Stop going in circles! Break the barriers to hourly rounding

By Leslee H. Shepard, EdD, MSN, RN, CMSRN

Hourly rounding, as the name implies, is the practice of nurses and unlicensed assistive personnel making scheduled visits to the rooms of hospitalized patients and performing specific nursing interventions every hour. The goal is to improve patient outcomes by addressing their needs in a proactive manner. The original concept was developed and introduced in 2005 and has since inundated the literature with reports of the benefits of hourly rounding on patient outcomes while saving valuable time for nurses who use it.1-3

Hourly rounding interventions typically performed include pain management; addressing elimination needs; offering nourishment; and ensuring applicable musculoskeletal needs are met, such as ambulation, range of motion, or proper positioning. Other tasks include, but aren’t limited to, a visual scan of the room to ensure there’s adequate lighting, the call bell and phone are within reach, medical equipment is properly functioning, and walk areas are free from clutter.

The primary purpose of hourly rounding is to improve patient outcomes by enhancing patient safety and patient satisfaction.2,4 An additional benefit of hourly rounding is improved time management. When patients understand that a healthcare provider will visit their room every hour, they’re less likely to request services between nursing rounds. Less interruption allows time for nurses to work more productively.

Despite the benefits of hourly rounding, compliance rates may be lower than expected. One study on hourly rounding reported that nurse managers made leadership rounds three times a week to ensure nurses were making the required patient rounds.4 The need to round on the roundsers gives reason to pause and speculate whether improved compliance rates are the result of personal behaviors being adapted to what’s expected when a person knows he or she is being watched.

Hitting the wall

Barriers to hourly rounding include buy-in, acuity levels, time management, and unexpected interruptions.

Buy-in

Nurses who don’t accept a new practice or don’t believe that a practice is worthwhile can be a barrier to successful rounding.5 Nurses who’ve been in practice for years may tell stories of how things “used to be.” Some may proudly report how they once took care of up to 16 patients, yet administered every medication on time, completed all head-to-toe assessments, changed wound dressings, admitted new patients, and completed the required documentation. And it was done all in an 8-hour shift! (Don’t forget this was done without one bathroom break or lunch.) These stories are hyperbole in most cases; nonetheless, the perception that these nurses have is that hourly rounding didn’t occur then and they got through their shift without untoward events, so why change?

Nurses with years of experience may show cynicism toward the idea of hourly rounding, and it’s these nurses who are socializing the new nurses to the role and can influence mindsets. It’s worthwhile to devote time and energy to help influential, experienced nurses on your unit understand and accept the concept of hourly rounding, which will motivate others to get on board. The
sooner you get buy-in from formal and informal nurse leaders on your unit, the sooner you make the process of hourly rounding a unit practice.

One potential strategy for gaining buy-in from seasoned nurses is to show the evidence of proven success. Provide staff members with reports of actual accounts of the benefits seen as a result of hourly rounding. The data can be generated from literature reviews of journal databases, but the most prevailing evidence is in-house data that the nurse can relate to first hand.

**Acuity levels**
Shifts in healthcare have led to a fundamental change in patient acuity on the average medical-surgical unit. Advanced technology and better community-based healthcare programs have allowed for fewer readmissions. A lack of insurance among many in the United States encourages patients to enter the unit “sicker” and leave “quicker.” As a result, when patients are admitted, they’re given a higher acuity level. Undoubtedly, sicker patients require more direct hands-on time and energy.

When a nurse on a typical medical-surgical unit is assigned to care for six or more patients with moderate to high care demands, organizing and prioritizing the plan of care becomes a barrier that interferes with hourly rounding. An important factor is to ensure a tool is used to adequately measure acuity levels, which will help appropriately distribute workloads.

**Time management**
Take a walk through the typical acute care facility and, in many cases, it’s obvious that the nursing units weren’t designed with the nurse in mind. Most have the nurses’ station strategically placed in the center of the unit. To the layperson, this makes perfect sense. However, ask the nurse who has an assignment with patient rooms located at the lower end of the unit or ask the patient who’s annoyed at listening to the I.V. pump alarms sounding for what seems like hours because the nurse is at the nurses’ station unable to hear the alarms. Without concerted efforts to plan daily nursing activities, nurses can lose valuable time maneuvering back and forth.

It goes without saying that time management is an essential skill required by nurses to be successful in any work setting. The amount of documenting that must be done continues to be a major time stealer for nurses. Increased technology has allowed for much of the charting to be done electronically; however, the perception of many nurses is that electronic charting has created more supplemental processes to manage. Time management is a complex strategy to master and, ironically, given the purpose of making hourly rounds, the key to managing time is to perfect the art of hourly rounding.

**Unexpected interruptions**
In some cases, all the planning in the world can’t prevent those pesky unexpected interruptions: the phone call from the irate physician, the lab with the wrong requisition sheet, the food trays that arrived with the wrong food choices, or more serious interruptions such as the patient who deteriorated without obvious cause, which could easily consume more than an hour of a nurse’s concentrated efforts.

The notion of team nursing (nursing staff members who care for a group of patients together) is one possible solution to reducing interruptions. There are a variety of team nursing models that can be implemented. Each model has a different variation of job roles to include RNs, LPNs, and certified nursing assistants (CNAs). All teams, despite their unique make-up, are led by the RN. Irrespective of the type of team nursing model used, the additional staff will help support compliance with hourly rounding. The added team members allow for alternating rounding schedules that enhance workflow by limiting interruptions. As the nurses perform activities that are within their scope of practice, such as medication administration, the CNA(s) can make patient rounds and vice versa.

