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Nurse Leader Rounding: A Stellar Strategy to Improve the Patient Experience of Care in the Emergency Department

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Abstract

Many clinical outcomes that occur in the emergency room determine the patient's continued care and experience in the hospital and beyond as well as influence the organizational reputation in the community. Mack and Fill emphasize that "an ED visit is a significant encounter between a patient and a hospital and one that affects 'repurchase' decisions for future health care" (as cited in Welch, 2010, p. 65). Thus, patient experience in the emergency department necessitates continued quality improvement efforts. The emergency room, or "the front door to the hospital", provides equitable and affordable care to patients who need urgent medical evaluation. A proposed intervention to optimize the patient experience is a structured nurse leader rounding, consisting of a patient informational interview, based on the AIDET approach, and real-time nurse coaching, which is a best practice from the STAR Feedback model. An alternative evidence-based tool which can be used to assess patient experience during informational interviews is the Watson Caritas Patient Score. The questions of the informational interviews correlate with the 4 CAHPS questions of interest: (1) Courtesy and respect by nurses; (2) Confidence and trust in the nurses; (3) Nurses explaining things in a way you could understand; (4) Likelihood to recommend this emergency department to friends and family. CAHPS scores for ED patients for these questions and the patient survey summary star ratings are the outcome measures for this project. This evidence-based, quality improvement project aims to accentuate the service mindset and patient experience as an organizational priority. After attending the training sessions, nurse leaders will consistently engage in rounding according to the newly proposed policy.

Keywords: nurse leader, patient experience, rounding, patient satisfaction, caring

Introduction

Unless someone like you cares a whole awful lot,
Nothing is going to get better. It's not.

Dr. Seuss

The Institute for Healthcare Improvement (IHI) defined the Triple Aim framework in 2007. The Triple Aim currently transformed into the Quadruple Aim, which encompasses focus on patient experience, population health, reducing costs, and care team well-being (Lippincott Solutions, 2017). All these dimensions are present and embodied in the equitable and affordable care provided by the emergency department to all community members. On the other hand, the emergency department is often characterized by a high level of clinician burnout, which is "associated with lower patient satisfaction, reduced health outcomes, and it may increase costs (Lippincott Solutions, 2017). Therefore, the achievement of the Triple Aim depends on the well-being of the care team, which is reflected in the more recent Quadruple Aim (see Appendix A). In their article on authentic human caring professional practices, Brewer and Watson (2015) reinforce the principle that "caring science practice approach applies to caregivers toward each other as well as patients/families and communities" (p. 1).

The work of the emergency department represents supporting evidence for the mission of the organization, which is to "enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in healthcare services" (Sutter Health, 1992-2019). Furthermore, many clinical outcomes that occur in the emergency room determine the patient's continued care in the hospital and beyond as well as influence the hospital's reputation in the community.

Through the Eyes of Patients

Recently, there has been renewed emphasis on the patient to actively participate in their care and to act as a rightful member of the health care team. Patients are encouraged to ask questions and to provide feedback; increasingly, representatives of the health care system would like to know more about their patient population to ameliorate processes and outcomes. The suggested questions to ask would be aligned with and supported by the Institute for Healthcare Improvement, for example, "what does the patient want and need?", or "is the outcome what the patient wanted" (as cited in Finkelman, 2016). Nelson, Batalden, and Godfrey (2007) emphasize that "viewing the process of care through [the eyes of the patient] is a powerful tool for gaining important insight into that process from the patient perspective" (p. 263). Additionally, this information will need to be shared with other health care professionals and stakeholders to achieve improvement and lasting change.

Problem Description

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is an unprecedented initiative, which "is the first national, standardized, publicly reported survey of patient's perspectives of hospital care" (Centers for Medicare & Medicaid Services [CMS], 2020). This validated scoring system allows patients to evaluate their experience of care, and, due to being publicly reported, scores can create a positive or negative image regarding the hospital's reputation in the community. Moreover, HCAHPS results allow for objective comparisons between hospitals and promote transparency and accountability in health care services for consumers. The survey is administered monthly to a random sample of patients, in different languages, and asks "19 core questions about critical aspects of patients' hospital experiences" (CMS, 2020). Additionally, the survey has been validated by numerous public

reports and endorsed by reputable quality reporting organizations, such as the Agency for
Healthcare Research and Quality (AHRQ) and the National Quality Forum (NQF). Ultimately,
according to Dempsey (2014), starting in October 2012, HCAHPS scores also determine about
30% of the value-based reimbursement from the Hospital Value-Based Purchasing program,

The Emergency Department Patient Experience with Care (EDPEC) surveys remain a
pilot measure. Nevertheless, they can be administered as a supplement to the existing HCAHPS
survey or as a separate survey for the patients being discharged from the Emergency Department
(CMS, 2020). These assessments are needed to evaluate the state of patient experience in the
emergency departments across the nation as well as to advance communication and coordination
among health care systems. In the fall quarter of 2019, the patient satisfaction scores for the
Emergency Department under study in categories of being treated with *courtesy and respect by
nurses* and having *confidence and trust in the nurses* were in the high 40th and 50th percentiles.
After the trial of the nurse leader rounding in this emergency department, the scores
subsequently reached the 70th percentile in both categories. Patient experience in the emergency
room can be frustrating for both patients and their families but, unequivocally, they deserve to
receive timely, safe, and quality care in any setting.

