

WILL EDUCATING STAFF REGARDING THE IMPORTANCE OF REGULAR
PATIENT ROUNDING INCREASE STAFF KNOWLEDGE OF PATIENT
ROUNDING IN THE EMERGENCY DEPARTMENT?

by

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ABSTRACT

Today's health care is facing tough challenges. More and more physicians are exiting primary care. Patients, left without primary care physicians, are inundating emergency rooms for their health care concerns. The ripple effect of this is overcrowded emergency department waiting rooms, increased wait times for initial medical screenings, decreased patient perception of quality of care, decreased patient satisfaction, increased incidences of patients leaving the ED without seeing a provider, and decreased revenue for the emergency department.

Patient rounding in the ED can be a solution to these problems. Patient rounding has been shown to increase communication between the ED staff and patients regarding wait times and plans of care. In addition, rounding is reported to increase patient satisfaction, increase patient safety, increase patient perception of quality of care, and increase revenue for the hospital.

Educating the ED staff as to the importance of patient rounding is a key factor to enable staff to perform patient rounding. The purpose of this study was to examine the relationship of educating ED staff, regarding the importance of patient rounding, with increasing staff knowledge of patient rounding.

An educational project utilizing an educational PowerPoint® in addition to a Likert style, pretest posttest questionnaire was implemented with participants. The participants' scores on the pretest-posttest were then statistically analyzed.

The results of the pretest-posttest questionnaire showed that the educational PowerPoint® did indeed increase the ED staff knowledge as to the importance of regular patient rounding in the emergency department.

CHAPTER 1

INTRODUCTION TO THE STUDY

Introduction

With more physicians navigating toward specialty practice and fewer entering private practice, the number of primary care physicians has dwindled causing more patients to utilize the emergency department for primary care issues. Consequently, for many patients the emergency department (ED) is the first stop for care. (Press Ganey, 2010).

Grumbach, Keane, & Bindman (1993) found nearly half of patients using the ED reported that access barriers to primary care led to an emergency room visit. This reliance on the emergency room as a source of primary care has dramatically increased the number of ED patients. The subsequent ripple effect strains many emergency departments as waiting rooms become overcrowded, wait times for initial medical screenings increase, patient to nurse ratios become greater, and patient perception of quality of care and satisfaction decreases (Press Ganey, 2009).

Thompson, Yarnold, Williams, & Adams (1996) reported it is not the actual wait time that decreases patients' perception of quality of care and satisfaction, but the mere perception of wait times. The authors suggested providing information regarding wait times might be an effective strategy to increase patient satisfaction.

Furthermore, patient complaints in the ED center around lack of communication between staff, patient, and the patient's family. Updating the patient about test results,

delays in treatment, plan of care, and anticipated wait times leads to a positive perception of received health care (Meade, 2007). Such communication by the ED staff to the patient can easily be achieved by regular patient rounding (Meade, 2007).

Purpose

Emergency departments constantly focus on safety, satisfaction, and patient treatment rates. Outliers are always a source of concern. Although the literature showed many positive benefits of performing regular patient rounding such as increased communication between staff and patients, increased patient perception of quality of health care received, and increased patient safety, staff resistance to performing rounding exists. Misunderstanding the value, as well as the positive aspects, of patient rounding contributes to the staff resistance (Bourgault, King, Hart, Campbell, Swartz, & Lou, 2008).

In this study, a staff education program to increase understanding and, therefore, knowledge regarding patient rounding in the ED was developed. Prior to completion of the educational sessions, participants completed a pretest. The educational session followed, and then a posttest was administered to evaluate whether the participant's knowledge of patient rounding in the ED had increased. The purpose of this study was to assess whether staff education about the importance of patient rounding increased staff knowledge regarding regular patient rounding in the emergency department.

Learning Objectives

The learning objective for this project was that participants will be able to successfully increase their knowledge base regarding patient rounding in the ED. The attainment of this objective was demonstrated by an increase of scores from the pretest to the posttest questionnaire.

Background and Significance of the Project

Patient Satisfaction in the Emergency Department

Nationwide, patient satisfaction scores regarding perceived quality of emergency department care have fallen from 84.3% in October of 2008 to 84% in October of 2009. Reasons related to the decrease in satisfaction include overcrowding of the nations ED's, increased wait times, and decreased communication between ED staff and patients receiving care. Keeping patients informed about delays in care is critical in increasing patient satisfaction regarding perceived care in the ED. In a nationwide survey conducted by Press Ganey from 2008 to 2009 71% of patients felt that they were poorly informed of delays and wait times, leading to decreased satisfaction of overall perception of provided care. These same patients stated they would not recommend that particular hospital to others for health care (Press Ganey, 2010).

Emergency departments generate profit for a hospital through admissions. One study found that ED's generate 20% of a hospitals profit. This study further reported that the hospital profits over twelve hundred dollars per patient per admission to the hospital (California HealthCare Foundation, 2003). A dissatisfied patient may chose not seek

treatment where they perceived to have received unsatisfactory care. This will lead to loss of revenue for the facility (Welch, 2009).

Patient satisfaction levels are indicative of perceptions of the quality of care received in addition to nurse and patient interactions (Gardner, Woollett, Daly, & Richardson, 2009; Bourgault et al., 2008). Historically, ED's receive the some of the lowest patient satisfaction scores compared to the other departments in the hospital.

The largest number of patient complaints in the ED center on patient treatment and communication (Meade, Kennedy, & Kaplan, 2008). Thus, nursing has a key role in determining patient satisfaction scores as the staff nurse is the center of the patient's ED experience. If a nurse provides timely attention, in addition to meeting the patient's perceived expectations of care, patients are more satisfied (Meade, 2007).

Selected aspects of nursing care, that increase patient satisfaction, include "compassion, kindness, humor, reassurance, anticipation of patient needs, and the physical presence of the nurse in the patient's room" (Meade, Bursell, & Ketelsen, 2006, p.59). Patients are more satisfied with the hospital stay when they feel help is available to respond to their needs in a timely manner as well as to answer questions regarding care (Woodard, 2009). A patient lying on an ED cot feels a great sense of uncertainty. This includes uncertainty as to the diagnosis as well as to whether basic needs will be met. These needs include pain control, being able to get up to the bathroom, having a comfortable position in bed, as well as, a comfortable environment in the room.

Role of Rounding to Improve Patient
Satisfaction Scores in the Emergency Department

Agarwal, Sands, & Schneider (2010) report a five hundred-bed hospital loses over four million dollars annually as a result of communication inefficiencies. If patient rounding is implemented, patients know they will see a staff member at least every hour to address these needs, thus increasing satisfaction (Editorial, 2007). As a result, patient rounding is reemerging as hospitals attempt to improve patient safety, satisfaction and communication.

Regular patient rounding creates an avenue in which the perceived needs of the patient can be met in a timely manner. This is because staff will round on the patient at least every hour to ensure that needs are being met, and questions are being addressed. In addition, rounding is a forum to communicate to the patient and family about the plan of care and any wait times included in the plan (Meade, 2007; Bourgault et al., 2008).

In addition, many hospitals are using different rounding models in the inpatient units. These models include hourly rounding done by charge nurses or hourly rounding completed by any staff member whether it is a nurse, nurse's aide, tech, or housekeeper. Some hospitals use rounding every two hours (Meade, 2007; Bourgault et al., 2008).

Literature supports that patient rounding helps maintain or improve patient satisfaction scores in the inpatient setting (Bourgault et al., 2008; Davies, 2010; Editorial, 2007; Gardner et al., 2009; Halm, 2009; Meade, 2007; Meade, Bursell, & Ketelsen, 2006; Melnyk, 2007; Woodard, 2009). Scant completed research, however, has been done to determine whether routine patient rounding will increase patients' satisfaction of perceived care in the ED.

Role of Educational Projects to Improve Staff's Use of Rounding in Emergency Departments

Staff education is essential to ensure that patient rounding will occur on a routine basis. If nursing staff do not believe that patient rounding is beneficial to the nurse-patient relationship, rounding will not be performed (Meade, Kennedy, & Kaplan, 2008). Educating nursing staff about the value of patient rounding in increasing patient satisfaction has been found to facilitate staff participation in rounding (Powell, 2008). Such training and education regarding patient rounding is usually done at staff meetings (Bourgault, et al., 2008). This study assessed whether staff education about the importance of patient rounding increased staff knowledge regarding regular patient rounding in the emergency department in one hospital in a rural Western state.

Statement of the Problem and Research Question

The Institute of Medicine set goals for all healthcare facilities to implement in an attempt to improve health care across the nation. These goals included increasing patient safety, which is further defined as not injuring a patient with the care intended to help them. An example of this would be to decrease the amount of patient falls (Welch, 2009).

An additional goal was to provide patient centered care that would be respectful and responsive to the individual patient. In essence, this goal meant that the health care provider should ensure that the patient's individual needs, perceptions and values would drive the plan of care provided to that patient (Welch, 2009).

Another goal regarded timeliness. This goal specifically requested the need for health care facilities to provide timely care to patients. This would reduce wait times and potentially harmful delays for the patient (Welch, 2009).

Implementing patient rounding in the ED is a means to satisfy these goals. Patient rounding has been shown to increase patient safety and reduce the amount of patient falls (Baker & McGowen, 2010; Meade, 2007; Meade, Bursell, & Ketelsen, 2006).

Additionally, patient rounding is a way to provide patient centered care. Patients who are regularly rounded on felt certain that their individual needs would be met (Halm, 2009; Woodard, 2009). Finally, patient rounding is an avenue of communication between the ED staff and patients. Wait times and delays for care can be communicated to the patient. (Meade, Kennedy, & Kaplan, 2008). Press Ganey (2010) reported that patients are satisfied with wait times as long as they are kept informed of delays and the reasons behind the delays.

Patient rounding has been linked to increased patient safety, increased patient satisfaction with the timeliness of delivered care, increased likelihood of the patient recommending the facility to others, and increased patient satisfaction of the staff in anticipating and meeting the patient's personal needs (Halm, 2009).

It is essential to educate ED staff to the benefits of performing patient rounding in the ED because of the many benefits rounding provides to the patient as well as to the health care facility. This project sought to answer the research question: will educating staff regarding the importance of regular patient rounding increase staff knowledge of patient rounding in the emergency department?