The contributions of the CNA in hourly rounding are just as significant as those of the nurse. Basic care and comfort needs related to grooming, hygiene, nourishment, positioning, cleanliness of the room, and removal of safety hazards are important to the overall well-being of the patient. Moreover, patient satisfaction scores improve when
patients see that their basic care and comfort needs are adequately met.6

Stopping the cycle
Hourly rounding is undoubtedly advantageous to patient outcomes and overall satisfaction rates. Frontline direct care nurses have the ultimate power to facilitate such important shifts in practice. However, any one of the potential barriers alone could be a major deterrent to nurses complying with hourly rounding. The truth of the matter is that most nurses are faced with the combined list of barriers during each and every shift worked. With a typical nurse-patient ratio on a medical-surgical unit of 1:6 compounded by the aforementioned barriers, hourly rounding may not be the most popular idea despite the volumes of documented benefits.

Nurse leaders within facilities committed to hourly rounding should assess barriers faced by their nurses then take immediate steps to alleviate or modify them. The goal should be no more rounding on the rounders to ensure compliance. Make the commitment to change the culture. Otherwise, efforts may be counterproductive as nurses become resentful about the increasing work demands with the perception of inadequate resources and support. As with any implementation of new practice standards, comply with continuous evaluation and subsequent revisions. Identifying the modifiable barriers early is the key to your success. NM

REFERENCES

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Hourly Rounding: A Replication Study

Introduction

While the concept of hourly rounding is not new, it is undergoing resurgence in hospitals throughout the United States (US). During the mid twentieth century, it was common practice for nurses to round on their patients. As staffing shortages increased, rounding occurred less frequently. What is now new with hourly rounding is a protocol associated with rounding delineating certain actions that result in better patient outcomes (Meade, Bursell, & Ketelsen, 2006).

The medical–surgical Clinical Nurse Specialist (CNS) at a northeast hospital read an article on hourly rounding, knowing that issues in the article pertained to the hospital at which he was employed (Meade, Bursell, & Ketelsen, 2006). He examined the data on his units for fall rates, call light usage, and patient satisfaction and found it showed that the fall rate was between 1.73 and 3.37 per 1000 patient days. Call light usage gathered from the computerized data retrieval system showed between 2,237 and 4,223 individual uses of the call light within a 2-week period. Of these call lights, 57.75% were related to requests for the bathroom, pain control, personal needs, or comfort related issues like positioning; all measures addressed by hourly rounding. These numbers demonstrated that significant opportunities for improvement exist.

Post discharge patient satisfaction data showed that 25% of patients were not highly satisfied nor would they definitely recommend the hospital to others, which indicated significant opportunities for improvement. Because of these numbers, the medical surgical CNS convened a team to examine interventions to improve patient fall rates, call light usage, and patient satisfaction. The team consisted of the medical surgical CNS, a
geriatric CNS, two nurse managers, a nurse researcher, and a statistician. It was decided to replicate Meade et al’s (2006) rounding study.

**Purpose**

The purpose of this study was to determine the effect of hourly rounding on fall rates, call light usage, and patient satisfaction in an inpatient medical surgical population.

**Literature review**

A literature search of Medline and CINAHL found three studies on hourly rounds. Meade, Bursell, and Ketelsen (2006), using a quasi-experimental design and non-equivalent groups, studied 1 hour and 2 hour rounding for six weeks. They used a specific protocol for nurses and nurses’ aides to follow when they rounded. The protocol consisted of eight actions described in the methodology section of this study (see Table A). When patients were asleep, staff did not wake them but performed environmental checks only. Reasons for call light usage were documented by nurses on a call light log. These data were jointly analyzed by the researchers and placed into one of 26 categories which were found in the literature. The results found both hourly and every two hour rounding decreased the number of times that call lights were used and that it increased patient satisfaction. However, patient satisfaction was higher in the hourly rounding units than the every two hour rounding units. Falls decreased only when rounding was done hourly. Limitations of this study included non-equivalence between the control and the experimental units, because the units were not randomly assigned. Additionally, nurses from the experimental units may have performed some rounding behaviors when floated to the control units.
Culley (2008) replicated Meade et al’s study as a pilot on three units over eight weeks plus one month of baseline data. It is unclear if control units were used. Culley found that patient satisfaction increased and call light usage decreased on the three units. He did not examine patient falls.

A third study on hourly rounds was published as a brief (Assi, Wilson, Bodino, Bognar, & Lemesevskin, 2008). The design, sample size, protocol, and analysis were not discussed making it difficult to evaluate the study. The authors found a decrease in the patient fall rate, a significant reduction in call light usage, and a significant increase in patient satisfaction.

While there are only three studies on hourly rounding, there are many on interventions to prevent patient falls in the acute care setting. According to Krauss et al. (2005) falls among hospital patients are a persistent problem accounting for 70% of hospital accidents. In US hospitals, fall rates range from 2.3 to 7 falls for every 1000 patient care days. Many falls take place during unassisted elimination-related activities. Healy, Oliver, Milne, and Connelly (2008) stated that 25 percent of falls result from falling out of bed. Approximately 30 percent of these falls result in injury; 4 to 6 percent are serious. Injuries include fractures or death. Fractures in the elderly population, who are most at risk for falling, are significant (Hayes, 2004). Injuries related to falls can lead to an extended hospitalization and increased costs. According to Amador and Loera (2006) hospital charges in patients injured during falls are $4,200 higher than patients who do not fall.

A systematic review from the Joanna Briggs Institute (JBI), examined falls in acute care hospitals (Evans, Hodgkinson, Lambert, Wood, & Kowanko, 1998). The objective
of the review was to examine the effectiveness of fall interventions. Evans et al. reviewed 100 studies, two of which were randomized control trials and the rest quasi experimental. Interventions included alarm systems, identification bracelets, evaluation of fall incidence reports, and programs using multiple fall prevention strategies. They found that none of the interventions were effective in fall prevention. Hourly rounding was not reviewed in this 1998 review. This review demonstrates the need to continue searching for effective fall prevention interventions.