Many clinical outcomes that occur in the emergency room determine further care that
patients receive during their hospital stay and after discharge, including the sense of a patients'
engagement, and their overall experience. Moreover, after having received care in the emergency
department, patients can choose whether to belong to a particular health care system and an
associated insurance carrier, or not. The initial impression that is created by care from emergency
room providers contributes substantially to the overall health care experience that the patients
remember. Therefore, patient experience in the ED deserves focused attention.

Available Knowledge

Supporting evidence for this project originates in several peer-reviewed publications. The first source by Littleton, Fennimore, Fernald, & Gonzalez (2019) is thought-provoking and asks several probing questions on the topic of nurse leader rounding; for example, how many and what kind of rounds are needed to generate a meaningful change in patient satisfaction scores and overall experience and nurses' practice? The authors of this article refer to other existing research that asserts the effectiveness of nurse leader rounding in improving the patient experience of care. On the other hand, the gaps in knowledge are also evident regarding the nature and quality of these rounds. Littleton et al. (2019) affirm that the rounds matter when a nurse leader engages in real-time coaching of the nurses, service recovery, or staff recognition, based on feedback and specific comments from patients. Such a nurse leader embodies excellence in care delivery and adheres to principles of *just culture*, in which criticism is viewed as an opportunity for improvement and nurses receive a fair, objective evaluation. When coached, nurses enjoy taking pride in their work and feeling that they provide the best possible care to their patients. Moreover, when a leader engages in staff recognition and acknowledges tough situations, care giver burnout may be avoided (Fitzpatrick, Bloor, and Blake, 2019, p. 187). Littleton et al. (2019) also recommend "for nurse managers and assistant nurse managers to round on at least 50% of the inpatient census each day and attempt to round on every patient at least once during his or her stay" (p. 12). As a result of this quality improvement project, the number of the nurse leader rounds more than doubled, and the maximum rounding time was close to 6 hours per day (Littleton, Fennimore, Fernald, & Gonzalez, 2019, p. 13). Moreover, when evaluating the effectiveness of the nurse leader rounding not only in terms of the hours dedicated to this intervention but also the number of professionals engaged, the authors suggest

that as many as "six rounders were required to meet the goal of visiting every patient every day"

(Littleton, Fennimore, Fernald, & Gonzalez, 2019, p. 13). Overall, according to the study, the

engaged nature and the increase of the quantity of the nurse leader rounds resulted in a

statistically significant increase in patient satisfaction. These conclusions accentuate the need for

additional labor and time resources invested in nurse leader rounding prompting improvements

in patient experience.

Ayaad et al. (2019) in their interventional study emphasize the standardization of the

nurse leader rounding and also discuss several barriers to its successful implementation, such as

patient's mental status, short length of stay, and nurse leader overload, all of which are

applicable in the emergency department setting (p. 534). In the study by McFarlan et al. (2019),

the authors make it clear that patients and families in the emergency department often experience

powerlessness and lack of control and information. Thus, clear, respectful communication by the

nurses and other health care providers becomes paramount. In this project, the authors evaluated

response to concerns/complaints during stay, degree to which hospital staff worked as a team,

likelihood of recommending, staff identified themselves, and overall rating on the institution,

which all increased after the daily nurse leader and hourly nursing rounds had been implemented

over the 2 months. The authors emphasize the standard work is associated with improved

collaboration as well as improved safety and patient experience. In their article, Gillam and

colleagues (2017) assert that "nurse leader rounding (NLR) is a valued hospital patient care

practice", and it is "also an established practice in most acute care hospitals" (p. 163). Therefore,

it warrants further study and improvement, especially as it relates to the patient experience.

Moreover, the authors assert the patient's age and cognitive impairment as confounding factors

on the impact of the nurse leader rounding. Finally, Kline and McNett (2019) suggest that real-

time, in-person nurse coaching could be a determining factor for the nurse leader rounding

impact on patient experience, as measured by patient satisfaction scores.

The PICOT question for this project is, in all emergency department patients, except

those with cognitive impairment, what is the number and nature of the nurse leader rounding to

produce statistically significant improvement from the baseline data in patient satisfaction scores

over a quarter, and, consequently, patient survey summary star ratings, compared to the existing

practice, within a year of implementation.

Rationale

The theory to guide this project is the Roy Adaptation Model (RAM) for Nursing,

originally developed by Sister Callista Roy in the late 1960s. She describes four essential parts of

nursing: person, environment, nursing, and health. Roy and Andrews (1986) postulate that "the

goal of nursing is to promote growth and meaningful life for the individual in harmony with his

or her social and physical environment. In this way, nursing promotes health" (p. 4). When a

nurse embraces his or her professional role from such a holistic perspective, he or she would not

simply tend to a fractured limb but to the whole person, their ways of coping, and their

experience of the incident. In such instances, a nurse would help patients adapt to the situation in

a positive way, thus treating a patient with courtesy and respect, reassuring them, and explaining

interventions, which correspond to the items on the patient satisfaction surveys. Using the Roy

Adaptation Model for Nursing, a nurse would be less focused on simply technical skills and tasks

but have a broader understanding of a patient's condition, experience, and emergency, which

could be both physical and psychological. This nursing practice would be inclined to keep

patients updated and provide safe discharge instructions because the goal is a patient's continued

well-being and positive coping in the context of their environment. Clearly, "Roy is committed to a philosophical belief in the innate capabilities, purpose, and worth of the human person" (Andrews & Roy, 1986, p. 6). This perspective is very meaningful when caring for patients in the emergency department, which accepts and treats everyone, independent of social status and disabilities. Improving the patient experience also includes meeting the needs and goals of the very vulnerable, uninsured, addicted, and homeless persons whose worthiness and perceptions may be concealed by their disheveled appearance or inappropriate behavior. In conclusion, "the RAM has stood the test of time because it is accessible, elegant, practical, and because it has an underlying spirit of unity and hope that is missing from society" (Clarke et al., 2011, p. 338). By using the Roy Adaptation Model for Nursing, a nurse can fulfill their professional role of caring for a human being from a holistic perspective.