Conceptual Framework

Nurse educators have long used Imogene King's interacting systems framework as a basis to help facilitate positive changes in the nursing process (Sieloff, 2006). This theory is based on three systems, personal, interpersonal, and social. A personal system is an individual such as a nurse or a patient. Interpersonal systems are made of two or more interacting personal systems such as nurse interacting with a nurse or a nurse interacting with a patient. A social system is made of groups. An example of this is the health care system (Sieloff, 2006). Messmer (2006) further explained,

These three systems are represented by the interactions of human beings in their social and physical environment with the inter-relationships of individuals (personal systems); and large groups (social systems). For example, a nurse may interact with a patient or physician, a personal system, in a health care system to achieve goals. A nurse administrator may interact with a group of nurses, which is an interpersonal system. (p.227)

Therefore, a nurse can interact with another group of nurses in an interpersonal or social system to communicate and share knowledge, thus, helping to improve communication between two interpersonal systems such as a nurse to a nurse, or a nurse to a patient. Furthermore, King's framework suggested that concepts such as communication flow dynamically across all three systems (Sieloff, 2006).

In this study, an interpersonal system will be a group of ED staff gathered for a staff meeting. The staff will then be given an oral presentation to educate them about the importance of performing patient rounding because oral presentations are an effective media to share knowledge with nursing. This is also a good way to bridge nursing knowledge between research and evidenced based practice (Billings & Kowalski, 2009).

Staff will be encouraged to utilize the concepts presented in the staff meeting during the patient rounding.

This educational project should also help increase communication between the patient and staff. Williams (2001) noted,

Good communication skills are imperative in the emergency room setting. In an environment that requires one to be reactive and responsive, clients often perceive nurses to be too busy or too hurried. The manner in which a nurse enters the client's room sets the tone for the entire encounter (p.27).

Addressing patient and family's general concerns, updating patients to expected wait times and plans of care, and meeting the basic needs of the patient can be achieved through basic communication during patient rounding (Meade et al. 2008). Patients in a busy ED suffering from numerous complaints may benefit from this project where the writer provides an opportunity for ED staff to increase awareness of patient rounding.

Definitions

The key terms identified for use in this study include emergency department, emergency department staff, staff knowledge, patient, patient rounding, and patient satisfaction. The *emergency department* is defined as a department of the hospital that provides acute care to patients who present without appointment. The care provided is initial care for a broad range of illness ranging from immediate life threatening to minor care. *Emergency department staff* are those who provide care to the ED patient. The ED staff consists of physicians, nurse practitioners, nurses, paramedics, certified nursing assistants, and secretaries (Meade, 2007). *Staff knowledge* is defined as facts or ideas

learned by the staff through education or personal experiences. *The patient* is a person who requires the use of the ED or hospital for treatment of illness. *Patient rounding* is an intervention tool that increases communication between staff and patients, increases patient's perception of quality of care, increases patient satisfaction, increases patient safety, and increases hospital revenue. This may be performed by any staff who works in the ED or hospital (Meade, 2007; Bourgault et al., 2008). *Patient satisfaction* is defined as the overall satisfaction a patient feels regarding perceived care. This is generally conveyed through a survey. Patient satisfaction also includes a patient's likelihood to recommend the healthcare facility to others as well as indicate willingness for the patient to return to the facility for further healthcare (Welch, 2009).

Assumptions

Lunenburg and Irby (2008) defined assumptions as "postulates, premises, and propositions that are accepted as operational for purposes of the research. Assumptions include the nature, analysis and interpretation of the data" (p. 135). This study has the following assumptions: (1) the ED staff will respond to the pretest and posttest questions in an honest and open manner; (2) the study group contains all members of the ER staff including nurses, paramedics, and CNA's; and (3) the results of the pretest and posttest scores will adequately report if there was a change in staff knowledge regarding regular patient rounding in the ED.

Limitations

Limitations are defined as factors that are not under the control of the researcher (Lunenburg & Irby 2008). Generalizability is one limitation of this study. The staff present at the oral presentation may not have the same perceptions on patient rounding as other staff. The pretest and posttest questions may be interpreted differently by different staff despite the general introduction instructions.

Some staff may be working or on-call during the presentation and may be called out prior to the end of the presentation. The pretest filled out by these staff members will be excluded because the posttest information will not be available.

Finally, lack of literature regarding patient rounding in the ED is a large limitation. Only one research study has been completed, and this study reported the positive findings of performing regular patient rounding in the ED setting (Meade et al., 2008).

Summary

King's research shows that knowledge can be disseminated between two people or a group of people (Sieloff, 2006). This research, utilized to teach the ED staff the importance of patient rounding, will use communication through and educational presentation (Williams, 2001).

In addition, one benefit of patient rounding includes better communication between the nurse and patient. Additionally, patient rounding increases patient safety, facilitates communication of the patient's plan of care, and increases patient satisfaction

of perceived care (Meade, 2007; Bourgault et al., 2008). These points will be stressed in the oral presentation given to ED staff members to increase knowledge about the benefits of patient rounding.

CHAPTER 2

REFVIEW OF THE LITERATURE

Introduction

Today's hospitals and health care workers provide safe and effective care for culturally diverse patients with complex disease processes in a constantly challenging and evolving environment. One method to achieve this is to provide effective communication with the patient (Joint Commission, 2010) Communication plays a major role in determining the quality of the workplace environment. Communication is how information is passed among staff members as well as between staff and patients. Effective communication allows for all staff and patients to receive information to achieve goals. Poor communication leads to breakdown in shared information and therefore unmet goals (Agarwal et al. 2010)

More importantly, quality of care and patient safety are also affected by communication. Poor communication leads to medical errors as well as a negative patient experiences. Patient experience is a quality indicator that assesses how attentive the nurse is to the patient's needs during their stay (Agarwal et al., 2010). Patient rounding is an excellent avenue to improve communication between the ED staff and patient fostering a positive patient experience (Meade, 2007). This chapter summarizes the literature on patient rounding in general as well as focusing on patient rounding in the ED. In addition, the effects of patient rounding will be discussed. Finally, the methods of teaching patient rounding to staff will be reviewed.

Patient Rounding

Hospitalized patients may have a difficult time providing basic self-care due to the nature of the illness requiring hospitalization. These patients, therefore, require assistance with basic needs such as ambulating, bathing, and using the toilet (Meade, 2007; Meade et al., 2006). Nursing is in a prime position to assist the patient with these needs, as nurses are consistently in a patient's room (Bourgault et al., 2008). Routine patient rounding is a forum where basic patient needs are addressed and, if necessary, met (Bourgault et al., 2008; Gardner et al., 2009; Meade, 2007; Meade et al.; 2006; Woodard, 2009).

Patient rounding is not a new concept to nursing. Florence Nightingale stated "apprehension, uncertainty, waiting, expectations, and fear of surprise, do a patient more harm than any exertion." (Woodard, 2009, p. 206). Patient rounding addresses these concerns by opening an avenue of communication where the patient is updated as to wait times and plans of care reducing apprehension, uncertainty and fear of the unknown (Woodard, 2009).

The concept of patient rounding was born in the late 1980's. One hospital experienced an increase in complaints regarding a slow response to answer call lights in addition to patient needs not being met. This hospital responded to these complaints by developing a unit hostess. The job expectations of this hostess was to "answer call lights within five minutes, provide amenities such as water, television remotes, telephones, bathroom supplies, and room temperature adjustments" (Davies, 2010, p.1). Within two

weeks of implementation of the hostess, complaints dramatically were reduced. These concepts were the start of patient rounding (Davies, 2010).

Rounding incorporates multiple nursing interventions into one action. Such interventions include adequately managing pain, manipulating the environment to ensure patient comfort and safety, identification of potential risks, fall prevention, and adequate communication between the patient and staff (Halm, 2009). Furthermore, rounding is considered “ ‘nursing 101’, representing good basic nursing care. (. . .) making hourly rounds can be viewed as a bundle of interventions that promote not only comfort but safety of both patients and staff” (Halm, 2009, p. 582).

Rounding is performed by checking on patients during a regular time interval. This can be done every hour or every two hours (Bourgault, 2008; Halm, 2009; Meade, 2007; Meade et al. 2006; Meade et al., 2008). Hourly and two-hour rounding can defined as the following:

One-hour rounding is defined as rounds being performed once an hour between six a.m. and ten p.m. and once every two hours between ten p.m. and six a.m. Two-hour rounding is defined as rounds being performed once every two hours during the entire 24-hour period. (Meade et.al., 2006, p. 60).

Additionally, in the study done by Bourgault et al. (2008), patient rounding was reduced at night to every two hours as long as the patient was awake. Night hours were defined as being between the hours of ten p.m. and six a.m. If sleeping, the patient was not wakened by staff just to perform rounding to allow for adequate rest.

The decision to perform rounding every hour or every two hours should be made by individual hospital administrations in collaboration with the staff. The managers of the

department will know what the unit staffing patterns are and will be better able to identify the time intervals (Meade et al., 2008).

Any staff member may perform rounding. This includes charge nurses, staff nurses, nursing aides, patient care assistants, dietary, and housekeeping. Bourgault et al. (2008) stated the patient rounding responsibility lies with the primary nurse, although all associates who enter the room are expected to assist the patient if necessary. Woodard (2009) further defined the person who performs the rounding as follows:

A registered nurse completing the routine rounding is more effective when considering the safety and outcomes of patients in today's hospitals. Taking it a step further, nurses with experience are the ideal persons to complete routine rounding to promote better outcomes and patient safety. (p. 202)

Accordingly, the decision on who should perform the rounding should be determined by collaboration between administration, management, and staff (Meade et al., 2006).

There are many points to address while rounding on patients. Bourgault et al., (2008), "Hourly Rounding Improves" (2007), and Woodard (2009) all agreed there are five main, basic components to rounding. This includes an introduction of the staff caring for the patient, the three P's, (pain, positioning, and potty) as well as an assessment of the environment.

The introduction is stated at the start of the shift or at the first contact with the patient. The introduction includes the name of the staff member as well as their credentials. Bourgault et al. (2008) cite an example of this in the following script: "Hello, Mrs. D., my name is Ramone. I'm the nurse who will be looking after you today (. .). I am here to round on you." (p. 20) The patient's room should include a white board where

the staff would then write the names of those caring for the patient as well as their credentials.

