Nurses Improve Patient Satisfaction through Hourly Rounding

Introduction

Routine patient rounding, once considered a standard of care in the nursing profession, has recently re-emerged with a new twist. As described in the 2006 research article by Meade et al., hourly patient rounding has been associated with increased patient satisfaction, decreased patient falls and decreased call light usage when performed in a standardized and consistent manner (Meade et al., 2006).

Patients expect their nurses to have the knowledge and technological skills necessary to perform their jobs, but often rank satisfaction based on their perception of nurses’ caring (Davis, 2005). Furthermore, hospital satisfaction is frequently correlated with patient perceptions of nursing care (Davis, 2006; Godkin et al., 2002; Gonzalez-Valentin et al., 2005). Themes equated to quality nursing care include good communication, kindness, responding readily to patient needs, and making time for patients (Davis, 2005; Fagerstrom et al., 1999; Godkin et al., 2002; Kralik et al., 1997). Other factors related to increased patient satisfaction include timely answering of call lights (Deitrick et al., 2006) and adequate pain management (Sterman, Gauker, & Krieger, 2003).

Regular patient rounding creates a forum where basic patient care needs are met through a proactive nursing intervention. Although different models of rounding are being performed in inpatient settings, common elements include regular one to two hourly patient rounding, with attention to pain management, toileting, repositioning, and environmental assessment (Castledine, 2002; Meade et al., 2006). Nursing care may be perceived more positively when basic patient needs are anticipated and addressed each hour. This heightened perception of nursing care may translate into increased patient satisfaction with the overall hospitalization experience.

In addition to improved patient satisfaction, a decrease in patient falls were found when rounding occurred each hour, compared to every two hours (Meade et al., 2006). Fall assessment scales typically include alteration in ambulation as a fall risk, suggesting that routine offers of
toileting assistance during rounding may reduce the incidence of patient falls (Morse, 1997; Poe, Cvach, Dawson, Straus, & Hill, 2007; Robey-Williams et al., 2007). In addition, fall risk may be further reduced by regular assessment and intervention of the immediate patient environment (Morse, 2002).

**Methods**

The three campuses of Saint Joseph Regional Medical Center: South Bend, Plymouth, and Mishawaka, IN were introduced to the concept of hourly rounding by the consulting firm Studer Group Inc. Studer Group coaches emphasized that hourly patient rounding should use consistent, scripted language to assess the “Three P’s” and the environment, rather than just entering the patient room to perform routine tasks. In addition to the assessment portion of the rounding intervention, the nursing associate should convey a friendly attitude through the use of positive verbal and body language.

Hourly rounding was initiated on all inpatient units, including the intensive care units in June 2006. The methodology and results discussed within this article are specific to the South Bend, IN campus. The medical-surgical units described include medical-renal, oncology, orthopedics, neurology, general surgery, progressive care, intermediate care, and a medical-surgical intensive care unit. The population at this institution is primarily a combination of Caucasian, African American, and Hispanic patients. Staffing patterns remained unchanged and there were no extra financial costs associated with this initiative.

The primary responsibility for hourly rounding was assumed by nurses and non-licensed clinical support staff, although all associates who enter patient rooms, such as housekeeping and dietary, were trained and expected to assist as required. Clinical associates performed rounding on all patients each hour between 0600 and 2200. Rounding was reduced to every two hours during the night to promote sleep. Patients were not woken up between the hours of 2200-0600, but rounding was performed if patients wakened. A number of units adopted a process where clinical support staff would round on odd hours and nurses would round on even hours.
Our nursing leadership received coaching on hourly rounding by the Studer Group and used a train the trainer model on the nursing units. Training of associates was completed primarily through education at unit-based staff meetings. Methods of education included face-to-face presentations, poster presentations, and online learning modules for all clinical associates. Education included scripting dialogue, expectations of the process, and documentation. Associates in non-clinical departments received information provided by their supervisors, in addition to an article in the hospital newsletter.

Hourly rounding included four basic components: An introduction of the associate to the patient, assessment of the three P’s, an environmental assessment, and conclusion. (See Table 1). Scripting of key concepts was encouraged to hardwire both the language and the process for associates and patients. The introduction included the name, credentials and years of experience of the nursing associate, “Hello Mrs. D., My name is Ramone. I am the nurse who will be looking after you today. I have been a registered nurse for over three years. I am here to round on you.” The associate would then write their name, along with the date and time of their shift, on a white board within view of the patient. Assessment of the three P’s included inquiring if the patient required assistance with pain management, potty, and repositioning. The environmental assessment included ensuring that commonly used equipment was within easy reach of the patient. These commonly used items included water, tissues, telephone, nurse call system, remote control (television, radio, bed), and garbage container. In concluding the rounding interaction, the associate informed the patient that someone would be in to round on them again in another hour. One final scripted message was delivered prior to leaving the patient’s room, “Is there anything else I can do for you while I am in the room? I have the time” (Studer, 2004).
A rounding log was utilized to track this new process. The associate performing the rounding was expected to complete a rounding log to capture timing of the rounding, and any applicable comments, such as analgesia administered, or patient sleeping. Each 24 hour rounding log was returned to the unit’s nursing leader for review.