Specific Project Aims

- Among all patients in the Emergency Department on a given day, except for those with cognitive impairments, the redesign and implementation of nurse leader rounding will result in sustained scores in the 70th percentile in four categories of the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey by the date of completion of this evidence-based, quality improvement project.
- Among all patients in the Emergency Department on a given day, except for those with cognitive impairments, the redesign and implementation of nurse leader rounding will contribute to the achievement of at least three stars on the HCAHPS Patient Survey Summary Star Rating by the date of completion of this evidence-based, quality improvement project.

Context

The Dartmouth Microsystem Assessment method of collecting and analyzing unit-based data emphasizes a focus on the 5 P's: purpose, patients, professionals, processes, and patterns. Nelson, Batalden, and Godfrey (2007) contend that "the 5 P's framework is a tested and useful method for microsystem members to begin to see their microsystem in a new way and to begin to ask new questions" (p. 260). An aptitude for clinical inquiry is an important quality of a nurse leader who engages in quality improvement work. A clinical nurse leader (CNL) examines the microsystem components and 5 P's to prepare a plan for growth and improvement in processes, outcomes and teamwork.

Purpose

The emergency room is a "front-door to the hospital". The purpose of the emergency department is to provide equitable, safe, and affordable care for all people in the community who experience urgent or life-threatening conditions.

Patients

This emergency department is non-trauma designated, serves both adult and pediatric populations, and has an approximate 30-bed capacity. The majority of patients are ESI (Emergency Severity Index) level 3, with ages ranging "from the womb and to the tomb". The top diagnoses include breathing difficulty, chest pain, stroke, sepsis, drug overdose, and body ache. A large number of patients suffer from homelessness, addiction, or both.

Professionals

The Institute for Healthcare Improvement (IHI) (2019), emphasizes that "everyone is healthcare has something in common, which is the desire to help patients", as is in this ED. The department staff includes mostly hospital employed physicians, nurses, technicians who are

specifically trained for the emergency room, unit secretaries, pharmacists, and security guards. All staff nurses recently completed a triage class and attended workplace violence training.

Processes

Sepsis and cardiac care in this ED microsystem meet and exceed standards of excellence. For example, the goal for the department in stroke care has also been met, which is defined as having a means to be examined by a physician in 5 minutes or less, to arrive in CT in 20 minutes or less and to receive tissue plasminogen activator (tPA) therapy, if eligible, in 45 minutes or less.

Opportunities for improvement also were identified in the microsystem assessment. The patient satisfaction scores for the emergency department indicate the need for a timely and evidence-based intervention. Furthermore, the survey questions related to nurses explaining things and the likelihood of recommending this ED to friends and family also deserves close attention. Notably, patient satisfaction is a challenge in many emergency departments due to "brief encounters with new providers, crowded conditions, uncertainty, and extended waits" (Handel et al., p. 604). Moreover, there had been about 60 days between the actual responses and the survey data, which was generated. This delay, as well as selection and attrition biases, could have influenced the outcomes.

Patterns

A Unit-Based Practice Council allows members of different professions to attend its meetings and to discuss topics of safety, quality, and practice. A poster board is meant to inform staff and leaders about current initiatives and their progress, to celebrate accomplishments and to display outcomes. This information is also communicated during shift huddles.

Data analysis, informational interviews, and staff coaching are meant to spark ideas for improvement. The project intervention and outcomes are to be shared with as many team members and stakeholders as possible, to implement a meaningful and lasting change in both culture and outcomes. Since high-performing health care organizations have established lasting relationships with their patients and partners, the patterns of data associated with patient satisfaction scores are particularly important to examine.

Cost-Benefit Analysis

The Value-Based Purchasing program is "a Centers for Medicare & Medicaid Services (CMS) initiative that rewards acute-care hospitals with incentive payments for the quality care provided to Medicare beneficiaries" (CMS, 2017). Medicare pays a hospital based on its performance on each quality measure compared to other hospitals' performance during the baseline period and also on its improvement for each measure compared to its performance during a baseline period (CMS, 2017). Even small adjustments in these payments can result in significant financial gains or losses for the hospital. The cost-benefit analysis aims to highlight potential losses and profits, which are associated with patient satisfaction scores in the emergency department as well as patient survey star ratings for the hospital. The introduction of the clinical nurse leader (CNL) role to implement practice change projects could optimize the intrinsic value of care delivery and contribute to improvement efforts associated with patient satisfaction scores. For example, the financial analysis of the Nurse Leader Rounding project is included as Appendix D.

The mission of the organization cannot be carried out without sustaining a reasonable financial margin, which is "the difference between the total costs the organization needs to provide patient care services and the total net revenue or reimbursement for those services"

(Agosto et al., 2020, p. 7). Reporting of CAHPS scores and HCAHPS patient survey star ratings give purchasing power to the patient.

SWOT Analysis

Key stakeholders in this microsystem are emergency room physicians and nurses, charge nurses, nurse managers, and the department director. Progress and outcomes of quality improvement initiatives, which are displayed on the unit board, are also regularly reviewed by the leadership team. The goal of this project is closely aligned with organizational priorities. Ultimately, focus on patients solidifies teamwork. A challenge exists in the integration of the exemplary patient experience into a fast-paced and unpredictable milieu of the emergency department. A visual representation of the strengths, challenges, opportunities, and threats analysis (SWOT) that formed one assessment related to this quality initiative is included in the Appendix E.

