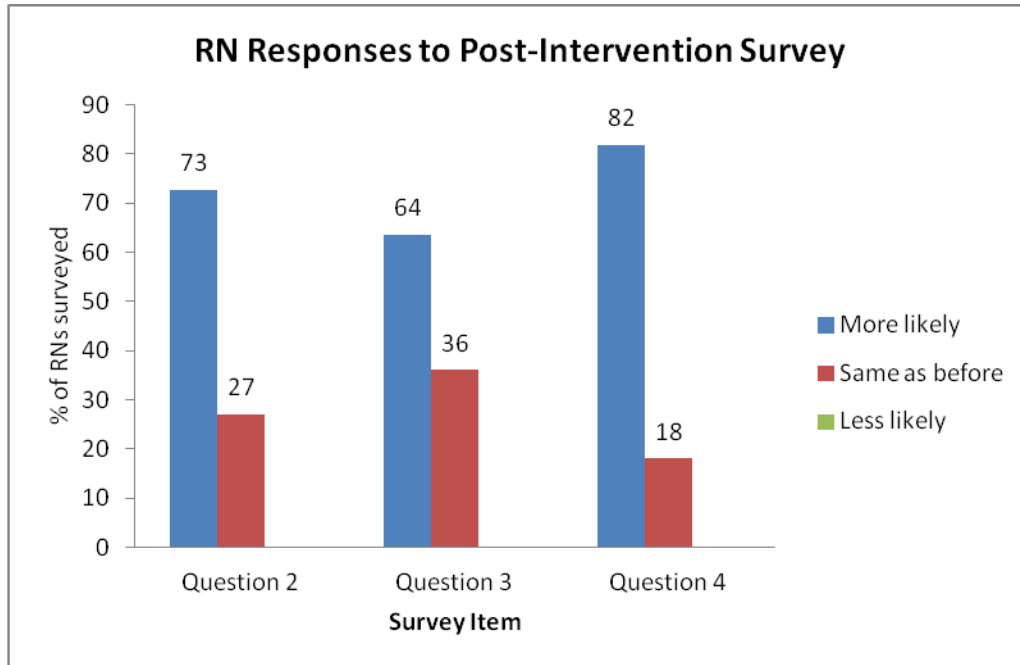


Figure 7. RN Responses to Post-Intervention Survey. This figure illustrates that 73% (8/11) of RNs who returned the survey would be more likely to communicate the rounding schedule with their NA partner (question 2) and 64% (7/11) would be more likely to communicate with their RN partner about the patient's responses to the 4 P's (question 3). Importantly, 82% (9/11) of RNs said they would be more likely to talk with their NA partner about areas of improvement regarding teamwork (question 4). See Appendix J for complete post-intervention survey.