Oliver et al. (2006) completed a meta-analysis examining strategies to prevent falls in hospitals and care homes. Forty three studies were included in their analysis but only thirteen pertained to hospitalized patients. Of these, 5 were randomized and eight were prospective studies. Of the eight, the authors deemed all but one was poorly designed. Most of the studies used multiple fall prevention strategies but not hourly rounding. Unlike the JBI review, some showed statistical significance.

Coussement et al. (2008) also performed a meta-analysis examining strategies to prevent falls in hospitals and long-term care facilities. They analyzed eight studies and, like the authors from the JBI, found no fall prevention programs that reduced the number of falls. Lastly, Healy, Oliver, Milne, and Connelly (2008) systematically reviewed 24 studies on the effect of bedrails on falls and found that bedrails do not increase the risk of falls or injury from falls.

Call lights were also a variable in this study. Roszell, Jones, and Lynn (2008) state that the call light is a “fundamental communication tool that connects the nursing staff and their patients” (p.69). According to Meade, Bursell, and Ketelsen (2006), call lights can be a lifeline for patients. However, answering lights imposes considerable demands
on nurses’ time. Several studies have documented the unfavorable effects of frequent use of call lights on the effectiveness of patient-care management on inpatient units, which may already be compromised by staffing shortages (Meade, Bursell, & Ketelsen, 2006). In hospitalized patients, the use of call lights is often related to the need for assistance with basic self-care tasks, such as toileting, ambulating, and eating. Therefore, a patient’s level of satisfaction with nursing care may depend principally upon the patient’s perception of how well the nursing staff has been able to meet his or her needs (Deitrick, Bokovoy, Stern, & Panik, 2006; Roszell, Jones, & Lynn, 2008). According to Meade et al. (2006) when nursing personnel round hourly there is a decrease in the usage of call lights. There is also a decrease in patient falls and an increase in patient satisfaction.

**Materials and Methods**

The site for this quasi-experimental study was a 506 bed teaching hospital in the northeast United States. Approval from the Institutional Review Boards of both the hospital and the university associated with the study were obtained. Informed consent of research participants was waived by the IRB. No patient identifiers were used, only aggregate data.

On two adult medical-surgical units, data were collected for patient falls, patient satisfaction, and call light usage prior to the implementation of nursing rounds. One unit was the experimental unit and one the control. In addition, the experimental unit was also its own control, with data compared pre intervention and during the intervention. The units were selected based on their similar size, significant fall rates, and mix of post-operative and medical patients. The sample consisted of all patients discharged from the units during the 1 year study period (n= 4,418).
The number of falls and the level of patient satisfaction were collected 6 months pre-intervention and 6 months during the intervention using pre-existing occurrence reports and post discharge patient satisfaction surveys. Call light data were collected for 2 weeks pre study and 4 weeks during the intervention using the call light retrieval system. Reasons for call light usage were documented by nurses on the same call light log used by Meade et al. (2006).

Two weeks prior to implementation of nursing rounds, all Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and unlicensed assistive personnel (UAP) on the experimental unit attended an 1.5 hour education session by one of two CNS’s on performing hourly rounds. Medical-surgical float pool RNs and float pool unlicensed assistive personnel were also trained on nursing rounds during this time period.

Hourly rounds were performed from 6am to 10pm and included all eight actions (see Table A). After each round the staff completed the rounding log kept outside the door. From 10pm to 6am rounds occurred every two hours. If the patient was asleep, staff completed the environmental check only.

<table>
<thead>
<tr>
<th>Table A: Nurse Specific Actions During Hourly Rounding</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following items will be checked for each patient:</td>
</tr>
<tr>
<td>1. Nursing staff enter room, greet patient and say, “Hi, Mrs./Mr Jones, I am here to do my rounds to check on your comfort.</td>
</tr>
<tr>
<td>2. Pain assessment using a pain assessment scale (if staff other than RNs are doing the rounding and the patient is in pain, RNs will be contacted immediately by the person rounding, so the patient does not have to use the call light for pain medication)</td>
</tr>
<tr>
<td>3. An hour prior to a pain medication is due the patient will be asked is s/he is starting to feel pain. If the answer is “yes” then the next hour the RN will schedule giving the pain medication</td>
</tr>
<tr>
<td>4. Toileting assistance will be offered</td>
</tr>
<tr>
<td>5. A patient positioning and comfort assessment will occur, including if the patient is covered and if he/she looks comfortable</td>
</tr>
<tr>
<td>6. Environmental check</td>
</tr>
<tr>
<td>- A check for the call light being within reach</td>
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<tr>
<td>- A check for the telephone being within reach</td>
</tr>
<tr>
<td>- A check for the TV control and bed light switch being within reach</td>
</tr>
<tr>
<td>- A check for the bedside table being next to bed</td>
</tr>
</tbody>
</table>
- A check for the tissue box and water being within reach
7. Prior to leaving the room, each staff member must ask: “Is there anything I can do for you before I leave, I have time to do it?”
8. Staff will also tell the patient when they will be back in the room (i.e., in one hour) to round on them again.

The Nurse Managers (NM) and CNS’s routinely completed leadership rounds three times a week on the experimental unit to ensure that staff were completing hourly rounds. During these rounds they spoke with each patient to determine if rounding occurred, reviewed rounding logs, and reminded staff to round. Rounding was also addressed in every staff meeting. If staff were not performing rounds the NM or CNS, with the staff, worked on removing barriers to help them be more successful. Four months after the start of hourly rounding all staff on the experimental unit attended a one hour refresher course, taught by one of the Clinical Nurse Specialists. This class reinforced rounding behaviors and gave staff feedback on the rounding process.

