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Cover Page Footnote
We would first like to acknowledge the incredible work and leadership of the teams and leaders of the regions, hospitals and emergency departments who implemented nurse leader rounds and achieved such positive results. Without their dedication and effort, this article could not have been written. We would also like to express our appreciation to the board and executive leaders whose oversight and guidance maintains patient experience and the work related to it as a high priority. We are particularly thankful to librarians Kathryn Gibbs and Basia Delawska-Elliott for their assistance in securing literature needed to inform this research. Advice provided by Tom French regarding statistical analyses was most valuable, and we are extremely grateful to have benefited from it. Michele Bedford deserves our eternal gratitude for her constant assistance to coordinate, support, and improve our efforts. Special thanks are extended to Michele Nafziger and Press Ganey for generous and ongoing support of our data analysis, reporting, and improvement work. This article is associated with the Culture & Leadership lens of The Beryl Institute Experience Framework. (http://bit.ly/ExperienceFramework). You can access other resources related to this lens including additional PXJ articles here: http://bit.ly/PX_CultureLeadership

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Patient Experience Practices

Improving the patient experience through nurse leader rounds

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Abstract
While providing exceptional care experiences to patients is a priority for many organizations, creating and sustaining measureable success in this area remains a challenge for many. This article examines the impact of implementing nurse leader rounds on patient perception of care in the hospitals and emergency departments of a large healthcare system. Nurse leader rounds were implemented as a system-wide improvement practice at Providence Health & Services in 2012. Analysis of Press Ganey and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results indicates that implementation of nurse leader rounds is associated with statistically significant improvement in patient perception of care, as well as greater rates of improvement than the Press Ganey national database. Results support the hypothesis that the effective implementation of nurse leader rounds can improve patient perception of care within a healthcare system's hospitals and emergency departments.

Keywords
Patient experience, patient satisfaction, patient loyalty, HCAHPS, Hospital Consumer Assessment of Healthcare Providers and Systems, nurse leader rounds, evidence based practice, leadership practice, hospital, emergency department, improvement, healthcare system

Introduction

Health care organizations are increasingly focusing on improving the experiences patients have when they interact with different parts of the healthcare system. While many health care leaders indicate that improving the patient experience is one of their highest priorities[1,2], few report that they are satisfied with results achieved to date even though certain "proven" practices, when reliably implemented, are associated with improved results.

Nurse leader rounds with patients have been described as an "evidence-based practice" associated with improved ratings from patients regarding their care experience. This article is intended to summarize: 1) research associated with the implementation of nurse leader rounds, 2) the implementation of nurse leader rounds in inpatient and emergency department settings in a large health care system, 3) results associated with the implementation of this nursing leadership practice and 4) lessons learned during the implementation period.

Background

The health care literature contains information and research about various types of rounds with patients, the rationale for different types of patient rounds, implementation considerations, and results associated with the implementation of different kinds of patient rounds on various measures of performance. For example, Haas and Gold[3] describe the history and use of administrator rounds with patients. L. Fillmore[4] summarizes various types of rounds with patients and the purpose of each.

This article focuses on one particular kind of round: nurse leader rounds with patients. Close and Castledine[5] describe nurse leader rounds, the rationale for implementing this proactive leadership practice, and considerations when implementing such an effort.

While many have cited the value of nurse leader rounds with patients, only a few have documented the impact of this practice on perceptions of patient care and/or have described key implementation considerations.

Stephanie Baker[6] described nurse leader rounds as a foundational evidence-based leadership practice "proven to deliver strong service, clinical and operational results." She indicates that this leadership practice allows Emergency Department leaders to proactively ensure the delivery of safe, high quality care, harvest recognition opportunities and identify improvement opportunities. She also summarized

evidence from one hospital Emergency Department that showed that the implementation of this leadership practice was associated with patient satisfaction gains from the 16th to 78th percentile five months after implementation.

Setia and Meade[7] describe the combined impact of implementing two evidence-based practices: discharge calls and nurse leader rounds in a large university affiliated medical center in the inpatient setting. In relation to nurse leader rounds, they found that when patients remembered being visited by a nurse leader during their stay, they rated the following aspects of their experience much more positively than patients who did not remember a visit from a nurse leader: overall rating of nursing care, response to concerns/complaints, and likelihood of recommending the hospital.