The three P's consist of pain, positioning and potty. The assessment of pain requires the use of a pain assessment scale as well as an intervention if one is required. If rounding is performed by staff other than the primary nurse, the patient's pain level must be relayed to the primary nurse as soon as possible (Meade et al., 2006). When considering positioning, the staff should inquire if the patient is comfortable in bed or if repositioning is required for increased comfort. Next, the staff should inquire if the bed itself needs repositioning for better patient comfort. Putting the head of the bed up or down may relieve uncomfortable pressure points (Woodard, 2009). The final 'P' is potty. With this component, the rounding staff assists the patient with any bathroom needs (Meade et al., 2006).

The final component is environment. The rounding staff should perform a quick assessment of the room, ensuring all of the equipment the patient may need is within the patient's reach. This equipment includes the call light, television remote, telephone, bed controls, bedside table, water, tissue, and the garbage can (Meade et al., 2006).

To conclude the rounding interaction, the patient should be informed staff would return to the patient's room in one hour or two hours, depending on the rounding policy. According to Bourgault et al. (2008), the following script can be used to conclude the rounding "Is there anything else I can do for you while I'm in the room? I have the time."(p.20). This relays to the patient that their perceived needs are important to the staff.

In summary, patient rounding, whether it is hourly or every two hours is important as it fosters a positive nurse-patient relationship, opens an avenue for communication as well as ensures the patient's perceived basic needs are met. The achievement of these actions leads to a positive experience (Meade, 2007).

Patient Rounding in the ED

The new health care policy of 2009 may cause many people to use the emergency department for primary health care (Press Ganey, 2010). Likewise, with the number of primary care physicians decreasing, the ED may be the only avenue available for health care. In addition, those who previously did not have health insurance will now be covered. These people do not have established primary care and tend to utilize the ED for primary care (Grumbach et al., 1993; Northington & Brice, 2004; Tang, Stein, Hsia, Maselli, & Gonzales, 2010).

Over half of all hospital admissions are generated through the emergency department (Press Ganey, 2010). Emergency departments are, accordingly, increasingly busy. The harried, often chaotic, nature of the emergency room may be intimidating to the patient. A typical ED patient thrust into the ED environment with a sudden, possibly traumatic, illness often feels helpless. The patient may feel that they have no say or control over the interventions or care placed upon them. Good communication between the ED staff and the patient may help to alleviate some of these feelings (Williams, 2001).

The major dissatisfaction regarding care in the ED centers on poor communication, wait times, patient treatment and poor staff attitudes (Meade et al., 2008). Patient rounding provides a means of communication between staff and patients. This is a forum where the patient can be informed of wait times, as well as an avenue for the staff to meet the patient's basic needs. Meade et al. (2008) found the following regarding the implementation of rounding:

Patients were better informed and updated about their care; patients saw a staff member regularly, rounding reduced patient anxiety; patient needs were met, patient conditions were monitored, there was less use of call lights; (. . .) patients did not feel they were overlooked or neglected; and they better understood delays (p. 6).

In the ED, the rounding can be performed every thirty minutes or every hour. According to Meade et al. (2008), reducing the timing from every one to two hours, the time interval rounding is performed on the inpatient units, to every thirty minutes is based upon the three plus theory. This states that a message, which is delivered fewer than three times, is delivered ineffectively. Therefore, the thirty-minute rounding was effective for those ED's that had a turnaround, or discharge, of patients within one hundred and fifty minutes or less, the average stay of the majority of ED patients. Otherwise, one hour rounding was considered more effective.

Staff performing the rounding included nurses as well as ED technicians. Managers of the ED were charged with designing the rounding plan. This is because the ED is unique in terms of staffing levels as different shifts start at different times around the clock. Registered nurses are to perform rounding on the hour and technicians are to perform rounding on the half hour. This creates a team environment and facilitates a

means for better communication with the patient seeing a health care provider every thirty minutes. (Meade et al., 2008).

In summary, the literature reviewed suggests that hourly rounding in the ED is beneficial in keeping patients informed of delays, increases communication between patients, staff, and adequately meets the patient's basic needs (Meade et al., 2008). The literature supported one-hour rounding in the ED as most effective instead of thirty minute rounding based on the three plus theory (Meade et al., 2008).

The Effects of Patient Rounding

The literature review found that patient rounding is successful in many areas. For instance, in Meade's (2007) study, hourly rounding yielded the following:

Achieved call light reductions in excess of 45%... [specifically calls for] bathroom assistance went down 40%, pain medication went down 35%, positioning went down 29%, and intravenous/pump alarms went down 22% (p.25).

This same study also reported a decrease of patient falls by 50% and a decrease in hospital decubiti.

Woodard (2009) found units implementing hourly rounding, improved patients' perceptions of obtaining help when needed. "Hourly Rounding Improves" (2007) also concluded regular patient rounding leads to better communication between staff and the patient and, therefore, increases trust. Bourgault et al. (2008) reported, "hourly rounding is a simple and cost-effective intervention to improve patient perception of quality service in an inpatient setting" (p. 24).

In Powell's (2007) study, patients seemed more satisfied and happy with their care upon discharge. The front line staff also stated rounding helped to decrease the number of angry patients. Furthermore, Meade et al. (2006) stated, "patient perception of the overall quality of care on the unit continued to increase over [the study period]" (p. 67). Similarly, Melnyk (2007) concluded that hourly rounding was effective in reducing call light usage, decreasing the number of patient falls, and increasing patient satisfaction.

Additionally, rounding increased staff satisfaction. Meade et al. (2006) reported rounding reduced the incidence of call light usage. As a result, staff had more time to perform other tasks, such as charting, because they spent less time responding to call lights. Another benefit was the level of unit noise decreased because the call lights were not engaged.

"Hourly Rounding Improves" (2007) further stated nurses did not have to run back and forth to patient rooms answering numerous call lights, a factor contributing to less stressful provision of care. Meade et al. (2008) reported rounding "relieved a lot of stress on the nurses because the patients were not [calling them into the room as often]" (p. 6) This is because the patient's concerns and needs were addressed during patient rounding and, therefore, the patient did not have to use the call light as much. Accordingly, this reduced the number of patient families needing to visit the nurses' station with questions regarding their loved one's outcome as these concerns would have been addressed during the rounding period.

Furthermore, patient rounding may increase hospital revenue. In the ED, patient rounding is a forum to keep patients updated regarding wait times to be seen by a

provider as well as wait times for test results. Lack of communication regarding delays is a major problem facing many ED's that leads to patients leaving the ED without being seen by a health care provider. The revenue that would have been generated by patient care therefore is lost (Welch, 2009).

Baker and McGowan (2010) reported that the average ED experiences at least 2% of patients who leave without being seen. The revenue lost is to the hospital related to this is \$219,000 to \$328,000 a year. In addition, unhappy patients may turn to the legal system and generate a lawsuit against the hospital that the patient perceives did not provide needed care. A great deal of revenue is lost by the hospital in fighting these lawsuits (Meade et.al., 2008; Welch, 2009).

In summary, patient rounding helped increase nurse-patient communication. This helped increase patient satisfaction. Importantly, rounding increased patient safety because patient falls as well as the incidence of decubiti ulcers, were reduced. Staff satisfaction was also increased because there were less call lights, allowing more time to complete nursing duties. Patient rounding may also increase hospital revenue by decreasing the amount of patients leaving the hospital without being seen by a provider (Baker & McGowan, 2010; Meade et al., 2008; Welch, 2009).

Teaching Methods

Because of the increase in evidenced base nursing procedures, nursing is constantly changing. Patient care and policies similarly are continually updated. Billings and Kowalski (2009) believed:

Nurses are qualified not only to practice, but also to generate and share new knowledge. They have a responsibility to participate in professional activities that facilitate dissemination because this begins the process of obtaining new knowledge for the betterment of society (p. 152).

Nurses should gain knowledge and then share that knowledge with others to better nursing's day to day practice. Billings and Kowalski (2009) further state that oral presentations conducted at work are an effective way to communicate new knowledge to others. This format is usually less stressful because it is in a less formal environment.

Oral presentations can be done in a multitude of venues including brown bag lunches, unit based meetings, continuing education classes, and nursing grand rounds. In her study, Woodard (2009) introduced patient rounding to the unit staff with a forty-five minute presentation. The presentation highlighted the staff benefits as well as evidenced based benefits of patient rounding.

Bourgault et al. (2008) reported that staff was educated through unit based staff meetings. This education consisted of face-to-face presentations, that outlined the expectations of patient rounding as well as the rewards and benefits.

In short, nurses can introduce new evidence based knowledge in a variety of ways. Billings and Kowalski (2009) find that oral presentations at the workplace are a cost effective way to share clinical information.

Summary

In summary, the researcher found patient rounding should be performed at a minimum of every hour. Patient rounding should address the patient's pain, positioning

as well as whether or not the patient needs the use of the bathroom. Likewise, the general room environment should be evaluated (Bourgault et al., 2008; Davies, 2010; Gardner et al., 2009; Halm, 2009; Meade, 2007; Meade et al., 2006; Woodard, 2009).

In the emergency department, patient rounding is an effective tool to increase nurse-patient communication. It is also an effective way to inform patients about expected delays and wait times. Additionally, patient rounding has been shown to increase patient safety Baker & McGowan, 2010; Meade et al., 2008).

Accordingly, rounding allows more time for staff to perform other duties. Patient rounding may also increase hospital revenue by decreasing the amount of patients leaving without being seen by a provider (Baker & McGowan, 2010; Meade et al., 2008; Welch, 2009). Presenting the benefits of regular patient rounding can be done through an oral presentation at a regular emergency department staff meeting, a cost effective manner for this evidenced base practice forum (Billings & Kowalski, 2009; Bourgault et al., 2008; Woodard, 2009).

CHAPTER 3

METHODS

Introduction to Research Methods

This chapter will detail the methods utilized in determining the research question. The purpose of this study was to assess whether staff education about the importance of patient rounding will increase staff knowledge regarding regular patient rounding in the emergency department.

A matched pair design was utilized to determine if education will increase knowledge regarding patient rounding. A match pair design measures a participant prior to and after a treatment is applied. The individuals are matched against themselves. Another name for this is a pretest- posttest experiment (Sullivan, 2007; Oktay, Taylor & Jensen, 2010). A group of ED staff was given a pretest to determine a baseline knowledge level regarding patient rounding. A presentation, designed to educate staff about patient rounding, was then administered. After the presentation, a posttest was administered. The results of the pretest and posttest examined if there is a difference in the answers reflecting a change in knowledge. Data was collected over a two-day period.