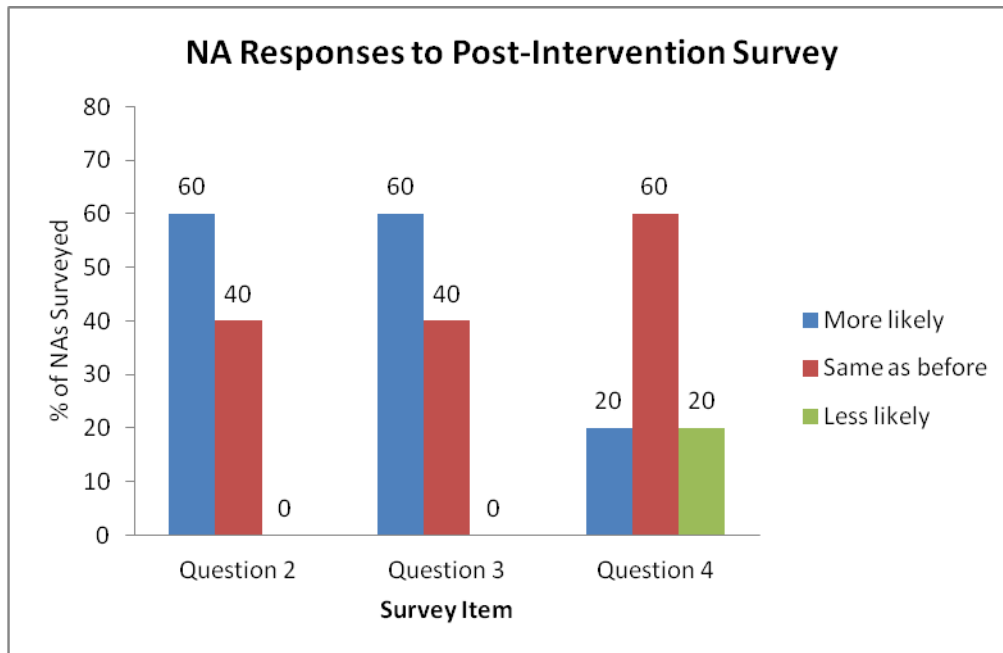


Figure 8. Nursing assistant (NA) Responses to Post-Intervention Survey. This figure illustrates that 60% (3/5) of NAs who returned the survey would be more likely to communicate the rounding schedule with their RN partner (question 2) and 60% (3/5) would be more likely to communicate with their RN partner about the patient's responses to the 4 P's (question 3). Sixty percent (3/5) of NAs said they would neither be more or less likely to talk about areas of improvement with their RN partner regarding teamwork after the in-service (question 4). See Appendix J for complete post-intervention survey.

The investigator also found that 73% (8/11) of RNs and 60% (3/5) of NAs surveyed believed that there was continued support and resources to do purposeful rounding after the in-service. This was compared to 71% (15/21) of RNs and 100% (3/3) of NAs before the in-service (Figures 4 and 5).

Limitations

Limitations of the study included the short timeframe to complete the intervention. More accurate responses from the post-intervention survey may have been obtained if the investigator implemented the in-services at more morning and evening huddles over a 2 or 3 week period rather than only to 2 morning and 2 evening huddles over a 1 week period. Due to the high census of certain shifts, some of the staff members completed the surveys 3 to 5 days after the in-service which may have reduced their ability to recall the material from the in-service and affected their survey responses. The RN return rate of 29% (11/38) for the post-intervention survey was lower than that for the pre-intervention surveys (55%, 21/38) which may affect the generalizability of the results.

Nursing Relevance

The Joint Commission has highlighted improved effectiveness of communication among caregivers as a National Patient Safety Goal for 2015 and 2016 (Joint Commission, 2015). This project uses the CNL role of educator, outcomes manager, and risk anticipator to identify and address the RN-NA communication barrier during the purposeful rounding process. The study aimed to improve an evidence-based practice behavior by facilitating staff communication before and after the rounding process. Specifically, the checklist designed in this project signaled RNs and NAs to communicate the rounding schedule with their RN/NA partner at the beginning of the shift and communicate the comfort and safety needs of each patient after asking about the 4 P's (pain management, personal or toileting needs, positioning, and prevention of falls).

As a result of addressing a communication barrier to purposeful rounding, nurses and nursing assistants can communicate the care and safety needs of patients with each other in a

timelier manner. Purposeful rounding, when carried out consistently, has the potential to increase patient satisfaction scores, improve pain management, decrease the number of call lights, and decrease patient falls (Deitrick et al., 2012; Ellis, 2013; Fabry, 2015; Mitchell et al., 2014).