Che Walker[8] described the impact of implementing nurse leader rounds in an Oregon hospital: a sustained differential of 50 percentile points or more when compared nationally in overall patient satisfaction. Specifically, patients who recalled that a nurse leader visited them during their stay reported much higher levels of overall satisfaction than those who did not recall a visit from a nurse leader during their stay.

Other writers have described how nurse leader rounds can be/have been implemented across a wide range of facilities/settings. For example, Lee and Manley[9] described the implementation of nurse director rounds with patients in a 19 bed surgical unit. Their case study explained a variety of implementation issues, such as the time needed to conduct rounds, nature of patient feedback gathered during rounds, proportion of patient comments requiring follow-up, nursing staff perception of director rounds with patients, and patient perceptions of this practice. C. Walker[8] described key elements of one hospital's rounding system and some of the challenges associated with fully implementing this leadership practice.

There has not yet been a description in the literature of efforts to implement this evidence based practice across a system of hospitals in both inpatient and emergency department settings. This article is intended to augment existing research relating to nurse leader rounds.

Implementing Nurse Leader Rounds across a Healthcare System

Providence Health and Services is a large health care system serving patients and their families across five states: Alaska, California, Montana, Oregon and Washington. The system employs more than 64,000 people and includes 32 hospitals, 350 physician clinics, senior services, supportive housing, and other health and educational services.

For years the system had established goals for patient satisfaction for each hospital and set expectations that all hospitals were accountable for achieving improved patient experience results. However, patient satisfaction across the system remained unchanged over a several year period. In response to escalating external focus and board-level concern regarding patient satisfaction performance, a system-wide, standardized approach to improving the patient experience was initiated. The strategy focused on implementing only a few proven practices consistently and very well.

Since nurse leader rounds had been shown to be an effective patient satisfaction improvement strategy in some hospitals and emergency departments and could provide the foundation for future improvements, it was decided that reliable implementation of nurse leader rounds would be a good initial step toward creating a predictably exceptional experience for Providence patients. Work began first in inpatient settings in early 2012 and was subsequently implemented in emergency department settings late in 2012.

Key elements of implementing this practice across the system are summarized below.

Site-specific annual goals were identified for each acute care and emergency department across the system. Expectations were set that all would make progress from baseline performance to one third of the way toward 90th percentile performance.

Minimum specifications were developed to clearly describe what all were expected to implement. Key elements included in the "minimum specification" document were sponsor/owner of the implementation, purpose/rationale for implementing the practice, key elements of an effective nurse leader round, performance targets, methodology for assessing progress related to the quantity and quality of rounds, recommended implementation steps, monitoring/accountability practices, and toolkit resources to assist in implementation.

A *toolkit* was developed to support local leaders in implementing nurse leader rounds. The toolkit included customizable slides for introducing the practice locally, the minimum specification document summarizing key implementation information/expectations, tools for tracking progress on consistency of implementation, sample competency assessment tools, and relevant articles.

Formal introduction of expectations for implementing this practice was made at a system-wide Patient Experience Collaborative meeting. These quarterly meetings included an accountable senior leader and local patient experience measurement and/or coaching representative from each facility.

Regular reports were developed and disseminated on a monthly basis to help each site identify implementation progress from the perspective of their patients. These reports were not only included in a system wide SharePoint site, they were pushed out to all collaborative participants at monthly intervals via email.

An internal website was developed to support leaders and teams in this effort to understand patient feedback and to share additional tools and resources that sites were finding helpful in their implementation efforts.

Regular sharing of implementation challenges and emerging lessons was done during the ongoing quarterly Patient Experience Collaborative. During these sessions local leaders and teams from sites making good progress presented their experiences and shared what they were learning about successful implementation along with adjustments they had made when they encountered barriers or challenges along the way. They often shared new/adapted tools they were using to assist them in achieving goals as well.

Feedback/recognition was provided at regular intervals. Sites making improvements and/or achieving targeted goals were publicly recognized at the quarterly collaborative meetings. Additionally, system staff periodically reached out to accountable facility leaders not yet reaching their goals or nurse leader rounding targets.

On-site coaching was made available to leaders and teams from large sites experiencing implementation challenges.

Research Questions

Key research questions include:

- What impact does implementing nurse leader rounds across an entire system have on patients' perceptions of care?
- What is the impact of the implementation of this practice on the rate of improvement over time?
- How does the rate of improvement compare to other hospitals across the country, pre and post implementation?