Human Subjects Approval

The Institutional Review Board at Montana State University approved this project of study as it involved research comparing instructional effectiveness. The study is exempt from a full IRB review because it did not identify the participants in any way.

Further, information was not recorded by the researcher in a manner that could ever place participants at risk of liability, financial hardship, employability, or reputation.

Additionally, the Patient Advocate of the hospital and the Director of the ED reviewed the study. Approval was obtained to conduct the study after it was determined no hardship would be afforded the participants of the study.

Project Setting

This teaching project was conducted in a fast paced, regional, Level II Trauma Center located in a rural Western state. The facility is a 358 bed, not-for-profit hospital that received full accreditation by the by The Joint Commission on the Accreditation of Health care Organizations (JCAHO). In addition, the American College of Surgeons has certified the facility as a regional, Level II Trauma Center (Benefis Healthcare, 2010).

The emergency department treats over 35,000 patients a year. The average length of stay for patients in the emergency department, from registration to discharge, was approximately 165 minutes. Staffing in the emergency department included board certified or eligible physicians, nurse practitioners, registered nurses, licensed practical nurses, certified nursing assistants, flight paramedics, registration clerks, and secretarial staff (Benefis Healthcare, 2010).

Population

A convenience sample of emergency department staff was utilized in this study. A convenience sampling utilizes participants who are the most conveniently available, and

this is also the most common sampling method researchers use due to simplicity and cost effectiveness (Polit & Beck, 2008). For this study, the ER minor (simple treatment area) was excluded. This is a separate department staffed differently than the main ED. Likewise, the ED physician group, including the nurse practitioners, was excluded because this group consisted of contracted employees of the hospital who do not participate in rounding in the ED.

The ED staff surveyed consisted of twenty-seven full time RN's, seven full time paramedics, two certified nurses' assistants, and five secretarial staff. The staff were asked to participate in the study voluntarily.

Information regarding the study, procedure for completion of the survey, risks and benefits, and confidentiality were all provided to participants prior to initiating the study. Consent was implied through completion and return of the survey.

Instrumentation

The researcher developed the questionnaire utilized in this study (see Appendix A). A demographics section was also completed by the participants. This section asked about the participant's level of education, the years worked in the ED and included a general comment area. This allowed the participants to share any ideas or concerns regarding patient rounding in the ED.

The pretest and posttest questionnaire entitled "Educating ED Staff as to the Importance of Patient Rounding" was designed using the Likert scale. The Likert scale is the most popular scale utilized in surveys because it is easy to apply for both the

participant and researcher (Polit & Beck, 2008; Preston & Colman, 2000). The Likert scale consisted of declarative statements designed to express a participant's viewpoint on a topic. To what degree the participants agree or disagree with the statement is the question asked. Usually, ten or more declarative statements are utilized in the questionnaire. In this research fourteen statements were used. In addition, the utilization of a five-point scale prevents distraction or frustration with the questionnaire and is easy for the participant to use (Polit & Beck, 2008; Preston & Colman, 2000).

The statements were either positively or negatively focused. In the positively worded statements, agreement was when the favorable answer was positive. This was indicative of a selection of the strongly agree category. In a negatively worded statement, agreement was usually reversed where the favorable answer was negative as in the selection of the strongly disagree category (Polit & Beck, 2008; Preston & Colman, 2000).

The designed pretest and posttest questionnaire consisted of fourteen questions related to knowledge of patient rounding. Thirteen of these questions were positive in focus and one was negative in focus. The five point scale consisted of strongly agree, tend to agree, neither agree or disagree, tend to disagree and strongly disagree.

A power analysis utilizing the G*Power® software (G*Power®, 2009) determined a sample size of forty-two was needed. This utilized a large effect size of 0.8, an alpha level of 0.05, a .80 power, and a 2-tailed analysis as determined by the software (G*Power®, 2009) The total population surveyed was forty as this was the amount of staff available to participate in the study.

Data Collection

Permission was obtained from the ED Director to present the pretest, presentation and posttest following a regularly scheduled staff meeting occurring on two days of one week in September 2010. An email was sent to the ED staff explaining the study and when it would take place. Participation was voluntary.

At the end of the staff meeting, the pretest questionnaire was distributed to those who wished to participate. The questionnaire was structured to determine the participant's general knowledge of patient rounding.

A twenty-minute PowerPoint® presentation (See Appendix B) was then administered. The presentation was designed to educate the staff about patient rounding in general as well as for the ED specifically.

Following the presentation, the posttest questionnaire was administered. The posttest had the same questions as the pretest. A demographics sheet was also completed by the participants.

Many staff stated lack of confidentiality was a barrier in participating in the study. Once confidentiality was assured more staff were willing to participate as well as answer the questionnaire truthfully, as there was less fear of retaliation by management. The completed questionnaires were placed into a file folder. The demographics were placed into a separate folder. The researcher maintained control over both file folders throughout the data analysis. The researcher destroyed the completed pretest posttest questionnaires, in addition to the demographics sheets after the data was analyzed.

A total of nineteen surveys were returned. The total study population was forty. Thus the response rate was calculated as 47.5 %.

Data Analysis

An analysis was performed on the demographics questionnaire to determine the participant's level of education in addition to years of service in the ED. This was recorded in the demographics area of the results.

The pretest questionnaire was then examined. A score was assigned to each category depending how it was answered. For the positively focused questions, a score of five was given for the 'strongly agree' category. A score of four was given to the 'tend to agree' category. A score of three was given to the 'neither agree nor disagree' category. A score of two was given to the 'tend to disagree' category. Finally, a score of one was given to the 'strongly disagree' category. Conversely, for the negatively focused question, a score of one was given to the 'strongly agree' category. A score of two was given to the 'tend to agree' category. A score of three was given to the 'neither agree nor disagree' category. A score of four was given to the 'tend to disagree' category. Finally, a score of five was given to the 'strongly disagree' category. The scores for each statement were calculated for the pretest. Both the mean and mode were determined. The mode determined how often the answer appeared while the mean determined the average of the scores.

The scores for each statement for the posttest were then calculated in addition to the mean and mode. The posttest scores were compared to the pretest scores to determine

if there is a change in the scores. A t-test analysis was completed to determine if there was a significant increase in knowledge regarding patient rounding.

CHAPTER 4

RESULTS

Introduction

This study examined whether educating emergency department staff, regarding the importance of patient rounding, would increase staff's knowledge related to patient rounding. This research question was examined by comparing answers provided by the ED staff on a pretest questionnaire to those answers provided by the same questionnaire completed as a posttest. An educational PowerPoint® presentation regarding patient rounding was administered prior to the posttest questionnaire with the presentation administered at two ED staff meetings. Additionally, the participants in the study completed a demographic questionnaire.

Descriptive statistics were utilized to provide an overview of the information collected from the questionnaires. According to Sullivan (2007), descriptive statistics organize and summarize collected data and provide an overview of information collected with the aid of numerical measurements, charts, graphs, and tables. In addition, quantitative analysis examined the participants' responses to the questionnaires. The data is presented in this chapter.

Demographics Descriptives

The surveys were presented to forty ED staff. Nineteen surveys were returned for a 47.5% return rate. Demographic questions regarding the participant's level of

education, gender, and years working in the ED were queried. Table 1 depicts the responses to the demographic surveys. One participant who completed the pretest and posttest declined to complete the demographics sheet. Gender was equally split between males nine (47.4%) and females nine (47.4%). The majority of the participants eleven (60%) were registered nurses. Additionally, there were three (15.8%) paramedics, one (5.2%) certified nursing assistant, CNA, and three (15.8%) secretarial staff. Ages varied ranging with five (26.3%) participants between 20 and 30 years of age, six (31.6%) between 31 and 40 years of age, four (21.1%) between 41 and 50 years of age, and three (15.8%) between 51 and 60 years of age.

Table 1. Descriptive Statistics for the Demographics of the Participants

Variable	Sample size (n)	%
Gender		
Male	9	47.4
Female	9	47.4
Not answered	1	5.2
Level of education		
RN	11	60.0
Paramedic	3	15.8
CNA	1	5.2
Secretarial	3	15.8
Declined to participate	1	5.2
Age		
20-30	5	26.3
31-40	6	31.6
41-50	4	21.1
51-60	3	15.8
Declined to participate	1	5.2

Pre/Posttest Questionnaire Analysis

The pretest and posttest questionnaire was designed by the researcher to examine the participant's knowledge of patient rounding. The questionnaire consisted of a five response Likert scale with fourteen declarative statements. Utilizing the SPSS® software (SPSS, 2010), the Cronbach's alpha for this study was determined to be .868 supporting the initial reliability of the questionnaire. The closer the Cronbach's alpha is to one the more reliable the test score (Sullivan, 2007).

Additionally, a factor analysis was attempted utilizing the SPSS® software (SPSS,2010). Unfortunately, the software was not able to determine the factor analysis because the correlation could not be computed for all pairs of the pre/posttest questions. Therefore, the initial validity of the questionnaire could not be supported.

The categories for the responses of the Likert scale included strongly agree, tend to agree, neither agree nor disagree, tend to disagree, and strongly disagree. Each category was assigned a number from one to five for scoring purposes. For the positive questions, a score of five was assigned to 'strongly agree'. 'Strongly disagree' received a score of one. For the negative question (question 9), the opposite scoring was assigned with 'strongly agree' receiving a one and 'strongly disagree' receiving a five. Table 2 outlines the question number, question, and whether it was a positive or negative question. Table 3 outlines the scoring system.