**Data Analysis/Results**

*Data analysis*

Three variables were analyzed: patient falls, call light usage, and patient satisfaction. Rate ratios comparing pre-intervention to intervention fall rates and call rates were calculated for the control and experimental units. Data were entered into SPSS version 14.0. Measures of central tendency and spread were calculated for all variables. Chi-square tests and rank sum tests were used to compare baseline and post-intervention demographic characteristics and reasons for call light usage between the experimental and control units.

*Results*
The fall rate on the experimental unit was 3.37/1000 patient days pre-study. The rate decreased to 2.6/1000 patient days or a reduction of 0.77 falls per patient day. While this was not statistically significant, the 23% reduction in falls was clinically significant. The fall rate on the control unit increased during the intervention time period.

A statistically significant lowering of call lights was shown during the first week of the intervention. However the next 2 weeks showed a statistically significant rise in patient call lights due to one delirious patient, who will be discussed under limitations. The final week of call light data showed no statistical change. The small sample size used in this study made it hard to validate a statistically significant change.

The change in the proportion of patients who indicated they were satisfied with their care on each unit before and after the intervention were also calculated and compared. There were no statistical differences in patient satisfaction in the pre-rounding and post-rounding groups. These data were garnered from post discharge patient surveys. While rounding did not affect the patient satisfaction on the discharge surveys, anecdotal evidence from the leadership rounds showed increased patient satisfaction.

**Discussion**

This study supports that hourly rounding by nursing personnel positively impacts the three variables studied: patient fall rates, call light usage, and patient satisfaction. Although not statistically significant, patient fall rates decreased 23% on the experimental unit. Second, this intervention has the ability to impact call light usage, and perhaps would have showed significance had our sample size been larger. We would recommend evaluating call lights over a longer period of time than was completed during this study. Third, satisfaction scores also have the potential for showing long term positive gains.
based upon our feedback from patients during leadership rounds. Patients who had frequent admissions to the unit noted that they could “feel” the difference after we implemented hourly rounds. They felt like the nursing staff was more attentive. Although statistical changes were not made in call light usage or patient satisfaction during the study, we feel this change will come with persistent re-enforcement of actions necessary in hourly and data collection. In future research a qualitative piece could be added that collects comments from patients during leadership rounds.

**Lessons Learned**

Many lessons were learned during this study. These include the need for staff champions, the necessity of sharing results with staff in a timely manner, and making sure that all staff were trained in rounding procedures. Staff were supportive of the idea of hourly rounding; however unit staff champions were not enlisted. The nurse manager and two CNS’s were the champions for this initiative. Of the two CNS’s, neither were based primarily on the experimental unit and had many other units and responsibilities to cover. Second, the temporary transfer of the nurse manager to another unit halfway through the implementation phase also hindered the success. The nurse manager was a major component driving this initiative and when she left a driving force was removed from the unit. Without constant support from a champion on all three shifts it was difficult to hardwire this change. We would recommend that staff champions from each shift be incorporated into the hourly rounding process from inception to and through maintenance.

In addition, sharing results and following up with the staff is especially important.
allow us to track data weekly throughout the study. Not having immediate weekly feedback on the rounding effects was detrimental in keeping staff interested in rounding. Likewise, it was not possible to receive timely reports on falls. Reports were not shared with staff until almost four months into the rounding process. To make rounds successful it is essential to have the data available in a readable form with results explained to staff on a weekly basis.

Third, staffing was low during the study. Many nurses, not in the float pool but from other units, were floated to the experimental unit. These staff members were not trained on how to follow the rounding protocol and why rounding is important. Therefore, many of these staff members did not perform rounding. Hourly rounding is effective when the patient trusts that a staff member will return. Patients who do not trust that this will happen were more apt to use the call light. With a large number of nurses floated from other units, this trust was broken many times. Floating of nurses to a rounding unit should be limited as much as possible or all staff in the hospital should be educated in the hourly rounding protocol.

**Limitations**

The major limitations of this study were a non-randomized sample and the small sample size. Replication of the study with a larger sample is needed. Because the sample was small, an outlier impacted the study perhaps to a greater degree than if there was a larger sample. The outlier, a delirious patient, used the call light 187 times in a six day period. He did not need a nurse but, in his delirium, kept ringing the light. This significantly biased our call light data for the second and third weeks of the intervention. If the data from this patient was eliminated from the study, a significant change in call
lights the second week and a lower than average number of call lights the third week would have been seen.

**Conclusion**

This study was initiated before the Centers for Medicare and Medicaid Services - Pay for Performance initiatives (P4P), one of which is no reimbursement for falls occurring during the hospital stay (CDC, 2009). While upper management was interested from the beginning, they became more interested once the P4P initiatives were announced. Hourly rounding is important for achieving better patient outcomes. This study has added to the body of knowledge demonstrating its importance.
Reference


Hourly Rounding
Challenges With Implementation of an Evidence-Based Process

Lynn M. Deitrick, PhD, RN; Kathy Baker, MPH, RN; Hannah Paxton, MPH, RN; Michelle Flores, BSN, RN; Deborah Swavely, MSN, RN

Introduction of an evidence-based practice change, such as hourly rounding, can be difficult in the hospital setting. This study used ethnographic methods to examine problems with the implementation of hourly rounding on 2 similar inpatient units at our hospital. Results indicate that careful planning, communication, implementation, and evaluation are required for successful implementation of a nursing practice change. Key words: evidence-based practice, hourly rounding, nursing workflow, quality of care