Intervention

One proposed intervention is a structured nurse leader rounding, which consists of two components: patient informational interview, based on the AIDET approach and real-time nurse coaching, which is a best practice from the STAR Feedback model (Appendices G and H). The informational interview incorporates questions regarding patient's individualized needs and the quality of nurses' care, their responsiveness and effectiveness of communication. These questions indirectly reflect the 4 CAHPS questions of interest: (1) Courtesy and respect by nurses; (2) Confidence and trust in the nurses; (3) Nurses explaining things in a way you could understand; (4) Likelihood to recommend this emergency department to friends and family. CAHPS scores for ED patients for these questions are the outcome measures for this project.

Notably, "managing up" co-workers is an important element of a nurse leader round, during which a nurse leader creates a positive impression for other professionals on the team.

An alternative, evidence-based tool, which can be used to assess patient experience during informational interviews is the Watson Caritas Patient Score (Appendix I). Brewer and Watson (2015) affirm that the scale possesses internal consistency, reliability, and validity (p. 5). The items *meet my basic needs with dignity*, *have helping and trusting relationships with me*, and *create a caring environment that helps me heal* correlate with all 4 CAHPS questions of interest. Moreover, the items *deliver my care with loving-kindness* and *value my personal beliefs and faith, allowing for hope,* are likely reflective of the CAHPS question of *likelihood to recommend this emergency department to friends and family*. In summary, "this direction for assessing and validating caring provides new forms of evidence consistent with transformation within systems for whole-person/whole-system shifts related to healthcare reform and evolved consciousness of the public beyond medical-technical care alone" (Brewer & Watson, 2015, p. 5).

Subsequently, a nurse leader engages in one-to-one coaching with a frontline nurse, using a STAR method (Appendix H). According to Kline and McNett (2019), this component of the nurse leader round may be the most influential for a tangible impact on patient satisfaction scores. During STAR coaching, a nurse leader discusses a nurse-patient interaction eliciting the actions that a nurse took to make a patient feel informed, comfortable, and valued (Popovich, 2012). Next, a conversation would take place regarding possible alternatives for nurse's actions, which would further enhance the patient experience of care. A nurse leader would conclude with thanking a nurse and making him or her feel valued as well. The standard workflow for nurse leader rounding is displayed in Appendix H.

Measurement Strategy and Measures

A pilot test for this intervention will occur over a quarter (3 months). Structured nurse leader rounds would likely be a shared responsibility among nurse unit leaders, or involve one leader, who attended a nurse leader rounding teaching session. Rounding would occur on all patients, excluding those who have cognitive impairment. These patients are excluded based upon a definition by Gillian et al. (2017), "cognitive impairment was indicated if patient records indicated dementia, alcohol/substance abuse, confusion, stroke/cerebral vascular incident (CVA), anxiety, debility, encephalopathy, bipolar disorder, memory deficit, or brain injury" (p. 165). In the quality improvement project by Littleton, Fennimore, Fernald, and Gonzalez (2019) "as many as six rounders (nurse leaders who rounded) were required to meet the goal of visiting every patient every day" (p. 13). Nurse leader rounds will be implemented for at least 2 hours, biweekly, but up to 6 hours, daily (as in Littleton et al., 2019). This frequency should be supported by the nursing leadership; for example, a chief nursing officer (CNO) or a chief nursing executive (CNE), and initiated and implemented by interested and responsible parties such as, students in a graduate nursing program or a practicing CNL, in collaboration with representatives from the quality department. The project team should have precise data on the pre- and post-pilot implementation over a quarter, which relates to the 4 CAHPS survey questions: (1) Courtesy and respect by nurses; (2) Confidence and trust in the nurses; (3) Nurses explaining things in a way you could understand; (4) Likelihood to recommend this emergency department to friends and family. CAHPS scores, associated with these questions, were chosen as the outcome measures because they were found to need most improvement, and they were simultaneously deemed to have the most impact on the quality of patient experience as well as consumer loyalty. The Unit Based Practice Council will aid the project team by tracking, presenting and communicating CAHPS scores monthly to the department staff and stakeholders.

The patient survey star ratings will be examined as well due to many hospital patients

reporting powerful recollections of their ED experiences in the HCAHPS surveys. These scores

matter even more in the context of the Value-Based Purchasing program compared to CAHPS

scores, specific to the ED. McFarlan et al. (2019) concur that "recent studies have addressed

patient satisfaction in the ED setting as having an impact on patient's perceptions of the health

care institution as a whole" (p. 137).

Ethical Considerations

In the emergency department, due to overcrowding and increased acuity of patients who

reside in the community, an important question remains: who are we going to help? Other

questions that are brought up by the IHI include "What does the patient want and need? Is the

outcome what the patient wanted? (as cited in Finkelman, 2016). Notably, patient experience can

be influenced by various factors, including and not limited to "the individual's demographic,

socioeconomic status, family, health status, residence, genetics, employment, and many more

factors. Equally variable and complex is the experience that an individual has with the healthcare

they receive" (Berkowitz, 2016, p.12). In alignment with the ANA *Code of Ethics* (2015), this

quality improvement project brings patient experience into focus. Their unique needs and the

value of care that they receive are considered. For example, Provision 1 of the *Code of Ethics*

(2015) asserts that "the need for and right to health care is universal" (p. 1). Moreover, nurses

need to provide services and relief of suffering to people according to their most urgent need,

without personal bias or depending on their ability to pay. A nurse should establish a

professional relationship of trust and mutual respect with a patient and provide care with cultural

sensitivity (ANA *Code of Ethics*, 2015, p. 1). Additionally, Provision 8 affirms that "the nurse

collaborates with other health professionals and the public to protect human rights, promote

health diplomacy, and reduce health disparities" (ANA *Code of Ethics*, 2015, p. 31). This quality

improvement project aims at bringing the best possible patient experience to patients in the

emergency room, among whom are anyone who seeks help and will be seen. Moreover, it

exemplifies the nurse leader's commitment to collaborating with other professionals and

disciplines in advancing excellence in health care services, reducing disparities, and advocating

for the significance of patient experience and point of view. This project has been approved as a

quality improvement project by faculty using QI review guidelines and is exempt from IRB; it

does not require IRB approval.