Patient satisfaction scores were calculated monthly using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®), a standardized survey tool used by hospitals across the nation to capture patients’ perceptions of hospital care. This survey tool, endorsed by the National Quality Forum (NQF), also allows for comparison of data between hospitals and is available in English, Spanish and Chinese. The HCAHPS® contains a core set of 27 questions with seven sub-sections including: care from nurses, care from doctors, the hospital environment, your experiences in this hospital, when you left the hospital, overall rating of hospital and demographic questions (Services, 2007) and has been assessed for reliability and contrast validity (Keller et al., 2005).

The self-administered HCAHPS® survey was mailed to inpatients who met diagnosis-related group (DRG) criteria following discharge from the hospital. Patients completed this survey by pen and paper and returned it to the hospital’s survey vendor in a self-addressed, stamped envelope. For the purpose of patient satisfaction, we focused on the following HCAHPS® survey questions: overall rating of care, would you recommend, got help as soon as wanted, help going to the bathroom as soon as wanted, and did everything to help your pain.
Data on patient falls was entered into a computerized reporting system by individual units and gathered retrospectively. We chose to evaluate fall rates, the measure of patient falls divided by 1000 patient days, for the purpose of our analysis.

**Results**

The endpoints evaluated following implementation of hourly rounding were five patient satisfaction scores from the HCAHPS® survey and patient fall rates. We divided the scores into two groups, one group with 5 months pre-hourly rounding and another with 7 months post-hourly rounding in the year 2006. We did not have access to the raw data from the HCAHPS® measures.

The Shapiro-Wilk normality test of the total score indicated that the normality assumption was not violated for any of the following results; therefore the independent two-sample t-test was used to compare the scores for two independent groups (pre- and post-hourly rounding). All statistical significance was assessed using an alpha level of 0.05. Statistical analysis was performed using the software program SAS 9.13.

All five patient satisfaction scores showed improvement following hourly rounding. (See Table 2). The satisfaction score for “would you recommend” showed a statistically significant difference between the mean total score pre- and post-hourly rounding ($t=-2.42$, $p$-value=0.0364). The post-hourly rounding group had a higher mean score (70.14) than the pre rounding group (65.24). (See Figure 1).

The satisfaction score for “overall rating of care” showed a statistically significant difference between the mean total score pre- and post-hourly rounding ($t=-2.67$, $p$-value=0.0479). The post-hourly rounding group had a statistically significantly higher mean score (66.87) than the pre rounding group (59.95). (See Figure 2).
The satisfaction score for “got help as soon as wanted” showed a statistically significant difference between the mean total score for pre- and post-hourly rounding (t=-3.20, p-value=0.0095). The post-hourly rounding group had a statistically significantly higher mean score (56.55) than the pre-rounding group (48.76). (See Figure 3).

The mean satisfaction score for “help going to the bathroom as soon as wanted”, although slightly higher post-hourly rounding (58.68), compared to pre-hourly rounding (56.85) was not statistically significant (t=-0.48, p-value=0.6402). In addition, the mean satisfaction score for “did everything to help your pain”, although slightly higher post-hourly rounding (75.64), compared to pre-hourly rounding (73.12) was not statistically significant (t=-1.44, p-value=0.1804).

The post-hourly rounding group for fall rate had a slightly higher mean score (3.35) than the pre-hourly rounding group (2.89). However, there was no statistically significant difference between the mean total scores of two rounding groups (t=-1.14, p-value=0.2806).

**Discussion**

Following implementation of hourly rounding, all five of the HCAHPS® scores related to patient satisfaction showed an increased trend. Improvement in three of the five HCAHPS® scores, “would you recommend”, “overall rating of care”, and “got help as soon as wanted” were statistically significant. Though we used a seven month period following implementation of rounding for statistical comparison, all five of our patient satisfaction scores continued to show an upward trend at the time of writing this article, 16 months following the implementation of hourly rounding.
Despite the decrease in total number of patient falls with hourly rounding in the Meade study, our fall rate and total number of falls did not decrease following implementation of hourly rounding. In an effort to improve fall rates, devices such as chair and bed exit alarms were purchased and further education was performed on restraint and non-restraint devices. Nurses were encouraged to review monthly fall rates and fall prevention audits, and additionally, nurse champions for fall prevention were trained for each unit. Fortunately, at the time of writing, a decreasing trend in patient falls with injury had been observed and the fall prevention program remains an active focus of the organization.

We were unable to compare call light usage, as we did not collect baseline call light data. Anecdotally, some associates, including a unit secretary, reported that it was much quieter at the desk following implementation of hourly rounding. It was the perception of the clinical associates that call light usage had decreased.