BACKGROUND AND PURPOSE

Despite a growing body of literature documenting the value of new evidence-based practices, some of these practices are not always implemented effectively in clinical nursing practice.1-4 Hourly rounding, as described in this study, is an example of this. Hourly rounding is a systematic, proactive nurse-driven evidence-based intervention to anticipate and address needs in hospitalized patients.3 According to the evidence, effective hourly rounding can promote patient safety,5,6 foster team communication,2-8 and improve staff ability to provide efficient patient care.2-4,8 The effectiveness of hourly rounding has been measured by tracking call bells,9 patient falls,3,5,6,8 and patient and staff satisfaction.2-8,10

DESPITE A GROWING BODY of literature documenting the value of new evidence-based practices, some of these practices are not always implemented effectively in clinical nursing practice.1-4 Hourly rounding, as described in this study, is an example of this. Hourly rounding is a systematic, proactive nurse-driven evidence-based intervention to anticipate and address needs in hospitalized patients.3 According to the evidence, effective hourly rounding can promote patient safety,5,6 foster team communication,2-8 and improve staff ability to provide efficient patient care.2-4,8 The effectiveness of hourly rounding has been measured by tracking call bells,9 patient falls,3,5,6,8 and patient and staff satisfaction.2-8,10

BACKGROUND AND PURPOSE

A 981-bed multicampus, regional health network introduced hourly rounding to all inpatient units in 2007 with mixed results. The roll out of the network hourly rounding initiative began as a pilot program on 1 unit where the process was readily embraced by the staff. Later, other patient care units also successfully integrated hourly rounding into their unit workflow. Some patient care units, however, were less successful with rounding. This mixed success of the implementation of hourly rounding prompted the network’s nursing senior management to request a study at the largest of the network’s hospitals to explore the barriers to integration of the hourly rounding process on 2 units where the introduction of rounding was less successful. The results of that work are described in this article.

LITERATURE REVIEW

The practice of hourly rounding may vary from 1 institution to another, and even from 1 patient care unit to another, but there are certain aspects of the process that are common across all settings.2-4,8 Nursing staff typically begin hourly rounding by introducing
themselves to the patient and explaining the process. The patient is told to expect to see a staff member for care every hour. During these visits, the staff member assesses and addresses the patient’s comfort needs; personal needs, such as toileting, positioning, and pain; and the safety of the room environment. Prior to leaving the room, the staff member asks the patient about any unaddressed needs. Once these needs are met, the patient is told when a staff member will return.3,5,8

Hourly rounding outcomes

Researchers have studied the impact on quality outcome indicators resulting from the introduction of the hourly rounding process on multisite medical/surgical units,3,6 single units,5,7 and in a specific orthopedic population.4 Each study sought to measure the influence of hourly rounding on selected outcomes, such as, a decrease in the number of call bells per shift, a reduced number of patient falls, reduction in pressure ulcers, increased patient satisfaction with care, and increased satisfaction of nursing staff because of enhanced team communication and teamwork.2–8 Patient satisfaction was the most common outcome variable reported. Although different measurement tools were used, each study reported a statistically significant improvement in patient satisfaction scores.2–8

Some studies focused on the number of call bell alerts, which were considered indicators of effectively anticipating patients’ needs. The number of call bell alerts was counted before and after implementing hourly rounding, and in each reported study, there were significant reductions.3,5,6,8 Hourly rounding also was associated with increased nurse satisfaction by providing nurses additional time for bedside care. Leighty10 described an association between hourly rounding and reductions in the number of nurses’ steps. Several researchers suggest that effective hourly rounding can increase staff satisfaction because of enhanced teamwork and communication.5,6,10

Translation of evidence into practice

Translation of an evidence-based practice change is challenging and complex, with no one proven effective method to guide successful implementation. Nursing experts identify several essential components to the successful translation of an evidence-based practice. These components include understanding the complexity of the intervention, completing a comprehensive assessment of adopters, and a well-designed implementation and communication plan.11–15 In addition, researchers stress the importance of evaluating the process and outcomes of translating an evidence-based practice change.15,16 It is important to identify measurable, sensitive outcomes that will evaluate the success of the initiative being implemented, in this case, hourly rounding.15 Much of the literature details the benefits of implementing hourly rounding, but little is written about how to identify barriers to implementation at the unit level.2–8,10

METHODS

This study was reviewed by the health network’s institutional review board and approved as a quality improvement study. Two inpatient units where hourly rounding was not consistently practiced were chosen for further study because of their similar patient demographics, campus location, and physical work environment. Unit 1 was a neurological and surgical unit, and Unit 2 was a transitional trauma and surgical unit. Both units had 35 beds in semiprivate rooms and were located in the largest of the network’s 3 hospitals. Staffing ratios were similar on both units. Unit leaders on both of these units embraced the study and were eager to understand the reasons for ineffective hourly rounding practice on their units.

Ethnography was the theoretical and data collection methodology used for this study. Ethnographic methods allowed the study team to listen to what people on the study units said, understand their perceptions, and see what the staff were doing.17–22
Ethnography enabled descriptive, focused observations regarding how unit staff was performing hourly rounding. The study team, consisting of 4 nurses working in a research department, was trained in ethnographic observation and interviewing by the study leader, a doctoral-level nurse- anthropologist experienced in ethnographic research.

As a first step, interviews were conducted with 13 stakeholders, including nursing administrators, unit managers, and those involved in developing and implementing the hourly rounding initiative. These interviews were conducted prior to the observational component of the study and provided background information about the hourly rounding initiative. Interviews were audio recorded with permission and were downloaded to a secure folder on the study team’s computer.

Next, the team reviewed existing documents and presentations about the hourly rounding process that were prepared by the nursing administration. These materials provided insights into how hourly rounding was explained to frontline staff and unit managers, including how the process was to be carried out on patient care units.