Expected Results

Patient experience, in the emergency department or hospital-wide, will become of utmost

importance for organizational nurse leaders as well as settle in the hearts of the front-line staff.

This evidence-based, quality improvement project is meant to highlight the need for openness for

service to others and to accentuate patient experience into daily practice. After the

implementation of the project, CAHPS scores for the emergency department for 4 survey

questions: (1) Courtesy and respect by nurses; (2) Confidence and trust in the nurses; (3) Nurses

explaining things in a way you could understand; (4) Likelihood to recommend this emergency

department to friends and family will be in the 70th percentile. Additionally, the HCAHPS

patient survey summary star rating is anticipated to increase to 3 or more stars within the year of

implementation.

After attending the training sessions, nurse leaders will consistently engage in rounding

according to the newly proposed policy. There will also exist an opportunity to discuss the new

process and feedback from patients and staff members. The stellar performance will be

recognized and rewarded with small tokens of appreciation such as public recognition and gift

cards.

Summary

Key findings from this quality improvement initiative center around the significance of

establishing relationships and human interconnectedness. During the very first interaction with a

patient, if a staff member or a nurse leader uses the steps of the AIDET model (Appendix G) to

establish mutual trust and respect, the patient experience will improve. Staff members and

patients want to feel valued and cared for, and they also would like to be informed. Therefore, it

is critical in a nurse leader's role to facilitate and to strengthen this nurse-patient relationship by

engaging in standardized rounding. As Littleton et al. (2019) emphasize "nurse leaders should

continue to engage clinical nurses in the delivery of high-quality, patient-centered care for every

patient" (pp. 13-14).

Another important lesson learned from this initiative is the complexity of addressing the

needs of patients who are cognitively impaired. The qualitative dimensions of their experience

should also be assessed; this may require consultation with specialty services, such as psychiatry

or neurology.

SWOT analysis (Appendix E) provided useful information about possible roadblocks to

the implementation of this project. Therefore, understanding and addressing them would prompt

the success of the initiative. For example, the emergency department environment is fast-paced

and hard to predict, with many different providers interacting with a patient in a short time. Thus,

the intervention should be focused and effective to make the best use of time. Additionally,

because of the stressful environment and high staff turnover, leadership, and visibility of the

nurse leader rounding on patients and with nurses is paramount in providing quality patient care

and high-value patient experience. Finally, clearly defined guidelines and genuine, timely

recognition could serve to maintain engagement of action-oriented staff. Education related to the

patient experience needs to be continuously emphasized for nurses at all levels of the clinical

ladder. Quality improvement projects at the point of care also reinforce the importance of change

management and the role of front-line staff for senior leaders in the organization.

Conclusions

Future studies of patient experience could be randomized clinical trials, in which patients

are assigned to intervention and control groups. CAHPS and HCAHPS scores should be

collected and evaluated prospectively to assess the impact and sustainability of the intervention.

As a nurse leader reviews patients' charts in preparation for rounding, important demographic

data should be recorded, such as age, gender, marital and work status, educational level, and

length of stay. The effect of these variables, and whether or not they are the confounding

variables, could be assessed in future studies. For example, Ayaad et al. (2019) concluded that

"patient's level of education was found to have a significant impact on the perception of nursing

care due to its role in increasing patient awareness of the nature of the disease and treatment

options, as well as patients knowing their rights and responsibilities" (p. 532). Other

characteristics, which could influence patient experience, are the reason for seeking care,

concurrent health conditions, mobility, and pain level (Brewer and Watson, 2015, p. 4).

If a CNL initiates nurse leader rounding, he or she would fulfill several professional

roles. The CNL would act as an Advocate by obtaining feedback from patients regarding their

care and experience. As an Outcomes and Information Manager, CNL would gather and analyze

data and information regarding the patient experience and share findings with staff in the

microsystem and stakeholders. As a Team Leader, A CNL would engage other professionals in making improvements in the process and content of nurse leader rounding. In summary, a newly hired CNL would strive for improved patient outcomes, facilitate care coordination and interprofessional communication as well as contribute to the increase in patient satisfaction scores for both the microsystem and macrosystem in the organization.

Allocation of resources, in terms of both time and labor, always needs to be carefully considered in any system change. As Littleton et al. (2019) contend, "to ensure sustainability, designated time for all organizational leaders to concentrate on patient rounds without competing for systemwide demands should be established" (p. 13). In addition to the newly proposed policy, nurse leaders should be educated and trained on how to conduct nurse leader rounding to internalize and to operationalize the ANA *Code of Ethics* Provision 2, which states that "the nurse's primary commitment is to the patient, whether an individual, family, group, community or population" (p. 5). Every nurse has a professional duty to provide high-value services. Clearly, nurse leader rounding can offer a stellar strategy to improve every patient's experience of care in the Emergency Department.