Recommendations for Future Practice:

It is recommended that the shared governance or implementation team of the unit ask RNs and NAs to serve as unit champions in order to engage frontline staff. This will address insufficient staff buy-in and provide more support for staff to sustain purposeful rounding (Brosey & March 2015; Deitrick et al., 2012; Fabry 2015; Goldsack et al., 2015; Olrich et al., 2012). According to the Agency for Healthcare Research Quality (2015b), a unit champion is a staff member with excellent communication skills who acts as the liaison between the implementation team and frontline staff. The unit champion is familiar with the care processes of the unit and has gained the respect and trust of peers. After obtaining the support from the unit manager, the investigator will proceed to ask 2 RNs and 2 NAs to volunteer as unit champions, based on their support of the CNL change project, in order to lead and role model the RN-NA communication steps in the purposeful rounding checklist (see Appendix I).

RN and NA unit champions can role model the use of the purposeful rounding checklist to the nursing team in order to improve RN-NA communication and meet the personal and safety needs of patients in a timely manner (see Appendix I). Two unit champions from each RN and NA team can role model the communication of the rounding schedule at the start of the shift *before* purposeful rounding begins and *after* a purposeful round in order to follow up on the patient's responses to the 4 P's. For example, if an NA recognizes that 2-person assistance is needed to turn an immobile patient every 2 hours in order to prevent pressure ulcers, than the unit champion can educate the NA to communicate this need with the RN partner immediately

after the purposeful round. This is demonstrated in the last step of the purposeful rounding checklist (Appendix I).

For fall prevention, if an RN or NA realizes after a purposeful round that 2-person assistance is needed to walk a patient to the bathroom, a unit champion can educate the staff member to quickly communicate this need to the RN/NA partner to prevent a fall. For personal needs, if an NA is concerned that the prescribed anti-emetic medication is not relieving the nausea and vomiting of a patient, a unit champion can utilize the checklist to educate the NA to communicate this concern with the RN partner so that a more effective anti-emetic can be prescribed from the physician. These examples demonstrate timely communication that addresses the personal and safety needs of the patient.

The investigator will follow up with the unit manager's interest in using the purposeful rounding checklist as an educational and coaching tool for newly hired nurses and nursing assistants. It is expected that this tool will familiarize new team members with the purposeful rounding process, the importance of RN-NA communication, and the crucial role of purposeful rounding to patient safety and satisfaction. The investigator recommends the designation of unit champions for each shift who can support new and senior frontline staff in order to sustain purposeful rounding.