After analysis of the background interviews and documents, the study team conducted ethnographic observations and interviews on the 2 study units for 1 month in spring 2010. Two team members were assigned to observe and interview staff on each study unit, individually observing for 2 to 3 hours at a time, and also to conduct impromptu interviews with available unit staff. A total of 40 hours of observations were conducted on each unit during all shifts, including weekends. The study leader also conducted observations on both units to cross-check the observational data.

Registered nurses (RNs) and technical partners (TPs; unlicensed nursing support staff) from each unit and shift spoke with researchers when not performing patient care tasks. A total of 48 staff members (29 RNs and 19 TPs) from the 2 units were interviewed. Staff interviews were not audio recorded to ensure confidentiality for respondents.

Interview questions focused on topics including process, purpose, implementation, documentation, accountability, and successful measurement of hourly rounding. Interviews continued until data saturation occurred and a representative sample had been achieved. The “lived experience” insights from unit staff about the practice of the hourly rounding process on their units were essential to this study. Photographs provided useful information about the context of the study setting.

Data analysis

Interview notes and observation field notes were transcribed and imported into an NVivo 7 (QSR International 2001) database for coding and analysis. The study team members individually read through all the notes and transcripts to identify themes such as staff perspectives and comments about process dissemination, purpose of hourly rounding, process of hourly rounding, staff accountability, and other topics. A second round of coding involved collapsing the initial themes into 6 thematic categories as agreed to by team consensus. Results provided insights about whether hourly rounding was being practiced effectively on the 2 study units as well as staff members’ thoughts about problems with the initial rollout of the hourly rounding initiative by nursing administration.

RESULTS

Themes identified from the ethnographic observations and interviews included (1) dissemination, (2) purpose of hourly rounding, (3) rounding process/workflow, (4) accountability, (5) staff attitudes about hourly rounding, and (6) patient safety. The themes are discussed in aggregate below because they were consistent between the 2 units.

Dissemination

From an examination of hourly rounding implementation materials and administrator and unit leadership interviews, it was clear that these leaders believed unit level staff had received adequate education about the
purpose and process of hourly rounding. However, there were few details about how to do hourly rounding in the staff education materials examined by the study team. Nursing leaders were aware of unit-level problems with the hourly rounding process, including issues with staff responsibility and documentation of hourly rounding. Still, they believed their staff had received sufficient education on rounding and should understand how to perform the hourly rounding process.

**Purpose of hourly rounding**

Nursing leaders were able to clearly articulate the purpose of hourly rounding as improving patient outcomes and patient and staff satisfaction. However, they could not identify specific quality indicators that could be used to evaluate the success of this initiative. Leadership stressed the need for staff to become proactive in anticipating and identifying patient needs, instead of waiting for patient call bells and alarms. In contrast, most staff members from both units were unable to verbalize the purpose or logic behind hourly rounding.

**Hourly rounding process and workflow**

As defined by the current hourly rounding process materials at the network, RNs and TPs were to perform hourly rounding using specific steps to address patient needs and the room environment. Staff members were to initial an hourly rounding log sheet hung on the patient room door each time rounding had been completed. Although observations on both study units confirmed that nurses and TPs were in and out of patient rooms frequently, trips into a patient room were usually the result of a call bell alert and involved performance of a specific task. Before leaving the room, the staff member usually asked the patient if they needed anything. Few staff members were observed signing the hourly rounding logs as they exited patient rooms.

Staff from both units identified several problems that made it difficult for them to integrate hourly rounding into their patient care work. First, most of the staff respondents were unable to list the steps of the hourly rounding process. Observations confirmed there were also no visible cues on the units that RNs and TPs could view to reinforce the steps included in the hourly rounding process. Second, RNs and TPs were expected to share the responsibility for completing hourly rounding but, having received little guidance from leadership, were unsure how to divide up the rounding responsibility with each other for their shifts. Staff from both units indicated that while unit leadership should set expectations for the performance and tracking of hourly rounds, leadership also have a responsibility to educate and work with staff to identify how hourly rounding should be integrated into their current workflow. Also, respondents from both units indicated that it would have been helpful to have had a unit-based champion or rounding expert available to help them learn to integrate rounding into their workflow.

**Accountability**

Unit leaders reported that accountability for hourly rounding was monitored by reviewing the hourly rounding logs, which were to be signed each hour by the staff, as they completed hourly rounds. Leaders from both units said they reviewed the rounding logs periodically and addressed compliance problems or discrepancies with individual staff members. The logs, not part of the medical record, were not retained more than a few months. Information from the logs, which indicated completion of patient care activities such as toileting, was not recorded in any kind of central database for tracking purposes.

Nurses and TPs on both study units reported that performing hourly rounding was not an option, but an expectation of their unit leadership. However, staff expressed concerns about having to sign a log every hour. They also indicated that not performing rounds or completing the rounding logs would be reflected in their yearly performance evaluations. Observations confirmed that documentation on the rounding log sheets often was not performed.
hourly. Rather, staff members were often seen completing all of their log sheet entries at the end of their shifts.

**Staff attitudes**

Registered nurses and TPs from both study units overwhelmingly viewed hourly rounding as more work instead of a proactive process that might have benefits for them and their patients. However, some staff members did feel that hourly rounding was a good idea but difficult to accomplish because of competing priorities and tasks. Some of these respondents also said that they did not feel a sense of ownership of the hourly rounding process and reported that hourly rounding was a top-down process imposed on them. These staff members were interested in knowing the origins of and logic behind hourly rounding and desired proof that the hourly rounding process would be effective and provide benefits for their patients.