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Appendices

Appendix A. **Quadruple Aim**

Source: Lippincott Solutions (2017)

Appendix B.   Annotated Bibliography

Ayaad, O., Alloubani, A., Al-rafaay, M., Arideh, A., Abualeish, M., & Akhu, Z. L. (2019).

Impact of structured nurse leader rounds on satisfaction with nursing care among

patients with cancer. *Journal of Nursing Scholarship*, *51*(5), 526–536.

doi:10.1111/jnu.12503

This article was published by Sigma Theta Tau International in 2019 and offers an international

perspective and experience with nurse leader rounds. Ayaad, Alloubani, Al-rafaay, Arideh.,

Abualeish, and Akhu (2019) contend that "this was the first interventional study conducted in a

specialized oncology center on improving satisfaction with nursing care in an oncology center"

(p. 528). This study had a two-group posttest design and a stratified random sampling technique

that was used to determine whether a structured nurse leader round influenced patient

experience. Furthermore, the authors recommend conducting randomized controlled trials in the

future to assess the practical usefulness of nurse leader rounds and to analyze patients'

demographic characteristics, which could influence outcomes.

Gillam, S. W., Gillam, A. R., Casler, T. L., & Cook, K. (2017). Increasing patient recall of nurse

leader rounding. *Applied Nursing Research*, *38*, 163–168.

doi:/10.1016/j.apnr.2017.10.013

This article includes data-based analyses of findings, confounding variables, suggestions for

sustainability and spread, and an Internal Q&A Instrument. This research study has "a

before/after pilot design using two groups of patients: a) a pre-intervention (baseline) group, and

b) a post-intervention group" (p. 165). Its content adds to the concerns associated with the mental

status of patients in being able to evaluate their experience of care.

Kline, M., & McNett, M. (2019). The impact of daily executive rounding on patient satisfaction

scores. *Nurse Leader*, *17*(5), 440–444. doi:10.1016/j.mnl.2018.12.018

The authors of this study aimed to assess the effect of the executive rounding on patient

satisfaction scores. They emphasized various HCAHPS categories and utilized a structured,

electronic rounding tool. The executives who rounded on patients included senior-level clinical

and administrative leaders, directors of nursing, and chief officers. Differences in patient

satisfaction scores in this study weren't notably different, perhaps, due to the missing component

of real-time coaching of nurses.

Littleton, L. L., Fennimore, L. A., Fernald, C. S., & Gonzalez, J. Z. (2019). Effective nurse

leader rounding improves the patient experience. *Nursing Management, 50*(10), 11–14.

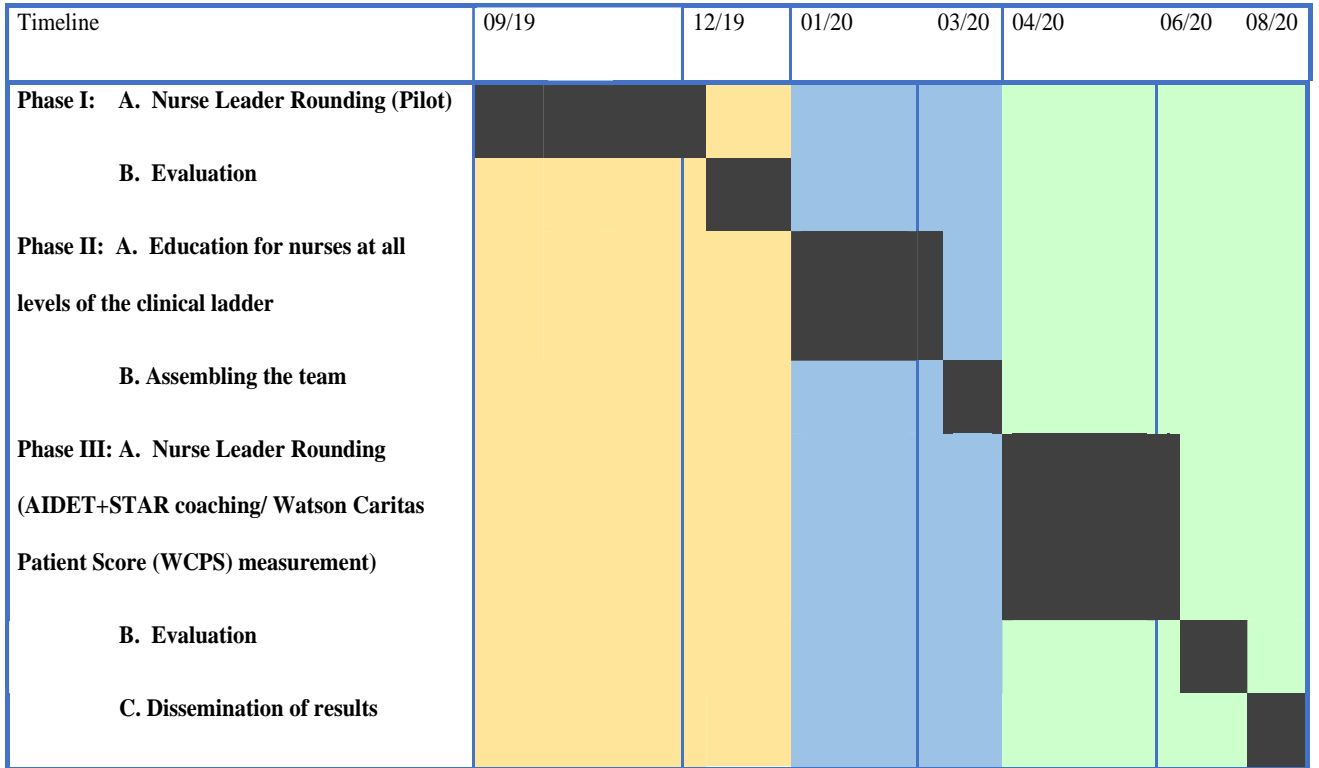doi:10.1097/01.NUMA.0000580620.45628.cd

This source is a joint work by the academic and industry leaders and describes valuable and well-

thought-out quality improvement project in improving both patient satisfaction and employee

performance. The authors emphasize the importance of clearly communicating and building

lasting relationships with patients. They also raise similar questions as this prospectus, including

but not limited to quality and frequency of nurse leader rounding needed to accomplish

meaningful change in nurses' practice and an observable increase in patient satisfaction scores.