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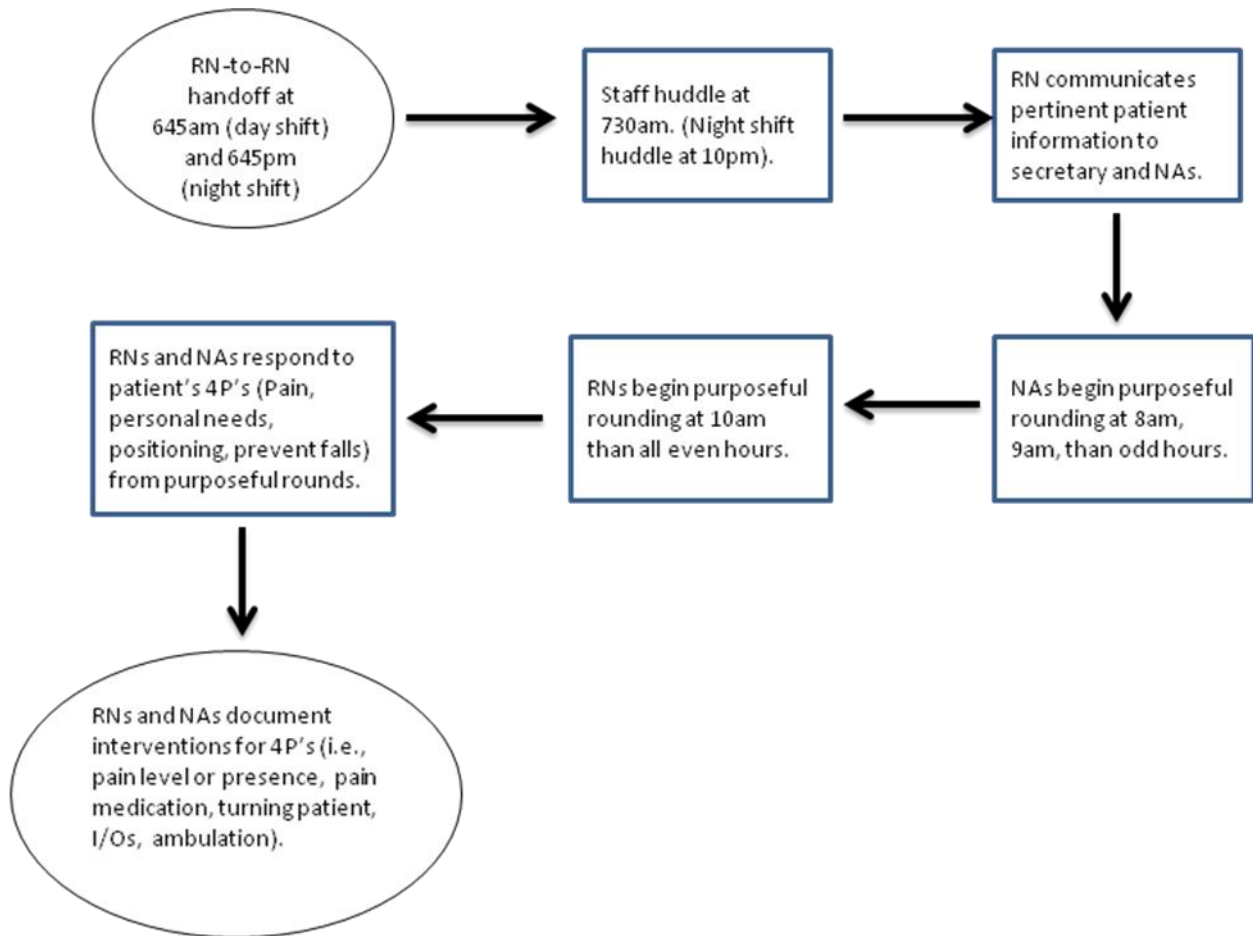
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Appendix A.
Flowchart for Purposeful Rounding Process

The circles in the flowchart represent the beginning and end points. The boxes represent activity steps and arrows represent the process flow direction. RNs = registered nurses. NAs = nursing assistants.



Appendix B.
SWOT Analysis of Microsystem Setting for Purposeful Rounding

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Support from management. • Priority on patient safety and satisfaction. • Mission, vision, and values of unit. • Magnet status promotes nursing excellence, optimal patient outcomes. 	<ul style="list-style-type: none"> • Lack of staff buy-in. • No RN or NA unit champions to support staff. • Inconsistent education for staff and patients. • Perceived lack of time.
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Increased awareness of teamwork and staff communication. • Improvement on Press Ganey nurse-sensitive indicator patient scores. • Increased reimbursement • Increased patient satisfaction • Decreased patient falls. 	<ul style="list-style-type: none"> • Multiple unit-focused projects. • Competing priorities. • Staff resistance.

Appendix C.
Staff Survey on Purposeful Rounding

Hello F3 Nurses, Nursing Assistants and Unit Secretaries,

My name is Jo Odias. I am a nursing student from University of San Francisco. I am working on a change project for our unit and the topic is BARRIERS TO PURPOSEFUL ROUNDING ENCOUNTERED BY NURSES AND NURSING ASSISTANTS. It would help me greatly if you can answer the following questions. Thank you for your time.