**Patient safety**

One stated goal of the hourly rounding initiative was to improve patient safety. However, neither administrators nor staff could point to specific patient safety outcome indicators that might have improved with implementation of hourly rounding. There were also no variables on the log sheets that leaders or staff could point to as outcome measures that could be tracked for improvement as a result of hourly rounding.

Staff members on both units took patient safety seriously and easily verbalized safety measures, such as assessing pressure ulcers or taking appropriate measures on the basis of fall risk. Staff also stated that they addressed the patient’s room environment to remove hazards and emphasized that it was important to make sure the patients always had their call bell within reach so they could alert staff if they needed assistance. However, no staff respondents were able to link hourly rounding with patient safety.

**DISCUSSION**

Despite a well thought out hourly rounding communication and dissemination plan similar to those that had worked with past patient care process changes, the implementation of hourly rounding did not translate well, especially at the 2 studied units within our health network. There appeared to be a gap in understanding of the benefits of hourly rounding between administrators and frontline staff on the study units, as well as lack of clarity about how to implement hourly rounding into the patient care workflow.

**Communication and documentation**

Clear communication and education about a new process being implemented on a patient care unit are essential because staff members need to know why they are being asked to perform a new task and what the new process means for patient care. Communication and documentation of the new evidence-based workflow process for hourly rounding could have been improved. Staff members needed to understand what hourly rounding was and how to perform it.

Staff accountability for hourly rounding seemed to be focused on documentation rather than on the staff’s ability to carry out the standard process for hourly rounding. The current hourly rounding log sheets did not reinforce the steps of hourly rounding but rather contained checklists of tasks, for example, toileting, or statements such as “needs met” that did not clearly link hourly rounding with patient outcomes such as a reduction in pressure ulcers or patient falls.

Unit-level educational support, including checklists and behavior prompts, are important in embedding new processes into unit workflow. Staff from both units wanted to know how to do hourly rounding, but after the initial education, no educational support or other information about the step-by-step hourly rounding process was provided. Such educational materials might have enabled staff to review and reinforce the process for themselves. Furthermore, neither of the 2 study
units had unit-level champions who could have modeled how to do hourly rounding for their peers and reinforced the benefits of it.24,25

**Process implementation**

Implementation of hourly rounding as described in this study could have been improved in several ways. Areas for improvement of the process rollout included the need for increased clarity about the purpose of hourly rounding, better instructions about how rounding should be performed and documented, and clearly defined measures of staff accountability for process performance. Also, well-chosen, sensitive outcome measures to evaluate the initiative should be defined and measured. Results of these evaluation measures should be provided back to unit staff to show them the results of hourly rounding.16,24,25

**Process evaluation**

Evaluation is another important component of successful translation of evidence into practice.16,23,25 The hourly rounding implementation at this hospital network would have benefited from the use of a quality improvement framework such as plan do study act (PDSA). Use of a framework would have prompted administrators to identify outcome variables they could use to study the implementation of hourly rounding as well as the effectiveness of hourly rounding in improving patient care quality.16,23

One challenge to evaluating the translation of hourly rounding into practice is finding meaningful outcomes that are easily measured to show that hourly rounding is making a difference in patient care.16,23,25 While patient satisfaction and other quality outcomes such as fall and pressure ulcer rates are routinely tracked on the units, fluctuations in these measures could not be attributed directly to hourly rounding. No measures were tracked specifically to evaluate hourly rounding as many of the outcomes suggested by the literature3-10 were too difficult to measure in the setting, for example, tracking call bells. Information collected on the log sheets could not be used to track the value of hourly rounding in improving patient care because it did not relate directly to variables that could be used to evaluate the impact of hourly rounding. Therefore, the link between hourly rounding and quality care did not exist for staff, and subsequently there was not a high value given to the hourly rounding process. Regarding patient satisfaction, the most common outcome measure cited in the literature,2-8,10,16 no additional satisfaction assessments were undertaken at the hospital network other than the commercially administered survey that patients receive by mail after discharge. Patient satisfaction as measured by this survey did not change appreciably on the study units after implementation of rounding, possibly because it was already fairly high and hourly rounding was not practiced effectively.

Currently there is little information in the translation literature about how to evaluate step by step why a practice change has not been successful.16,23,25 This study illustrates how to use qualitative methods to assess the effectiveness of patient care processes such as hourly rounding at the unit level. Similarly the results show the importance of frontline nurses as valuable sources of information for process improvement studies.

**Next steps**

The next step is to translate the findings from this study into a meaningful redesign of the hourly rounding process. Recommendations for the hourly rounding redesign group will include the following: (1) a more extensive assessment of adopters, particularly early adopters who can champion the process for unit staff; (2) use of the network’s leadership development model to help train unit-level champions to lead this implementation effort; (3) inclusion of unit-level staff at all phases of the redesign; (4) establishment of a more robust communication and education plan; (5) use of a project management and/or a quality improvement process such as PDSA to enhance the strength of the redesign; and (6)
identification of meaningful outcome indicators, such as falls or pressure ulcers, that can be used to evaluate the effectiveness of hourly rounding.

CONCLUSIONS

Results from this study indicate that translating complex evidence-based interventions into clinical practice can be fraught with challenges and unintended results. Implementation must be carefully planned and carried out with the needs of frontline staff as a major consideration. Also, a strong evaluation plan with meaningful outcomes is essential to document for staff that the intervention is working.

This study provides an example of how to evaluate problems with the implementation of evidence-based practices at the unit level. Nurses and nurse managers at other hospitals should be able to replicate this work to continue the understanding of issues related to problems with the translation and implementation of evidence-based practices.

REFERENCES

Communication between caregivers is an important aspect of patient care. Consistent and accurate exchange of patient information is imperative to maintain patient focus and promote a culture of safety and trust. The American Nurses Association estimates that 80% of serious medical errors involve miscommunication between caregivers when patients are transferred or handed off. In addition to patient harm, defective hand-offs can lead to delays in treatment, inappropriate treatment, and increased length of stay in the hospital.