McFarlan, S., O'Brien, D., & Simmons, E. (2019). Nurse-leader collaborative improvement

project: improving patient experience in the emergency department. *JEN: Journal of*

Emergency Nursing, *45*(2), 137–143. doi:10.1016/j.jen.2018.11.007

This improvement project is specific to the emergency department setting. Two groups, the

leader group and the bedside nursing care groups, aimed to standardize the rounds. After both the

leader rounds and the hourly nursing rounds had been implemented over the 2 months, patient

experience scores, measured by five survey questions, all improved. The authors of this study

refer to other stakeholders in the field of patient experience, such as the Studer Group, which is

valuable to gain outside perspective on the issue. This project was conducted by an assistant

professor and MSN students, who included force field analysis and tables demonstrating

"Standard work for leader rounds" and "Standard work for hourly patient rounding in the

emergency department". According to the authors, the project didn't sustain the ED due to an

overwhelming number of flu cases and competing organizational priorities as well as a change in

CNO and the MSN students. They suggest that continued training and support are needed for the

ongoing implementation and project sustainability in the future.

Appendix C.   Timeline/Gantt Chart

Timeline	09/19	12/19	01/20	03/20	04/20	06/20	08/20
Phase I: A. Nurse Leader Rounding (Pilot)							
B. Evaluation							
Phase II: A. Education for nurses at all levels of the clinical ladder							
B. Assembling the team							
Phase III: A. Nurse Leader Rounding (AIDET+STAR coaching/ Watson Caritas Patient Score (WCPS) measurement)							
B. Evaluation							
C. Dissemination of results							

Appendix D.   **Financial Analysis - Nurse Leader Rounding Project**

Improvement Revenue (cost avoidance)	Cost/Quarter	Annual Cost
MS-DRG X 2%	X/4	X

Improvement Costs	Cost/Quarter	Annual Cost
Clinical Nurse Leader	$25,000	$100,000
Education Materials/ Supplies	$100	$400
Project Savings (cost avoidance)	X/4 -- $25,100	X-$100,400

Note: "The Hospital VBP [Value Based Program] is funded by reducing hospital's base operating MS-DRG [Medicare Severity Diagnosis-Related Group] payments by **2.0 percent**" (Centers for Medicare & Medicaid Services, 2017, p. 12).

Appendix E.   **SWOT Analysis**

SWOT

Strengths

- ➢ Action-oriented staff
- ➢ Patients are eager to provide feedback
- ➢ Private rooms allowing for HIPAA compliance
- ➢ Common purpose to help patients

Weaknesses

- ➢ Staff turnover
- ➢ Stressful environment
- ➢ Fast pace of care
- ➢ Focus on what we do rather than how we do it
- ➢ Unplanned interaction with multiple providers

Threats

- ➢ Length of stay due to prolonged boarding
- ➢ Budget-allocated 3 hours of service per patient
- ➢ Regional competitive market for services
- ➢ Shortage of equipment and supplies

Opportunities

- ➢ Alignment with organizational priorities
- ➢ Participation in value-based purchasing
- ➢ Urban location
- ➢ Staff recognition
- ➢ Education for nurses at all levels of clinical ladder

Appendix F.   **Teaching Plan**

Needs Assessment

- Staff members in the emergency department need to know that there exists an urgency for a timely, evidence-based practice change related to care delivery in the emergency department. Specific CAHPS survey questions to be addressed are (1) Courtesy and respect by nurses; (2) Confidence and trust in the nurses; (3) Nurses explaining things in a way you could understand; (4) Likelihood to recommend this emergency department to friends and family. Additionally, the hospital-wide patient survey star ratings are affected as well by the experience a patient has in the ED.

- Patient experience needs to become an organizational priority, even in the context of possible competing demands such as patient surges, flu season, and other quality metrics.

- The culture shift needs to occur to illuminate staff norms and beliefs that impact patient experiences in the ED.

Learning Objectives

- The learner will accept patient-centered care as the foundation of their professional nursing practice.

- The learner will conduct informational patient interviews and engage in one-on-one nurse coaching, as outlined in the corresponding Nurse Leader Rounding Policy (Appendix J).

- The learner will recognize nurse leader rounding as a best practice to stimulate improvement in the patient experience in the ED, reported patient satisfaction scores, and patient survey star ratings.

- The learner will internalize Provision 2 of the ANA *Code of Ethics*, which states that "the nurse's primary commitment is to the patient, whether an individual, family, group, community or population" (ANA, 2015, p. 5).

Implementation

- The concept of coaching. Rich Bluni, RN, from the Studer Group, (2012) recommends that a nurse leader engages in coaching, which may often be uncomfortable, similar to a swimming instructor rather than a lifeguard. He advises the nurse leader to empower the staff and to find solutions collaboratively.