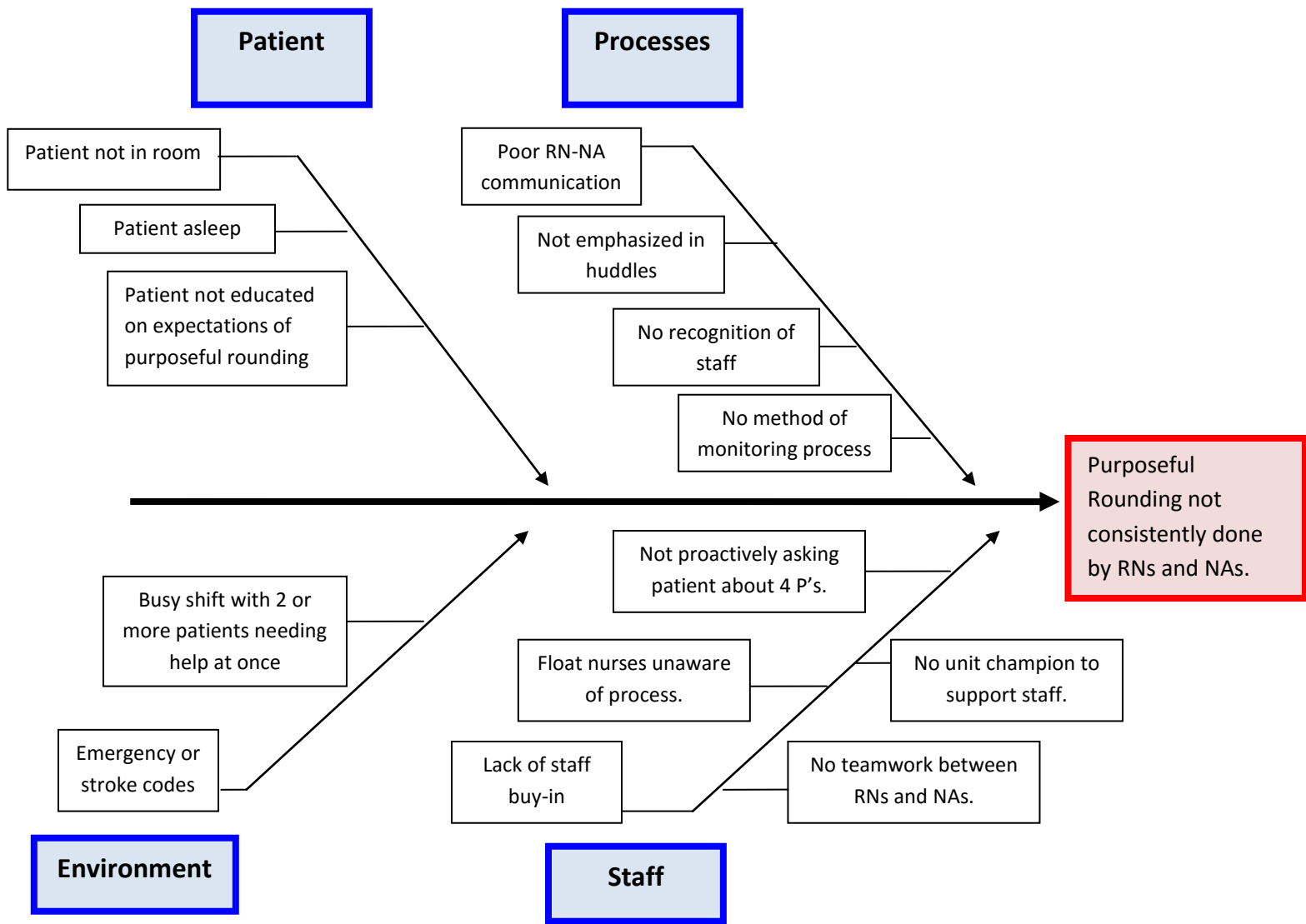
1. How do you define purposeful rounding? **Please write in:**
2. What do you need in order to do purposeful rounding? **Circle all that apply**
 - a. Rounding Log-In Sheet
 - b. Better communication between RNs and NAs
 - c. Refresher course on purposeful rounding
 - d. Other, please write in: _____

For questions 3-8, please circle Yes or No.