Methods

Nurse leader rounds were defined as a systematic process in which nurse leaders make daily visits to check-in with patients to build relationships, verify consistency of care, gain real-time feedback, perform immediate service recovery as needed, and follow-up with staff regarding compliments and opportunities for improvement. Nurse leaders include department managers, assistant managers, supervisors, and charge nurses.

A good nurse leader round involves introducing oneself as a nurse leader and asking about the patient's care experience so far (including asking about high priority topics identified via patient satisfaction data and/or inquiring about how well key unit practices are going). An additional component of an effective nurse leader round involves asking the patient or family member(s) if there is anyone who has made their stay extra special and if so, asking for a description of what that person did that the patient especially appreciated. If gaps are identified during the round, the nurse leader is expected to address concerns while the patient is still on site. The round is not completed until follow-up occurs. Follow-up includes documenting that the round occurred for internal implementation monitoring, following through on any commitment made to the patient, and providing feedback to staff mentioned during the conversation with the patient.

A subset of nurse leaders, identified as champions, from throughout the system were trained on this process during a patient experience learning collaborative, including opportunity to practice and role play rounds with each other. Additional training was provided at regularly occurring nursing- or emergency department-specific meetings. Larger sites experiencing implementation challenges received further training at their locations from system coaches who observed nurse leader rounds in action and provided customized feedback.

To help each hospital team evaluate their progress on implementing nurse leader rounds and improving the patient experience, each hospital added a question to their patient satisfaction survey: "Did a nurse leader visit you during your stay?" Response options differed by hospital. While some hospitals had a Yes/No response option, others had a Yes/No/Not Sure response option.

The survey vendor's analysis of results clustered responses related to various topics, e.g., admission, and created a "composite" for different parts of the patients' overall experience. Each of the survey composites, as well as the composite of all survey responses and the likelihood of recommending

question were split based on whether the respondent indicated having received a nurse leader visit or not. Hospitals that included the response option, "Not Sure" were coded with the "No" responses. If the respondent skipped the nurse leader rounding survey question, the patient case was excluded from this analysis.

Results

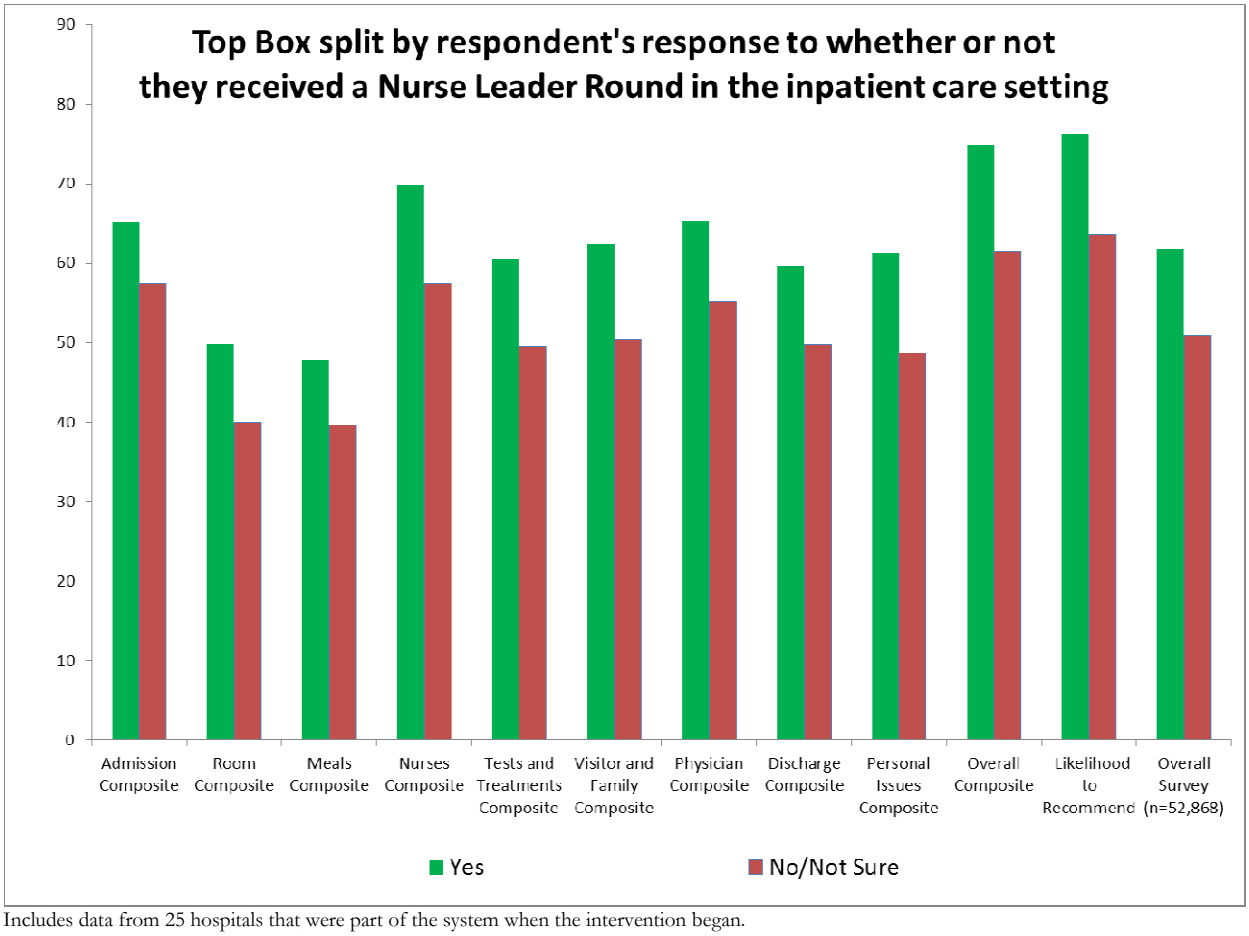
Figure 1 shows the percent of top box ratings associated with the implementation of nurse leader rounds in the inpatient setting. Top box ratings summarize the percent of respondents who rated the item/composite in the most positive response category.