- Conceptual frameworks. A review of models, including AIDET and STAR Feedback Model (Appendices G and H) and the Watson Caritas Patient Score (Appendix I) will provide the evidence base for adopting best practices.

- Targeted education and skill-building sessions. Nurse Leader Rounding educational sessions are to be allocated 4 hours, including the presentation, role-play, and discussion. These sessions are planned to reach approximately one hundred employees representing unit directors, nurse managers, unit-based practice council, and charge nurse groups.

- Content of teaching/learning activities. The presentation includes recent data related to the patient satisfaction scores in the ED, with case studies of both positive and negative scenarios, and additional unit-specific data from the department of quality, which closely corresponds to the CAHPS questions under review. The presentation will also reinforce the organizational mission and how it relates to each nurses' daily work, including personal patient experience stories.

Evaluation

- Peer observation and coaching. Nurse leaders will engage in providing peer support and reciprocal validation of this new competency.

- Teaching Plan Evaluation Questionnaire. Participant surveys and feedback regarding targeted education and skill-building sessions will include both quantitative and qualitative information.

Teaching Plan Evaluation Questionnaire

We value your feedback on our skills-building session.
To what extent do you agree with the following statements?   Patient Experience ⭐

	Very unlikely	Unlikely	Neutral	Likely	Very Likely
This session will lead to a change in my nursing practice	○	○	○	○	○
I'll pause what I'm doing and introduce myself.	○	○	○	○	○
I'm going to establish personal rapport with others.	○	○	○	○	○
I'm going to provide valuable feedback to others in a respectful way.	○	○	○	○	○
I'll keep my patients informed and up to date.	○	○	○	○	○
I'll express my gratitude whenever possible.	○	○	○	○	○

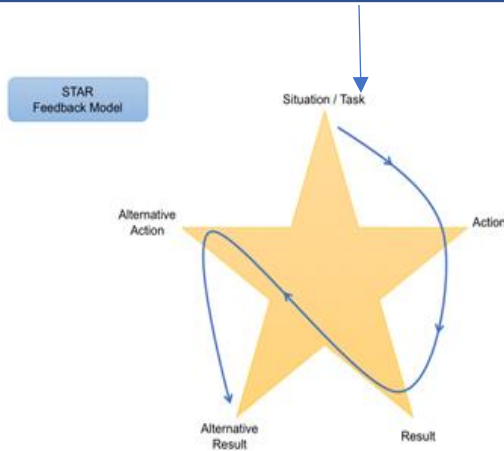Please, answer the following questions:

● What does excellent patient experience mean to you?

● What did you like about this session?

● How can it be improved?

Appendix G.   **AIDET Model**

A	Acknowledge	*Benefit:* Increase safety and Patient loyalty *Key message to patient:* "You are important."
I	Introduce	*Benefit:* Decrease anxiety *Key message to patient:* "You are in good hands."
D	Duration	*Benefit:* Increase compliance *Key message to patient:* "I anticipate your concerns."
E	Explain	*Benefit:* Increase quality of experience *Key message to patient:* "I want you to be informed and comfortable."
T	Thanks	*Benefit:* Increase patient loyalty *Key message to patient:* "I appreciate the opportunity to care for you."

Source: Popovich (2012)

Appendix H.   Standard Workflow for Nurse Leader Rounding

Review patient 's chart to capture demographic characteristics and to assess for conditions

Check for safety and assess information on patient's whiteboard

AIDET-based patient informational interview:

- Hello, my name is __. I'll be her for the next 5 to 10 mins. We care about your experience.
- Tell me who your nurse is today? What can you say about the care that they provided? How did it make you feel?
- Tell me what is the plan of care for you today.
- What would make this experience better for you?
- Whom would you like to recognize?
- Anything else that you need?
- Thank you for your time and entrusting your care to us.

STAR Feedback Model

Situation / Task

Alternative Action

Action

Alternative Result

Result

Source: McChristie (2016)

Appendix I.

Watson Caritas Patient Score[©]

DIRECTIONS: When answering the questions, please consider the overall consistency of human-to-human CARE you have received **during this hospital stay**. Please circle the number for the one best answer.

_____

My caregivers:	Never						Always
Deliver my care with loving-kindness.	1	2	3	4	5	6	7
Meet my basic human needs with dignity.	1	2	3	4	5	6	7
Have helping and trusting relationships with me.	1	2	3	4	5	6	7
Create a caring environment that helps me to heal.	1	2	3	4	5	6	7
Value my personal beliefs and faith, allowing for hope.	1	2	3	4	5	6	7

We invite you to share any notable caring or uncaring moments you experienced during this hospital stay.

Thank you for completing our questionnaire!

Watson, J., Brewer, B.B., & D'Alfonso, J. (2014). *Watson Caritas Patient Score (WCPS) ©.* Watson Caring Science Institute: Boulder, CO.
www.watsoncaringscience.org

Appendix J.   **Nurse Leader Rounding Policy/Procedure**

- A nurse, in a leadership position, who attended a patient experience skills-building

  session, will engage in nurse leader rounding on at least 10 patients per his or her shift.

- If a nurse leader is unable to conduct nurse leader rounding on a particular day, he or she

  will delegate this task to another trained nurse leader.

- A nurse leader rounding will occur according to the standard workflow (Appendix H).

- A nurse leader will conduct follow-up to rounding including but not limited to staff

  recognition, patient referral to senior leadership, patient relations, ambassador, and

  pastoral services.

- Summary of nurse leader rounding will be discussed in staff and leadership meetings.

- A nurse leader will exchange information regarding patient experience with the

  department of quality improvement, the operations team, as well as the physician group.