3. Was there clear communication on the benefits of purposeful rounding for patients? Yes No
4. Do you believe purposeful rounding contributes to better management of patients' pain? Yes No
5. Do you believe purposeful rounding makes patients safer by preventing falls? Yes No
6. Do you believe purposeful rounding makes patients safer by preventing hospital-acquired pressure ulcers? Yes No
7. Do you feel ownership of the purposeful rounding because you were involved in the planning? Yes No
8. Is there continued support and resources available to you to do purposeful rounding? Yes No
9. What barriers prevent you from doing purposeful rounding? **Please write in:**
10. What changes can be made to increase and sustain purposeful rounding? **Please write in:**
11. **Please circle your role on our unit:** RN NA US 12. Shift (**Circle One**): Day/
Eve/ Night

Adapted from: Fabry, D. (2015). Hourly rounding: Perspectives and perceptions of the frontline nursing staff. *Journal of Nursing Management*, 23, 200-210.

Appendix D.
Fishbone Diagram on Barriers to Purposeful Rounding



Appendix G.

Gantt Chart for Four-Month Improvement Strategy: Addressing the Communication Barrier to Purposeful Rounding.

Green boxes represent completed tasks. Blue boxes represent tasks in progress. CNL = clinical nurse leader. RN = registered nurse. NA= nursing assistant.

Action Item	Responsible	Month															
		September 2015				October 2015				November 2015				December 2015			
	Week	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Observed and interviewed staff on purposeful rounding challenges.	CNL Intern, RNs, NAs.	█	█	█													
2. Obtained buy-in from unit manager and assistant managers.	CNL Intern, manager			█	█												
3. Collected pre-intervention/needs assessment survey data.	CNL Intern							█	█	█	█						
4. Reviewed literature on challenges to implementing purposeful rounding.	CNL Intern			█	█	█	█	█	█	█							
5. Researched 2015 Press Ganey Results.	CNL Intern				█												
6. Researched Mission, Values, and Vision of unit and purposeful rounding protocol.	CNL Intern, manager				█												
7. Discussed purpose of project with project scientist, manager, and instructor.	CNL Intern, manager, scientist				█												
8. Obtained IRB approval from Research Compliance Officer.	CNL Intern					█											
9. Obtained approval from Unit Partnership Team for purposeful rounding checklist and in-service poster.	CNL Intern									█	█						
10. Presented communication in-service at morning and night huddles.	CNL Intern										█	█					
11. Collected post-intervention data.	CNL Intern											█	█				
12. Presented findings to management, staff, and research council.	CNL Intern												█	█			
13. Use purposeful rounding checklist as a training and self-assessment tool. Monitor outcomes.	RNs, NAs, manager													█	█	█	█

Appendix H.

Staff In-Service on Enhanced Communication to Improve Purposeful Rounding

An infographic poster, containing the unit mission and vision and pre-implementation survey results, was presented to unit staff during morning and evening huddles. The investigator collaborated with a CNL student colleague, who carried out a project on teamwork, in order to emphasize the importance of enhanced communication in improving purposeful rounding and teamwork.

Enhanced Communication to Improve Purposeful Rounding and TEAMWORK

Jo and Vanessa, MSN-CNL Students

Unit Mission Statement

- We value one another, knowing that **together** we achieve more.
- We are a team that creates an experience where **each patient feels valued and safe.**

Unit Vision: To be the best nursing team.

86%

of staff surveyed believe “**Better RN-NA communication**” is needed to do **Purposeful Rounding.**



Increase Communication during Purposeful Rounding with a Competency Checklist:

- Plan with RN/NA partner *at the beginning* about purposeful rounding schedule.
- Follow up on 4 P's with your RN/NA partner *after rounding* to improve care.