Figure 2 summarizes the percentile rankings for different aspects of the patient experience and how they differ when patients remembered receiving a nurse leader round and when they did not.

As shown in Figures 1 and 2, inpatients who reported receiving a nurse leader round during their stay rate both global and all individual aspects of their stay more positively than those patients who did not report receiving a visit from a nurse leader. This difference was found to be statistically significant for top box percentages. Similarly, percentile rankings were substantially higher for all aspects of care and individual global ratings for patients who remembered that a nurse leader visited them during their stay than they were for patients who did not remember such a visit.

It is important to note that although a causal relationship cannot be drawn between the implementation of nurse leader rounds and the above measures of patient experience, Figures 1 and2 show that implementation of this practice is associated with more positive ratings of the patient experience in all survey domains and for all global areas.

Figure 1. Top Box Ratings for Different Aspects of the Patient Experience in the Inpatient Setting (when patients reported receiving a nurse leader round versus not)



Includes data from 25 hospitals that were part of the system when the intervention began.
Includes 2012 and 2013 discharge data.
All differences between yes and no/not sure responses were significant, $p \leq .001$

Figure 2. Percentile Rankings of Different Aspects of the Patient Experience in the Inpatient Setting (when patients reported receiving a nurse leader round versus not)

Patient Survey Components (n= 51,785)	Percentile Ranks		
	Yes	No/Not Sure	Difference
Admission Composite	63	24	39
Room Composite	45	11	34
Meals Composite	45	14	31
Nurses Composite	51	6	45
Tests and Treatments Composite	50	9	41
Visitor and Family Composite	47	7	40
Physician Composite	61	14	47
Discharge Composite	55	6	49
Personal Issues Composite	57	8	49
Overall Composite	70	14	56
Likelihood to Recommend	74	25	49
Overall Survey	54	8	46

The second and third research questions, "How does the implementation of nurse leader rounds impact the rate of improvement over time?" and "How does the Providence rate of improvement compare to other hospitals across the country?" are addressed in Figure 3, which summarizes patient ratings of overall care on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey from the

Figure 3. Inpatient Nurse Leader Rounding's Impact on HCAHPS Overall Rating of Care