Table 2. Questions

Question number	Question	Positively or Negatively directed
1	Patient rounding is an avenue where patients and families receive updates regarding the plan of care.	Positive
2	Patient rounding improves communication between emergency room staff and patients	Positive
3	Patients perceived needs are met through rounding.	Positive
4	Patient rounding includes the 3 p's: pain, potty, position, and environment.	Positive
5	Staff is updated as to the patient's condition of care with patient rounding.	Positive
6	Patient safety is increased with patient rounding.	Positive
7	Any ED staff member can perform patient rounding.	Positive
8	Patient rounding will become a standard of quality of patient care.	Positive
9	Patient rounding is difficult to perform.	Negative
10	Patient rounding should be performed at least every hour by ED staff.	Positive
11	Patient satisfaction will increase with patient rounding.	Positive
12	Patient rounding is a valued intervention provided by ED staff.	Positive
13	Patient rounding decreases dissatisfaction projected upon ED staff by patients.	Positive
14	Increasing knowledge of patient rounding will increase ED staff performance of rounding.	Positive

Table 3. Scoring System

Category	Score for positive questions	Score for negative question
Strongly agree	5	1
Tend to agree	4	2
Neither agree nor disagree	3	3
Tend to disagree	2	4
Strongly disagree	1	5

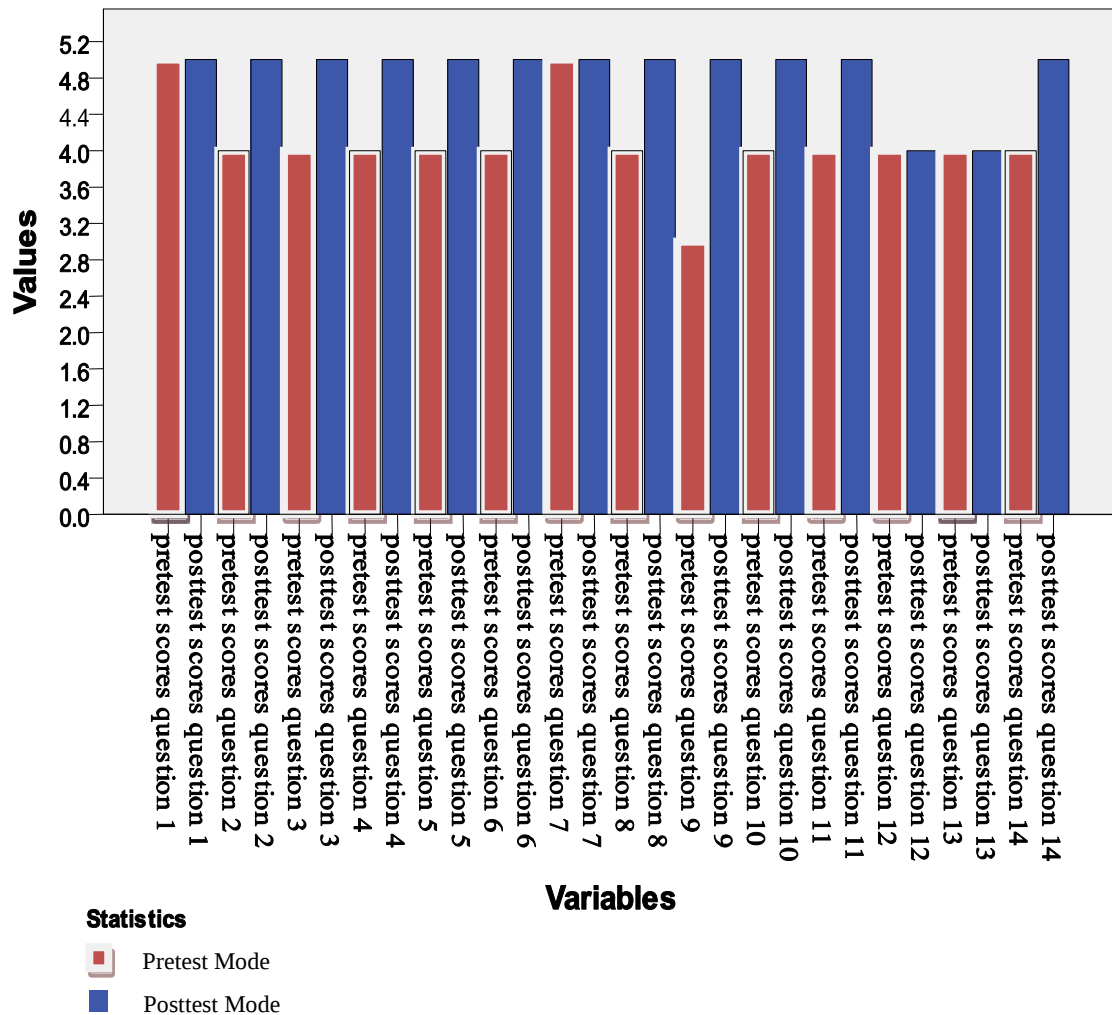
Mode of the Pre/Posttest Statements

The scores were entered into the Statistical Package for the Social Sciences (SPSS®) data analysis program (SPSS®, 2010) to conduct the descriptive analysis. First, the scores of the pretest were entered followed by the corresponding posttest score. The mode was determined by identifying the most frequently selected category. The pretest and posttest modes for each question were determined as it was the measure of how often a category was chosen in the pretest compared to the posttest .

The mode for the both the pretest and posttest questions 1 and 7 was 5. The mode for questions 12 and 13 on both the pretest and posttest was 4. The mode for questions 2, 3, 4, 5, 6, 8, 10, 11, and 14 on the pretest was four whereas the mode for the corresponding posttest question was five. For question 9, the mode for the pretest was three whereas the mode for the posttest was five.

The increase in the mode shows that there was an apparent increase in knowledge for nine questions (2, 3, 4, 5, 6, 8, 10, 11, and 14). Graph 1 depicts the modes in the pretest and posttest questions.

Figure 1. Pretest and Posttest Modes



Descriptive Statistics of the Pre/Posttest Statements

The scores on the pretest and posttest were also analyzed using a t-test and the SPSS program (SPSS, 2010). This analysis focused on the differences between the pretest and posttest scores to determine if the change of scores was significant. The significance value was obtained for each question. If the significance value was less than

0.05, the difference between the pretest and posttest questions cannot be related to chance and, therefore, knowledge was indeed gained by the participants. Table 4 shows the results of the significance value for each question. Significance values for nine of the fourteen questions were less than 0.05. This finding supports that the participants gained knowledge regarding patient rounding from the educational presentation.

Table 4. Paired Samples T Test Significance Values

Declarative Statements	Paired Differences			95% Confidence Interval of the Difference Mean		t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	Lower	Upper			
Question 1 pretest and posttest	-.474	.841	.193	-.879	-.068	-2.455	18	.025
Question 2 pretest and posttest	-.316	.582	.134	-.596	-.035	-2.364	18	.030
Question 3 pretest and posttest	-.737	.872	.200	-1.157	-.317	-3.684	18	.002
Question 4 pretest and posttest	-.789	.855	.196	-1.202	-.377	-4.025	18	.001
Question 5 pretest and posttest	-.895	.875	.201	-1.317	-.473	-4.456	18	.000
Question 6 pretest and posttest	-.526	.841	.193	-.932	-.121	-2.727	18	.014
Question 7 pretest and posttest	-.421	.961	.221	-.884	.042	-1.909	18	.072
Question 8 pretest and posttest	-.737	.806	.185	-1.125	-.349	-3.986	18	.001
Question 9 pretest and posttest	-.947	1.129	.259	-1.492	-.403	-3.6	18	.002

Table 4 - Continued

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Question 10 pretest and posttest	-.474	.841	.193	-.879	-.068	57 - 2.4 55	18	.025
Question 11 pretest and posttest	-.737	.933	.214	-1.187	-.287	- 3.4 41	18	.003
Question 12 pretest and posttest	-.737	.806	.185	-1.125	-.349	- 3.9 86	18	.001
Question 13 pretest and posttest	- 1.316	1.157	.265	-1.874	-.758	- 4.9 56	18	.000
Question 14 pretest and posttest	- 1.000	.745	.171	-1.359	-.641	- 5.8 48	18	.000

Summary

To summarize, the mode of each question determined which category was picked the most frequently. If the category score increased in positively reflected questions, the participant was perceived to have gained knowledge from the presentation. The majority of the modes (9; 64%), did increase in the posttest questions.

In addition, the significance values show that the increase in scores from the pretest to the posttest was likely not related to chance. Thus, it can be inferred that the participants did gain knowledge regarding patient rounding as a result of the educational presentation.

CHAPTER 5

DISCUSSION

Introduction

In the preceding chapter, the statistical data and analysis related to this research project was presented. This chapter will provide: 1) a summary of the study, 2) discussion of the findings, 3) implications for nursing practice, 4) implications for nursing education and nursing management, 5) recommendations for further research, and 6) conclusions.

Summary of the Study

The purpose of this study was to assess whether staff education about the importance of patient rounding increased staff knowledge regarding regular patient rounding in the emergency department. A matched pair design was utilized in this study because of simplicity. The researcher designed a Likert style, pretest posttest questionnaire, that was distributed to participants at staff meetings, held on different days. Initially, the pretest was given. Following the pretest, an educational presentation regarding patient rounding was administered. Then, the posttest questionnaire was administered. Finally, a demographic questionnaire was handed out to the participants. This demographic questionnaire yielded information regarding the demographic characteristics of the participants regarding their level of education, age, and gender.

A total of nineteen pretest-posttest questionnaires were returned from the participants for a return rate of 47.5%. Data from the questionnaires was analyzed to

determine if knowledge of the patient rounding was gained through the education, thereby providing an answer to the research question: does educating staff about the importance of patient rounding increase knowledge regarding regular patient rounding in the ED?

Instrumentation

Participants were asked to participate in the study while gathered at a monthly staff meeting therefore, participant randomization was not achieved. The researcher developed the pretest posttest questionnaire utilized in the study. Cronbach's alpha for the questionnaire was determined to be .868 supporting the reliability of the questionnaire. Unfortunately, the validity of the questionnaire was not supported as the SPSS® software was unable to compute the factor analysis (SPSS®, 2010).

Discussion of the Findings

The purpose of this study was to determine if educating ED staff about the importance of patient rounding would increase staff knowledge regarding patient rounding. The pretest scores were analyzed and then compared statistically with the posttest questionnaire scores. Paired samples t-test was performed. The significance value for nine of the fourteen questions were less than .05, therefore, knowledge regarding patient rounding was gained by the participants with these questions. The remaining questions had significant values greater than .05, therefore the education did not help

increase knowledge in these questions. Overall nine questions, (64%), showed a gain in knowledge.

Additionally, the mode of each question was then determined. As Likert scales can be considered ordinal data. The statistical analysis showed that the mode increased from the pretest to the posttest for nine of fourteen questions. The researcher expected the mode to increase if the participant increased knowledge. For instance, statement 3 asked, “patients perceived needs are met through patient rounding.” The mode of the pretest was equal to four (tend to agree) while the mode of the posttest equaled five (strongly agree). The participants’ increased knowledge led to a stronger agreement with the statement. This trend occurred in 9 of 14 (64.3%) questions. This finding provided support that the educational presentation did increase the participants’ knowledge.