Historically, nursing shift-to-shift reports have occurred away from the bedside, at a central nursing station on a patient-care unit. Patient history, plan of care, and information vital to the care of the patient are exchanged during this time. This traditional practice of one-way communication from the off-going provider to the oncoming nurse can be lengthy, incomplete, and fraught with interruptions. Nurses often become frustrated with workflow and feel they lose valuable time that would be better served at the bedside. Hand-off report at the nurses’ station or in conference rooms occurs with no patient involvement, which can lead to errors, confusion about treatments or diagnosis, and an overall dissatisfaction with the exchange of information and communication between the nurse and patient.

Bedside report has been shown to empower staff, improve patient involvement, and allow for a safe transition of care between providers. It establishes and promotes trusting relationships between patients and staff members, which serve as a foundation for teamwork.

**Communication and safety**

Hand-off, or shift, is the transfer of information from one caregiver to another and includes vital information pertaining to patient care. Effective communication is a key component when providing quality care. Breakdowns of communication may jeopardize patient safety and cause dissatisfaction among patients and nursing staff. As patient care becomes more complex, it’s important to communicate in a clear, concise manner that focuses on a patient-centered approach.

Safety goals have been established by The Joint Commission to improve the effectiveness of communication between caregivers and reduce medical errors. In a report entitled “What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety,” The Joint Commission advocates for healthcare facilities to “create organization cultures of safety and quality that value patient-centered communications as an integral component of delivering patient-centered care.” The Institute of Medicine (IOM) has also identified communication as a vulnerable aspect of patient safety. The IOM report “Crossing the Quality Chasm,” recommends that “care be patient-centered and that information should be shared freely with the patient, keeping the patient the center of control.”

With the adoption of value-based purchasing and pay-for-performance measures being implemented in the near future, it’s important—not only from a safety aspect, but also from a financial standpoint—that healthcare organizations work toward finding effective communication methods that enhance the patient experience while providing a safe and trusting environment. With Medicare reimbursement dollars at stake, healthcare organizations need to refine communication methods to provide a safe and exceptional healthcare experience for their patients.

**Implementation**

A 592-bed acute care community hospital recognized the need for implementing a method of transferring information that would focus on patient safety and improve the patient experience. It was thought that moving report to the bedside and encouraging patient participation would foster a sense...
of respect and trust between the patient and caregivers, allowing for a more accurate exchange of information. To successfully implement the process and engage the staff, all direct care nurses attended an educational session to learn the various aspects of bedside shift report. Handouts were distributed containing evidence-based information on bedside shift report, as well as a standardized Situation, Background, Assessment, Recommendations (SBAR) tool that would be utilized for report. Questions and concerns were addressed and discussed.

Conversations ensued about the intent of the Health Insurance Portability and Accountability Act and the impact bedside report would have on patient privacy. It was determined that highly confidential information or new diagnoses or results that hadn’t yet been communicated to the patient by the physician should be discussed in private after leaving the bedside. Over the next 2 weeks, the unit director oversaw the process and met regularly to discuss barriers and concerns related to patient confidentiality and physician buy-in. Staff became comfortable with the process, and patients expressed satisfaction in knowing their plans of care. Bedside report became a mandatory requirement for all nursing staff on December 1, 2011.

The impact

Initially, staff members were concerned that bedside shift report would increase the length of hand-off. Using a standardized method of reporting such as SBAR, a systematic process was created that eliminated impertinent information. By taking report to the bedside, interruptions from physicians and phone calls, which frequently affected the old method of reporting, were greatly reduced. Report became a streamlined and efficient process. The length of time for report was also reduced.

Nursing staff members were able to visualize their patients within the first 30 minutes of their shift, which led to increased staff satisfaction. Bedside reporting also allowed for increased mentoring opportunities between nursing staff. By visualizing the patient and equipment during the report time, nurses were prompted to ask questions based on the current patient situation. Patients were encouraged to participate in the report process, thereby gaining a better understanding of the plan of care and verifying information. This patient-centered and transparent approach helped foster an environment of trust, mutual respect, and understanding.

The impact of bedside shift report was dramatic and immediate. An increase in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores in all four communication domains became apparent soon after implementation. (See Table 1.) In addition to patient satisfaction, staff members have embraced the value of bedside shift report, and it has helped to foster a sense of teamwork among caregivers.

Satisfaction guaranteed

Moving report to the bedside has impacted patient satisfaction and allows for free flow of accurate information centered on the patients. Additionally, bedside report cultivates an environment for mentoring relationships to develop among nursing staff and creates relationships of mutual respect. Nurses are able to visualize patients and implement safety checks at the start of their shift, reducing the length of time they spend at the nurses’ station and away from the bedside. This facilitates a smoother workflow and improves the reporting process. Lastly, HCAHPS scores have shown that bedside shift report has had a positive impact on patients’ perception of effective communication.

Table 1: Impact of bedside shift report on HCAHPS scores

<table>
<thead>
<tr>
<th>Median domain score</th>
<th>Before</th>
<th>After</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with nurses</td>
<td>74</td>
<td>80</td>
<td>8</td>
</tr>
<tr>
<td>Nurses treat with courtesy/respect</td>
<td>83</td>
<td>91</td>
<td>10</td>
</tr>
<tr>
<td>Nurses listen carefully</td>
<td>66.5</td>
<td>71</td>
<td>7</td>
</tr>
<tr>
<td>Nurses explain in a way you understand</td>
<td>64</td>
<td>71</td>
<td>11</td>
</tr>
</tbody>
</table>

REFERENCES


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