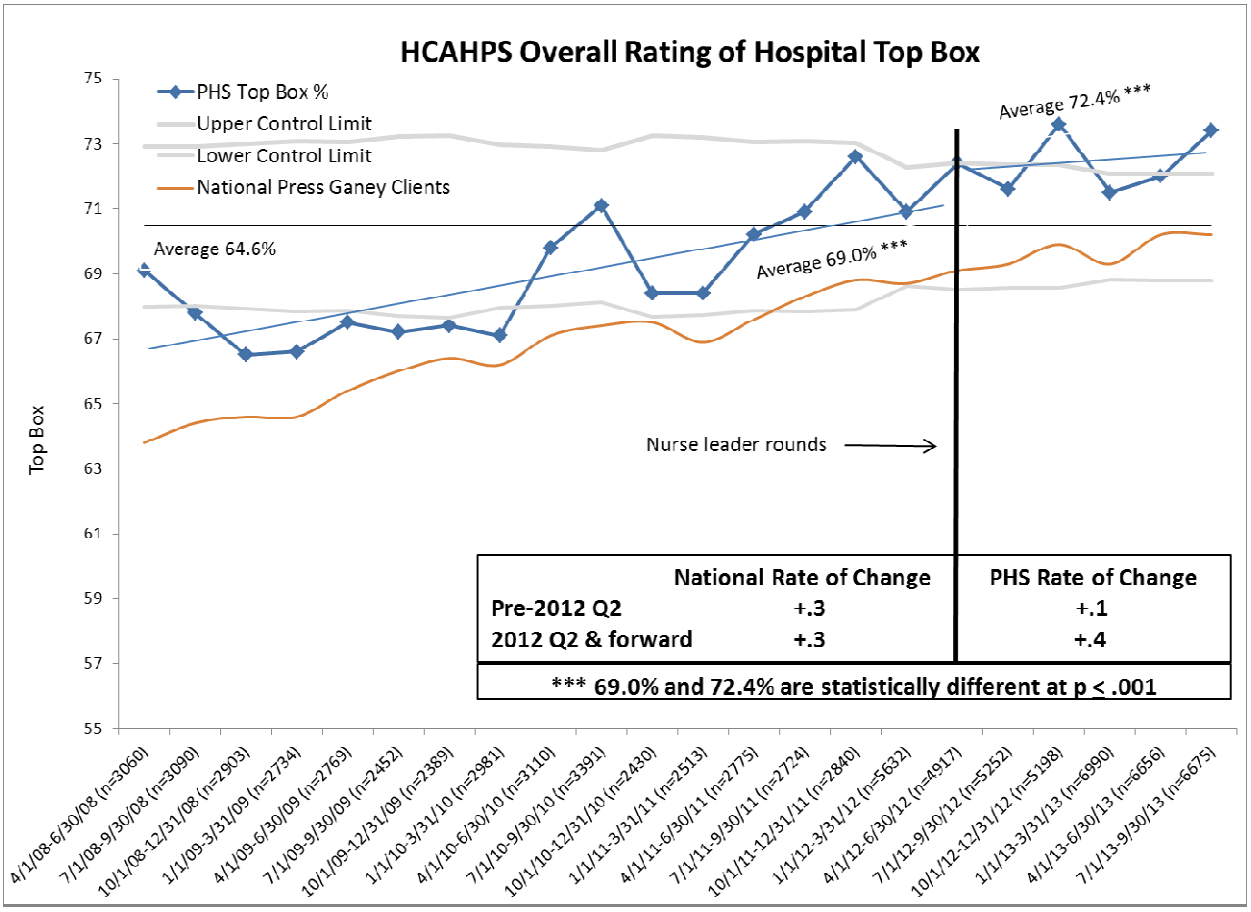
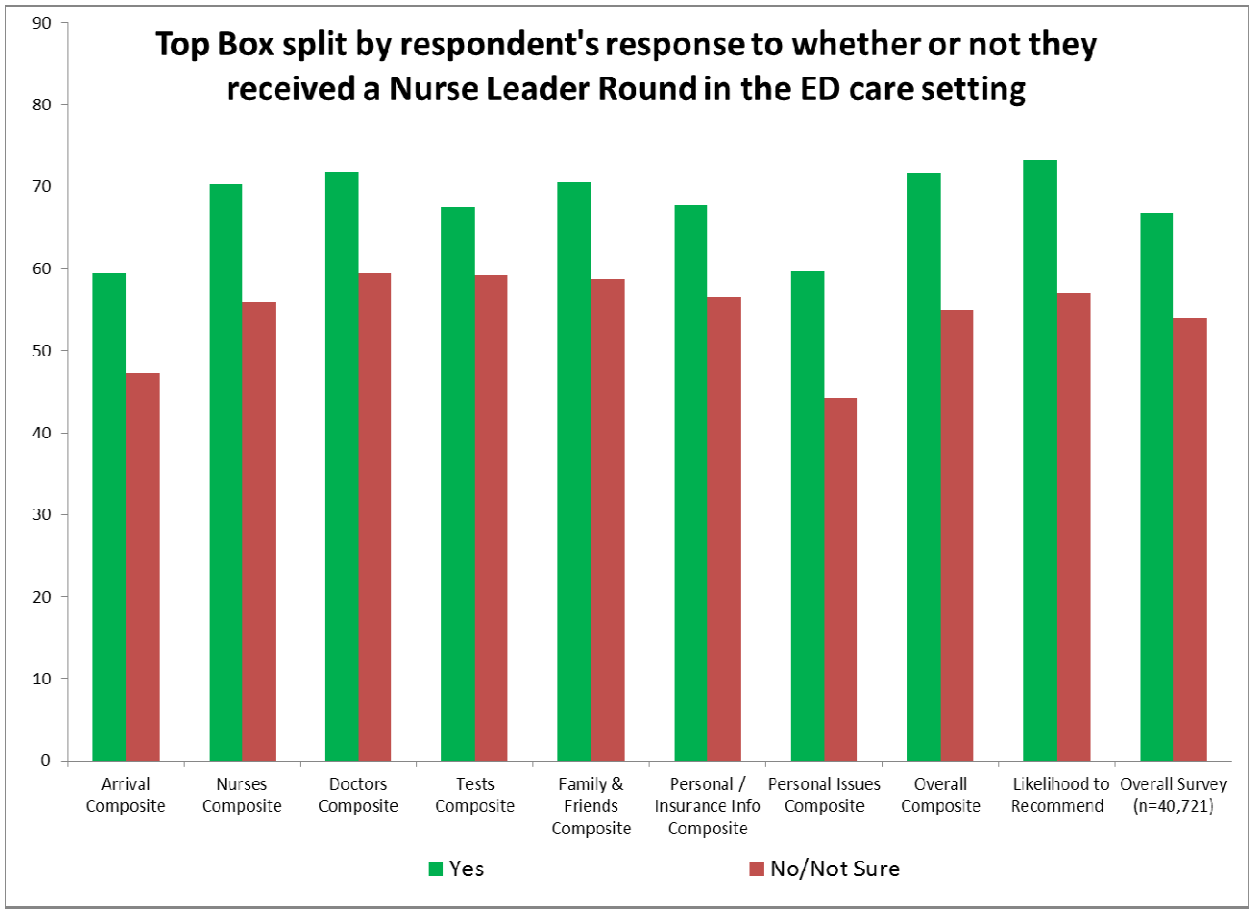