Limitations of the Study

Limitations are factors beyond the control of the researcher that may have an effect on the reader’s interpretation of the findings (Lunenburg & Irby, 2008). The researcher in this study identified the following limitations.

The study was completed in a small ED utilizing a convenience sampling of staff. Therefore, the answers may not be representative of all ED staff because only a portion of the staff participated in the study. If all staff members had participated, the survey outcome may have been different because of the added survey answers (Polit & Beck, 2008). In addition, the sample size was not chosen randomly because of time and cost constraints... This may create less internal validity of the study (Polit & Beck, 2008).

Additionally, the findings may not generalize to other ED's across the nation. This may be due to the difference in staff levels and education levels of different ED across the nation. In addition, nineteen staff filled out the survey. The study should have had forty-two participants for the sample size to be considered adequate to generalize the results to other ED's.

Secondly, the researcher is an employee of the ED where the research was completed. Therefore, social response bias may have been evident in the questionnaire answers as the participants may have felt the need to answer the questionnaires differently than if the researcher was unknown to them. This is also referred to as the Hawthorne effect where knowledge of being included in a study affects the participant's behavior and manner in which they may answer questions on the questionnaire (Polit & Beck, 2008).

Additionally, the researcher designed the pretest-posttest questionnaire utilized in the study. The Cronbach's alpha was .868, which showed adequate initial reliability. However, the validity of the questionnaire could not be determined with the SPSS® software (SPSS®, 2010). This means the strength of the conclusions was not determined (Polit & Beck, 2008).

The questionnaire also utilized a Likert scale. Participants may have simply agreed with the statements or chosen answers in the middle of the scale to avoid using extremes. Consequently, these actions could have created bias (Polit & Beck, 2008).

Lastly, the staff of the ED was previously exposed to patient rounding and as a result may have had preconceived notions regarding the usage of regular patient

rounding. These thought processes may have biased the participants' responses on the pretest by having the "agree" or "strongly agree" categories selected more frequently than if there was no prior exposure to patient rounding.

Implications for Nursing Practice

Health care institutions are challenged to implement health care policies and procedures to increase patient's perceived quality of care, maintain patient safety, and protect the incoming revenue of the agency (Vest & Gamm, 2009). Regular patient rounding in the ED has been found to help with the achievement of all three challenges as the literature has shown that patient rounding increases patient safety by: 1) decreasing patient falls and incidence of decubiti ulcers, 2) increases patient perception of quality of care by routinely meeting perceived needs, as well as 3) increases communication between ED staff and patients (Meade, Kennedy, & Kaplan, 2008).

Lack of communication regarding wait times and plans of care can decrease patient satisfaction. Such communication inefficiencies could then decrease hospitals' revenues by millions (Agarwal, Sands, & Schneider, 2010). Patients may choose to leave the facility without being seen, therefore, decreasing revenue to the health care facility. Additionally, the patients experiencing these problems may voice negative comments regarding the facility, keeping other patients from utilizing the facility and further decreasing revenue (Meade, Kennedy, & Kaplan, 2008). The educational component of this study teaches staff that patient rounding is a powerful communication tool through which patients can be updated to potential wait times and plans of care. Keeping patients

updated increases patient satisfaction regarding the health care facility. These patients will continue to utilize the health care facility as well as recommend the facility to others, leading to increased revenue for the facility (Welch, 2009).

This study supported the premise that educating ED staff about regular patient rounding can increase staff's knowledge regarding regular patient rounding. If staff is more knowledgeable regarding the positive aspects of patient rounding, commitment to perform patient rounding may increase. The patient's experience in the ED may then become more positive, increasing patient satisfaction as well as patient's perceptions of their care.

In the future, hospital revenue will be tied to patient satisfaction scores. The Center for Medicare and Medicaid Services (CMS) is implementing the concept of value driven health care where Medicare payments are directly linked to the quality of care provided by a health care institution (CMS, 2008). The quality of care will be determined by studying patient satisfaction surveys. Thus, the higher the patient satisfaction scores, the more revenue will be reimbursed to the hospital (CMS, 2008). Regular patient rounding in the ED is one strategy that could help a hospital improve patient's perception of the quality of care they receive and their associated satisfaction with that care, thereby leading to increased revenue.

This study has already affected the hospital where it was performed. The management of the ED is reviewing new policies to incorporate rounding done on the half hour by medics as well as on the hour by nursing staff in the ED. This will ensure that the patient is rounded on every thirty minutes with different members of the staff

rounding every hour. In addition, the educational presentation utilized to educate ED staff will be provided for the hospital management team to increase their knowledge on patient rounding to facilitate the ongoing implementation of rounding in all patient care areas (C. Ludlum, personal communication, August 31, 2010).

Implications for Nursing Education

The health care environment is constantly changing requiring nursing to evolve as well in order to provide the most updated care to patients. Nursing education is a key component in ensuring the most updated care is provided to patients (Declan, 2009).

Bridging the gap between nursing education and nursing practice is essential in providing quality and safe patient care (Mulready-Shick et. al., 2009). Educating staff as to the importance of patient rounding helps to ensure the staff will embrace the concept and, therefore, perform it regularly. Starting a pilot study in one department of the hospital can demonstrate the positive outcomes of patient rounding to the other departments of the hospital. Once rounding is established in the pilot unit, those staff can then start an educational team to increase the knowledge and benefits of patient rounding to the remaining units of this hospital. Continuing education can then be done on a yearly basis to ensure the concepts of patient rounding are consistently and continually updated to the staff (Davies, 2010).

Implications for Nursing Management

Nurse managers have a key role in determining whether patient rounding is successful. It is the job of the nurse manager to ensure that the staff is following the rounding policy. Staff members should be praised when performing patient rounding. Conversely, staff should be counseled when inadequately performing patient rounding, and reeducated as the importance of patient rounding (Meade, 2007).

Nurse managers can initiate training sessions to ensure patient rounding is consistently performed. Educational programs such as presentations or computer generated programs regarding patient rounding can also be initiated. In addition, nurse managers may inquire if a patient rounding is being completed by asking the patient if rounding has occurred (Davies, 2010).

Another benefit would be the cost savings to the unit. For the ED, patient rounding has been linked to decreasing the amount of patients leaving without being seen. This increases revenue for the unit as the patient stays in the ED for care and revenue is generated. Additionally, patient rounding has been linked to a decrease in the amount of patient falls. The estimated average cost of accrued by the hospital for one patient fall is \$24,962. Eliminating this fall with the help of patient rounding would be a cost saving strategy for any nurse manager (Woodard, 2009).

Recommendation for Further Research

The goal of this study was to examine if educating ED staff regarding patient rounding increased knowledge of patient rounding. Further studies could demonstrate

whether this increased knowledge leads to an increased performance of patient rounding by ED staff.

Additionally, the sample size utilized in the study was small. Repeating the study using a larger sample size increases the amount of data available and may more accurately reflect the feelings of the total population, yielding more significant findings (Polit & Beck, 2008). Furthermore, additional studies could be performed to examine the relationship between patient rounding, patient satisfaction, and quality of care.

Additional tests could be performed to study the reliability and validity of the questionnaire developed by the researcher. This could help to eliminate internal validity problems.

Finally, research could be completed utilizing patient rounding in the waiting rooms of ED's. This type of research could examine whether patient rounding in the waiting rooms reduces the number of patients leaving without being seen by a health care provider.

Conclusion

This study supported the positive relationship between educating ED staff regarding the positive outcomes of regular patient rounding and an increase in staff knowledge of patient rounding. It is the hope of this researcher that ED staff will incorporate this knowledge into their practice and increase their performance of regular patient rounding. Hopefully, this will result in improved patient satisfaction and improved patient's perceptions of the quality of their care. This, in turn, may also result

in increased revenue for the hospitals because fewer patients will leave without being seen. In addition, may reduce revenue spent in treating patients who have fallen or received decubiti ulcers (Meade et al., 2006, Meade 2007). Thus, increasing performance of patient rounding may help to provide safe, cost effective, efficient, and patient centered health care which is a goal of many health care organizations today.

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APPENDICES

APPENDIX A

PRE/POSTTEST QUESTIONNAIRE

Pretest

Educating ED staff as to the importance of patient rounding

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree
Patient rounding is an avenue where patients and families receive updates regarding the plan of care.	O	O	O	O	O
Patient rounding improves communication between emergency room staff and patients.	O	O	O	O	O
Patients perceived needs are met through rounding.	O	O	O	O	O
Patient rounding includes the 3 p's: pain, potty, position, and environment.	O	O	O	O	O
Staff is updated as to the patient's condition of care with patient rounding.	O	O	O	O	O
Patient safety is increased with patient rounding.	O	O	O	O	O
Any ED staff member can perform patient rounding.	O	O	O	O	O
Patient rounding will become a standard of quality of patient care.	O	O	O	O	O
Patient rounding is difficult to perform.	O	O	O	O	O

Patient rounding should be performed at least every hour by ED staff.	☐	☐	☐	☐	☐
Patient satisfaction will increase with patient rounding.	☐	☐	☐	☐	☐
Patient rounding is a valued intervention provided by ED staff.	☐	☐	☐	☐	☐
Patient rounding decreases dissatisfaction projected upon ED staff by patients.	☐	☐	☐	☐	☐
Increasing knowledge of patient rounding will increase ED staff performance of rounding.	☐	☐	☐	☐	☐

Posttest

Educating ED staff as to the importance of patient rounding

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree
Patient rounding is an avenue where patients and families receive updates regarding the plan of care.	☐	☐	☐	☐	☐
Patient rounding improves communication between emergency room staff and patients.	☐	☐	☐	☐	☐
Patients perceived needs are met through rounding.	☐	☐	☐	☐	☐

Patient rounding includes the 3 p's: pain, potty, position, and environment.	O	O	O	O	O
Staff is updated as to the patient's condition of care with patient rounding.	O	O	O	O	O
Patient safety is increased with patient rounding.	O	O	O	O	O
Any ED staff member can perform patient rounding.	O	O	O	O	O
Patient rounding will become a standard of quality of patient care.	O	O	O	O	O
Patient rounding is difficult to perform.	O	O	O	O	O
Patient rounding should be performed at least every hour by ED staff.	O	O	O	O	O
Patient satisfaction will increase with patient rounding.	O	O	O	O	O
Patient rounding is a valued intervention provided by ED staff.	O	O	O	O	O
Patient rounding decreases dissatisfaction projected upon ED staff by patients.	O	O	O	O	O
Increasing knowledge of patient rounding will increase ED staff performance of rounding.	O	O	O	O	O

APPENDIX B

DEMOGRAPHICS QUESTIONNAIRE

Demographics

	Less than 1 year	1-3 yrs	3-10 yrs	11-20 yrs	21+ yrs	Prefer Not to Answer
How many years have you worked in the emergency department	☐	☐	☐	☐	☐	☐
	Student	EMT I/II Tech	LPN	RN	Other _____	Prefer Not to Answer
What license/certification do you hold?	☐	☐	☐	☐	☐	
Do you have a comment you would like to share about this survey?						