Support from nursing leadership was key to the success of hourly rounding at our institution. Nurse leaders on the units provided ongoing reminders to the clinical associates, including tips for successful scripting during rounding. In an effort to support continued hourly rounding on the inpatient units, an hourly rounding video was later produced that would be viewed by all associates and also used for clinical orientation of new associates. The hourly rounding videotape captured fundamental components of the rounding process, providing examples of scripting and modeling the expected behavior by clinical associates. It is essential that associates use body language that is congruent with the scripted language. In addition, it is important that patients perceive positive nursing care for patient satisfaction to be impacted.
Although implementation of hourly rounding was relatively uncomplicated, clinical associates expressed some initial apprehension. Concerns included the value of rounding, since nurses considered it part of their usual practice to be in the patient’s room each hour, in addition to the scripted language “Is there anything else I can do while I am in the room? I have the time”. To address these reservations it was important for nursing leadership to help the nurses understand that rounding is about more than just entering the patient room to perform task related duties. They reinforced the need for scripted language, to ensure that care needs, such as assistance with pain control, repositioning and toileting would be addressed consistently. Once hourly rounding was underway, nurses voiced their surprise that patients did not abuse their offers of having time to perform other duties while still in the room. Once the basic patient care needs were met, any additional patient requests were usually minor. One nurse stated that she felt hourly rounding “saved her career”. In addition to performing excellent patient care, she was now able to clearly communicate these standards to her patients.

Once the practice of hourly rounding was hardwired as a routine intervention, the process of completing rounding logs became optional on some of the units. Hardwiring is defined as repetition of language or process to ingrain tools or systems into an organization (Studer, 2004). Hardwiring of the rounding terminology proved valuable when we later initiated patient rounding by nursing leaders. Patients were familiar with the term “rounding” and could respond appropriately when asked if they were being rounded on regularly by the nursing associates.

Hourly rounding has become a routine and valued standard of customer service for the inpatient units in our organization. This evidence-based practice is viewed positively by our patients, as demonstrated by the increased HCAHPS® patient satisfaction scores. Hourly rounding is a simple and cost effective intervention to improve patient perception of quality service in an inpatient setting.
References


Morse, J. M. (1997). Morse Fall Scale: Janice M. Morse, The Pennsylvania State University, School of Nursing, 201 Health and Human Development East, University Park, PA 16802-6508.


**Table 1. Summary of Hourly Rounding Process**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Hello Mrs. D., my name is Ramone. I am the nurse who will be looking after you today. I have been a registered nurse for over three years. I am here to round on you.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ramone writes his name on the white board in the patient’s room, along with the date and hours of his shift.</td>
<td></td>
</tr>
<tr>
<td>Assessment: The Three P’s</td>
<td>1. Pain: Are you having any pain? If yes, a further assessment is completed and the patient is offered analgesia.</td>
</tr>
<tr>
<td></td>
<td>2. Potty: Do you require any assistance to the restroom*? (*Insert bedpan, commode chair as appropriate)</td>
</tr>
<tr>
<td></td>
<td>3. Positioning: Can I assist you with repositioning?</td>
</tr>
<tr>
<td>Environmental Assessment</td>
<td>Ensure that that following items are within easy reach of the patient:</td>
</tr>
<tr>
<td></td>
<td>☐ Water</td>
</tr>
<tr>
<td></td>
<td>☐ Tissues</td>
</tr>
<tr>
<td></td>
<td>☐ Telephone</td>
</tr>
<tr>
<td></td>
<td>☐ Call system</td>
</tr>
<tr>
<td></td>
<td>☐ Remote control for television, radio, bed controls</td>
</tr>
<tr>
<td></td>
<td>☐ Garbage container</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Someone will be in to round on you every hour. Either Susan or I will be in next hour to round on you.</td>
</tr>
<tr>
<td></td>
<td>Is there anything else that I can do for you while I am in the room? I have the time.</td>
</tr>
</tbody>
</table>
Table 2. Mean Patient Satisfaction Scores Pre- and Post-Hourly Rounding

<table>
<thead>
<tr>
<th>Patient Satisfaction Measure</th>
<th>Pre-Hourly Rounding</th>
<th>Post-Hourly Rounding</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would You Recommend</td>
<td>65.24</td>
<td>70.14*</td>
<td>0.0364</td>
</tr>
<tr>
<td>Overall Rating of Care</td>
<td>59.95</td>
<td>66.87*</td>
<td>0.0479</td>
</tr>
<tr>
<td>Got Help as Soon as Wanted</td>
<td>48.76</td>
<td>56.55*</td>
<td>0.0095</td>
</tr>
<tr>
<td>Help Going to the Bathroom as Soon as Wanted</td>
<td>56.85</td>
<td>58.68</td>
<td>0.6402</td>
</tr>
<tr>
<td>Did Everything to Help Your Pain</td>
<td>73.12</td>
<td>75.64</td>
<td>0.1804</td>
</tr>
</tbody>
</table>

Mean patient satisfaction scores 2006. Time frame measured was 5 month period pre-hourly rounding and 7 month period post-hourly rounding.
*statistical significance p< 0.05.
Figure 3. Got Help As Soon As Wanted