41% of surveyed RNs **disagreed** with "Patient treatment and care are not adequately discussed between and among team members" while **75%** of NAs surveyed **agreed.**

Purposeful Rounding:

- Evidence-based, systematic intervention to anticipate and address the 4 P's (Pain, Personal Needs, Positioning, Prevent Falls).
- Why? → Decreases falls, improves pain management, increases patient satisfaction

Teamwork Improvement

Debriefing at the end of shift is a great way for individual and team learning while the day's events are fresh.

Who: RNs, NAs, and US

When: End of NAs shift

How: By simply going over three questions

- 1) What went well today?
- 2) What can we improve upon?
- 3) What do we need in order to improve?



Banana!!



Appendix I.
Purposeful Rounding Competency Checklist.

The top yellow section prompts RNs and NAs to communicate with each other about the purposeful rounding schedule *before* purposeful rounding begins. The bottom yellow section prompts RNs and NAs to communicate with each other about the patients' responses to the 4 P's (pain, personal needs, positioning, and prevention of falls) *after* a purposeful round. Adapted from C-I-CARE Script (2014) and Studer (2007).

Name:	Time:		Date:		
Evaluator:			Role:		
	Self-Assess		Evaluator		Comments
	Yes	No	Yes	No	
Communicates with RN/NA partner about purposeful rounding schedule.					
Connect					
Gels in. Uses appropriate PPE.					
Knocks on door prior to entering- Asks permission.					
Makes eye contact, smiles, and greets patient by preferred name					
Introduce					
Introduces self by name and role to patient and family if not already done so.					
Communicate					
Uses a conversation starter to maintain relationship with patient.					
Explains to patient what you are going to do.					
Ask					
Eliminates distractions (e.g., lowers volume of TV, sets aside computer)					
Proceeds with asking the 4 P's (Pain, Personal needs, Position, Prevent Falls) . LISTENS ATTENTIVELY: Focuses on patient. Pauses. Waits for patient's response.					
Pain: Asks for patient's pain level (e.g. "What's your pain level from 0 to 10?"). Listens ATTENTIVELY. Provides comfort measures and pain meds. as appropriate.					
Personal Needs: Offers to help patient go to the bathroom; offers oral care, hydration, and nutrition. Listens ATTENTIVELY.					

<p>Positioning: Helps patient get in a comfortable position; helps turn immobile patients. Assures patient's essential needs (call light, phone, tissue, basin, urinal) are within reach.</p>					
<p>Prevent Falls: Informs patient to call prior to getting out of bed, chair, or toilet. Informs patient about risks of injury from falls (e.g., from medication side effects, lower extremity weakness, etc.).</p>					
<p>Respond</p>					
<p>Responds to patient's requests to 4 P's with urgency and respect.</p>					
<p>Exit</p>					
<p>Offers further assistance. Exits courteously by restating name and role and time of return.</p>					
<p>Gels out upon exiting.</p>					
<p>Communicates with RN/NA partner about patient's responses to 4 P's.</p>					

Appendix J.
Post-Intervention Survey

Purposeful Rounding and Teamwork Post-Intervention Survey

Background information (**mark the one that applies**): [] RN [] NA [] US

Shift (**mark one**): Day / Eve / Night

1. After this communication in-service, how often will you do purposeful rounding?
 - a) More often
 - b) Less often
 - c) Same as before

2. After this communication in-service, how likely are you to communicate with your RN/NA partner at *the beginning* of the shift about the purposeful rounding schedule?
 - a) More likely
 - b) Less likely
 - c) Same as before

3. How likely are you to communicate with your RN/NA partner *immediately after* a purposeful round about the patient's needs and the 4 P's (e.g., Reporting to RN that patient is in pain; Reporting to NA or RN that patient must be turned)?
 - a) More likely
 - b) Less likely
 - c) Same as before

4. How likely are you to communicate with your RN/NA partner about a problem regarding teamwork?
 - a) More likely
 - b) Less likely
 - c) Same as before

- 5) Is there continued support and resources available to you to do purposeful rounding? Yes No