APPENDIX C

INFORMATIONAL LETTER

Informational Letter

Title: Educating ED staff as to the importance of patient rounding

Principal Investigator: Sharon Lyons, RN, BSN

Co-investigator (Instructor): Christina Sieloff, PhD, RN, NE BC

INFORMATION LETTER**A. Introduction and Purpose**

You are being asked to participate in a research study conducted by a graduate student from Montana State University, College of Nursing. The purpose of this study is to examine whether or not ED staff will have increased knowledge regarding patient rounding after viewing an educational PowerPoint designed to educate participants regarding the importance of regular patient rounding in the ED.

B. Procedure

You will be asked to complete a questionnaire which has been distributed to the emergency department staff by the researcher. The estimated completion time for this questionnaire is 10-15 minutes.

C. Benefits

There is no direct benefit to you for participation in this study. The results from this study will provide information that may be used to help emergency department better understand factors which affect compliance or noncompliance with unit rounding and patient safety guidelines.

D. Risks

No risks or additional effects are likely to result from your participation in this study. In the unlikely event of harm arising from your participation, no reimbursement, compensation, or free medical treatment will be offered by Montana State University Bozeman, Benefis Health System, or the researcher.

E. Voluntary Participation/Withdrawal

Your participation in this study is voluntary and you are free to withdraw at any time. If you should choose to withdraw from the study you will in no way be compromised. Because you are not asked to sign this survey or for any other identifier, after your information has been returned to the researcher it will no longer be identifiable.

F. Costs

There are no costs involved in your participation in this study.

G. Compensation

There is no compensation being offered for your participation in this study.

H. Confidentiality

All information collected from the course of this study will be kept confidential to the extent permitted by law. All identification in the research records will be identifiable by unit only, and the completed questionnaires will be stored in a locked file cabinet that will be accessible only to the investigator and instructor. All results will be summarized and presented in aggregate; no individual study participant will be identifiable.

I. Questions

If you have any questions about the items on the questionnaire or the purpose of the study, please feel free to contact the investigators at your earliest convenience. Sharon Lyons or Dr. Sieloff can be contacted at 406-657-2614. If you would like information regarding your rights as a research participant, please feel free to contact Dr. Mark Quinn, chairman of Montana State University Internal Review Board at 406-994-4707.

J. Consent to participate in a research study

The return of your completed questionnaire is evidence of your willingness to participate in this study. You will not be asked to sign a separate “willingness to participate” document because of participant anonymity. Please retain this information letter in case you have any questions or would like additional information about this study.

APPENDIX D

INSTITUTIONAL REVIEW BOARD DOCUMENT

Institutional Review Board Document

MONTANA STATE UNIVERSITY
Request for Designation of Research as Exempt from the
Requirement of Institutional Review Board Review
 (7/01/09)

Include copies of PI's and Co-PI's "Completion Certificate(s)" as proof that all have received the education and instructions for researchers using human subjects. The preferred instruction and education is: Collaborative Institutional Training Initiative (CITI) <https://www.citiprogram.org/>

Beginning January 1, 2006, University policy requires that all protocols submitted from individuals NOT employed by or students of Montana State University be charged a \$500 review fee per application. Renewals for those proposals will be at no charge. Applications from private entities (i.e. projects not administered by MSU's Office of Sponsored Programs) will be charged the \$500 fee per application. Renewals for those proposals will also be at no charge.

THIS AREA IS FOR INSTITUTIONAL REVIEW BOARD USE ONLY. DO NOT WRITE IN THIS AREA.

Confirmation Date:

Application Number:

PLEASE TYPE. Submit one (1) copy of this application, along with one (1) copy of the subject consent form, one copy of grant contract proposal (if applicable) and all other relevant materials, to: Institutional Review Board Chair, Mark Quinn, Veterinary Molecular Biology, MSU, 960 Technology Blvd., Room 127, Bozeman, MT 59717. For information and assistance, call 994-6783. ***[To save paper, delete instructions prior to printing.]***

DATE:

I. INVESTIGATOR:

Name: Sharon Lyons

Department/**Complete** Address: 1313 3rd Ave NW, Great Falls, MT 59404

Telephone: (406) 952-4974

E-Mail Address: Lyoshar@aol.com

DATE TRAINING COMPLETED: 12/12/08 *[Required training: CITI*

training; see website for link] Name of Faculty Sponsor: Christina Sieloff, Ph.D, R.N., Associate Professor, College of Nursing (if above is a student)

Signature _____

II. TITLE OF RESEARCH PROJECT: This study will assess whether staff education about the importance of patient rounding will increase staff commitment to perform regular patient rounding in the Emergency Department. Regular patient rounding is important as it increases patients' perceived quality of care, patient safety, and patient satisfaction.

III. BRIEF DESCRIPTION OF RESEARCH METHODS (also see section VII): This project will be an educational project provided to emergency department staff at their regular staff meeting with pre-test questions and post-test questions given to emergency department participants. The education will consist of a power point presentation intended to educate the staff about patient rounding. There will be no procedures performed. Since the presentation will occur at a regular staff meeting so there will be no additional time requirement for the ED staff.

IV. RISKS AND INCONVENIENCES TO SUBJECTS (also see section VII): There will be no procedures performed. Since the presentation will occur at a regular staff meeting so there will be no additional time requirement for the ED staff. There will be neither risks nor inconveniences to the staff.

V. SUBJECTS:

A. Expected numbers of subjects: _25-50_

B. Will research involve minors (age <18 years)? No
(If 'Yes', please specify and justify.)

C. Will research involve prisoners? No

D. Will research involve any specific ethnic, racial, religious, etc. groups of people?
(If 'Yes', please specify and justify.) No

E. Will a consent form be used? (Please provide a copy.) No

VI. FOR RESEARCH INVOLVING SURVEYS OR QUESTIONNAIRES:

A. Is information being collected about:

Sexual behavior?	No
Criminal behavior?	No
Alcohol or substance abuse?	No
Matters affecting employment?	No
Matters relating to civil litigation?	No

- B. Will the information obtained be completely anonymous, with no identifying information linked to the responding subjects? Yes. The pretest and posttest survey will be provided on one double-sided paper. Pencils to fill out the survey will be provided. The surveys will not contain any demographic information. The surveys will be returned to a box, which will be handled by the investigator only.
- C. If identifying information will be linked to the responding subjects, how will the subjects be identified? (Please circle or bold your answers)
- | | |
|----------------------------------|----|
| By name | No |
| By code | No |
| By other identifying information | No |
- D. Does this survey utilize a standardized and/or validated survey tool/questionnaire? No
A copy of the survey is attached

VII. FOR RESEARCH BEING CONDUCTED IN A CLASSROOM SETTING:

- A. Will research involve blood draws? (If Yes, please follow protocol listed in the "Guidelines for Describing Risks: blood, etc.", section I-VI.) No blood draws will be collected

VIII. FOR RESEARCH INVOLVING PATIENT INFORMATION, MATERIALS, BLOOD OR TISSUE SPECIMENS RECEIVED FROM OTHER INSTITUTIONS:
No patient information, materials, blood or tissues will be utilized.

- A. Are these materials linked in any way to the patient (code, identifier, or other link to patient identity)? Not applicable
- B. Are you involved in the design of the study for which the materials are being collected? Not applicable
- C. Will your name appear on publications resulting from this research? Not applicable
- D. Where are the subjects from whom this material is being collected? Not applicable
- E. Has an IRB at the institution releasing this material reviewed the proposed project? (If "Yes", please provide documentation.) Not applicable

F. Regarding the above materials or data, will you be:

Collecting them	Not applicable
Receiving them	Not applicable
Sending them	Not applicable

G. Do the materials already exist? Not applicable

H. Are the materials being collected for the purpose of this study? Not applicable

I. Do the materials come from subjects who are:

Minors	Not applicable
Prisoners	Not applicable
Pregnant women	Not applicable

J. Does this material originate from a patient population that, for religious or other reasons, would prohibit its use in biomedical research? Not applicable

IX. FOR RESEARCH INVOLVING MEDICAL AND/OR INSURANCE RECORDS

A. Does this research involve the use of:

Medical, psychiatric and/or psychological records No

Health insurance records No

Any other records containing information regarding personal health and illness No

If you answered "Yes" to any of the items in this section, you must complete the HIPAA Worksheet.

APPENDIX E

EDUCATIONAL POWERPOINT® PRESENTATION

Patient Rounding Is it Really Important?

Sharon Lyons, RN, FNP Student Montana State University

1

Introduction

- Increasing amounts of physicians are navigating toward specialty practice. Fewer are entering private practice.
- Fewer primary care physicians available to care for patients.
- Increasing amounts of patients utilizing Emergency Departments.

➤ (Press Ganey 2009)

2

ED Focus

- Patient safety
- Patient satisfaction
- Patient treatment rates – how long it takes to treat the patient's illness from door to disposition.



Emergency

3

Issues challenging the ED

- Increased number of patients
- Crowded waiting rooms
- Increased wait times for initial medical screenings
- Increased patient to nurse ratios.
- Decreased patient perception of quality of care
- Decreased patient satisfaction



➤ (Press Ganey, 2009, Grumbach, Keane, & Bindman 1993)

4

Perceptions?

- It is not the actual wait time that decreases patient perception of quality of care and satisfaction, but the mere perception of wait times.

➤ Thompson, Yarnold, Williams, & Adams (1996)

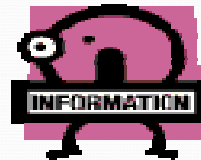


5

Solution?

- Information!!
- Providing information regarding wait times might be an effective strategy to increase patient satisfaction.

Thompson, Yarnold, Williams, & Adams (1996)



6

Problem

- Patient complaints in the ED center around lack of communication between staff, patient and the patient's family
- Agarwal, Sands, & Schneider (2010) report a five hundred-bed hospital loses over four million dollars annually as a result of communication inefficiencies



7

Communication

- Communication plays a major role in determining the quality of the workplace environment. More importantly, quality of care and patient safety are also affected by communication. Poor communication leads to medical errors as well as a negative patient experience. Patient experience is a quality indicator that assesses how attentive the nurse is to the patient's needs during their stay (Agarwal et al. 2010).

8

Satisfaction

- Patient satisfaction levels are indicative of perceptions of the quality of care received in addition to nurse and patient interactions
- Historically, ED's receive the some of the lowest patient satisfaction scores compared to the other departments in the hospital
- The largest number of patient complaints in the ED center on patient treatment and communication

9

Satisfaction

- Patients are more satisfied with the hospital stay when they feel help is available to respond to needs in a timely manner as well as to answer questions regarding care (Woodard, 2009).

10

Uncertainty

- Emergency departments are accordingly increasingly busy. The harried, often chaotic, nature of the emergency room may be intimidating to the patient. A typical ED patient thrust into the ED environment with a sudden, possibly traumatic, illness often feels helpless.
- The patient may feel that they have no say or control over the interventions or care placed upon them.
- Good communication between the ED staff and the patient may help to alleviate some of these feelings

• Williams, 2001

11

Uncertainty

- A patient lying on an ED cot feels a great sense of uncertainty as to:
 - ❖ the diagnosis
 - ❖ whether basic needs will be met including:
 - Pain control
 - Being able to get up to the bathroom
 - Having a comfortable position in bed
 - Having a comfortable environment in the room

• Woodard, 2009



12

Solution

- ED staff
 - ❖ Key role in determining patient satisfaction
 - ❖ Center of the patient's ED experience
 - ❖ If staff provide timely attention in addition to meeting the patient's perceived expectations of care, patients are more satisfied (Meade, 2007).
 - ❖ Some aspects of care, which increase patient satisfaction, include compassion, kindness, humor, reassurance, anticipation of patient needs, and physical presence of the nurse in the patient's room (Meade, Bursell, & Ketelsen, 2006).

13

Solution

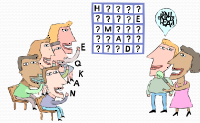
- Rounding is a forum to communicate to the patient and family about the plan of care and any wait times included in the plan.
- Regular patient rounding creates an avenue in which the perceived needs of the patient are met in a timely manner.
- Staff will round on the patient at least every hour to ensure that needs are being met, and that questions are being addressed.

➤ Meade et al., 2008

14

Solution

- Good communication skills are imperative in the emergency room setting. In an environment that requires one to be reactive and responsive, clients often perceive nurses to be too busy or too hurried. The manner in which a nurse enters the client's room sets the tone for the entire encounter. (Williams, 2001)



15

Patient Rounding in General

- Not a new concept.
- “Rounding is considered “ ‘nursing 101’, representing good basic nursing care. (. . .) making hourly rounds can be viewed as a bundle of interventions that promote not only comfort but safety of both patients and staff” (Halm, 2009, p. 582).

16

Patient Rounding in General

- Excellent avenue to improve communication between staff and patients
- Fosters a positive patient experience
- Addresses basic patient needs



17

General Patient Rounding

- Incorporates multiple nursing interventions into one action
 - ❖ Managing pain
 - ❖ Ensures patient comfort
 - ❖ Ensures patient safety
 - ❖ Identifies potential risks
 - ❖ Fall prevention
 - ❖ Communication

18

General Patient Rounding

- When do we round?
 - ❖ Every hour if the patient is awake
 - ❖ Every two hours during the night



19

Timing

- One-hour rounding is defined as rounds being performed once an hour between six a.m. and ten p.m. and once every two hours between ten p.m. and six a.m.
- Two-hour rounding is defined as rounds being performed once every two hours during the entire 24-hour period. (Meade et.al., 2006)
- Patient rounding was reduced at night to every two hours as long as the patient was awake. If sleeping, the patient was not wakened by staff just to perform rounding (Bourgault et al., 2008)

20

Who Rounds

- Anyone!
 - ❖ Charge nurses
 - ❖ Staff nurses
 - ❖ Nursing aides
 - ❖ Patient care assistants
 - ❖ Dietary
 - ❖ X-ray technicians
 - ❖ Housekeeping
 - ❖ Managers
 - ❖ Any hospital associate who enters the room

21

Components of Rounding

- Five main components
 - ❖ Introduction of the staff caring for the patient
 - ❖ The 3 p's
 - Pain
 - Positioning
 - Potty
 - ❖ Environment

❖ Bourgault et al., (2008), "Hourly Rounding Improves" (2007), and Woodard (2009)

22

Introduction

- At start of the shift
- At first contact with the patient
- Includes
 - ❖ Name of the staff member
 - ❖ Credentials of the staff member
 - ❖ Names written on a white board in the patient room
 - ❖ Credentials written on a white board in the patient room



23

Introduction

- Bourgault et al. (2008) cite an example of this in the following script: “Hello, Mrs. D., my name is Ramone. I’m the nurse who will be looking after you today (. . .) I am here to round on you.”
- The patient room should include a white board where the staff would then write the names of the those caring for the patient as well as their credentials.

24

Pain

- Requires use of pain assessment scale
- Intervene if needed
 - ❖ Pain medications
 - ❖ Non pharmacological
 - Ice
 - Warm blankets
 - Repositioning



25

Positioning

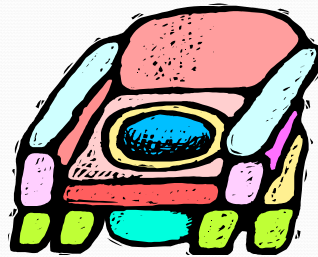
- Inquire if the patient is comfortable in bed.
- Does the pt require turning to one side or the other?
- Does the head of the bed need to be raised or lowered?
- Putting the head of the bed up or down may relieve uncomfortable pressure points (Woodard, 2009)



26

Potty

- Inquire if the patient requires the bathroom
- Assist the patient to the bathroom, bedside commode or bedpan.



27

Environment

- Perform a quick assessment of the patient room
- Ensure all of the equipment is within reach of the patient
 - ❖ Call light
 - ❖ Television remote
 - ❖ Bed controls
 - ❖ Bedside table
 - ❖ Water
 - ❖ Tissue
 - ❖ Garbage can



28

Concluding the Interaction

- Inform the patient the staff will be in the patient's room at least every hour.
- Following script can be utilized
 - ❖ "Is there anything else I can do for you while I'm in the room? I have the time." Bourgault et al. (2008)

29

The ED

- Changes on the horizon
- New 2009 healthcare policy may increase usage of the ED.
- Previously uninsured will now be insured without primary care MD's
- Patients may therefore utilize the ED for primary care
- Reimbursement to be based on patient satisfaction.

30

Why Round in the ED

- Patient rounding provides a means of communication between staff and patients. This is a forum where the patient can be informed of wait times, as well as an avenue for the staff to meet the patient's basic needs.

31

Rounding in the ED

- Meade et al. (2008) found the following regarding the implementation of rounding:
 - ❖ Patients were better informed and updated about their care; patients saw a staff member regularly, rounding reduced patient anxiety; patient needs were met, patient conditions were monitored, there was less use of call lights; (. . .) patients did not feel they were overlooked or neglected; and they better understood delays. (p. 6)

32

ED Timing of Rounding



- Can be every 30 minutes or every hour.
 - ❖ Meade et al. (2008), reducing the timing from every one hour to every thirty minutes is based upon the three plus theory. This states that a message, delivered fewer than three times, is delivered ineffectively.
 - ❖ Therefore, the thirty-minute rounding was effective for ED's that had a turnaround, or discharge, of patients within one hundred and fifty minutes or less, the average stay of the majority of ED patients. Otherwise, one hour rounding was considered more effective.

33

ED Timing of Rounding

- The ED has unique staffing levels
- Different shifts start at different times around the clock
 - ❖ 7am-7pm
 - ❖ 11 am-11 pm
 - ❖ Noon to midnight
 - ❖ 1pm to 1 am
 - ❖ 3 pm to 3 am
 - ❖ 7pm to 7am

34

ED Timing of Rounding

- Nursing may round on the hour.
- Technicians round on the half hour
- Creates team environment
- Allows for the patient to interact with staff every 30 minutes



35

Who Rounds in the ED

- Anyone!
 - ❖ Charge nurses
 - ❖ Staff nurses
 - ❖ Paramedics
 - ❖ Patient care assistants
 - ❖ X-ray technicians
 - ❖ Housekeeping
 - ❖ Managers
 - ❖ Any hospital associate who enters the room

36

Effects of Patient Rounding

- Increases patient's perception of obtaining help when needed
- Leads to better communication between staff, patient, and family
- Simple
- Cost effective
- Improves patient perception of quality of care in the ED
- Decreased the number of angry patients
 - (Woodard, 2009), (Bourgault et al., 2008), (Powell, 2007)

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Effects of Patient Rounding

- Increased staff satisfaction
 - ❖ Reducing the number of call lights
 - ❖ Allows more time perform other tasks because less time spent in answering call lights
 - ❖ Meade et al. (2008) reported rounding "relieved a lot of stress on the nurses because the patients were not [calling them into the room as often]." This is because the patient's concerns and needs were addressed during patient rounding and, therefore, the patient did not have to use the call light as much.
 - ❖ Reduced the number of families going to the nurses station for questions

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Effects of Patient Rounding

- Meade et al. (2006) found
 - ❖ Reduction in call lights by 37%
 - ❖ Decreased pain medication calls by 35%
 - ❖ Reduced bathroom assistance requests by 40%
 - ❖ Decreased re-positioning requests by 29%
 - ❖ Reduced IV pump alarms by 40%
 - ❖ Reduced rate of falls by 50%
 - ❖ Improved patient satisfaction by 12%
 - ❖ Saved nursing staff a weekly average of 326 hours
 - ❖ Reduced hospital costs by \$143,546 on average.

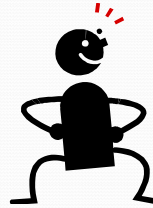


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Conclusion

Pt Rounding is Important

- Increases communication between staff the patients
- Increases patient perception of quality of care
- Increases patient satisfaction
- Increases hospital revenue
- Increases staff satisfaction
- It easy to perform
- Becoming a standard of care



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- So.... Lets go round.



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Questions?



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References

- List of references provided upon request.