Figure 4. Top Box Ratings for Different Aspects of the Patient Experience in the Emergency Department (when patients reported receiving a nurse leader round versus not)



Includes data from 25 emergency departments that were part of the system when the intervention began.
Includes 2012 and 2013 discharge data.
All differences between yes and no/not sure responses were significant, $p \leq .001$

first quarter of January 2008 to the first quarter of January 2014. The blue line shows Providence's performance on this global measure, and the orange line shows the performance of the Press Ganey national database (which includes 1713 hospitals and 1763 emergency departments) as a comparison.

Due to the large size of the Press Ganey database, it was used as a proxy for the nation. Figure 3 shows that the national rate of change stayed constant from 2008 to 2011 and post 2012. The Providence rate of change improved from being below the national rate from 2008-11(before systematic implementation of nurse leader rounds) to exceeding the national rate of change following implementation of this leadership practice. It is important to note that various other improvement practices in addition to nurse leader rounds have been underway and continue throughout the system. However, none were implemented to the same degree of system-wide consistency during that time period.

The remaining figures summarize the equivalent survey response data from patients who visited the emergency department during the same time period.

As was the case in the inpatient setting, emergency department patients rate all individual and global aspects of their care more positively when they report receiving a nurse leader round than when they do not recall such a visit (see Figure 4). The differences are statistically significant, $p \leq .001$, for all individual and composite domain areas.

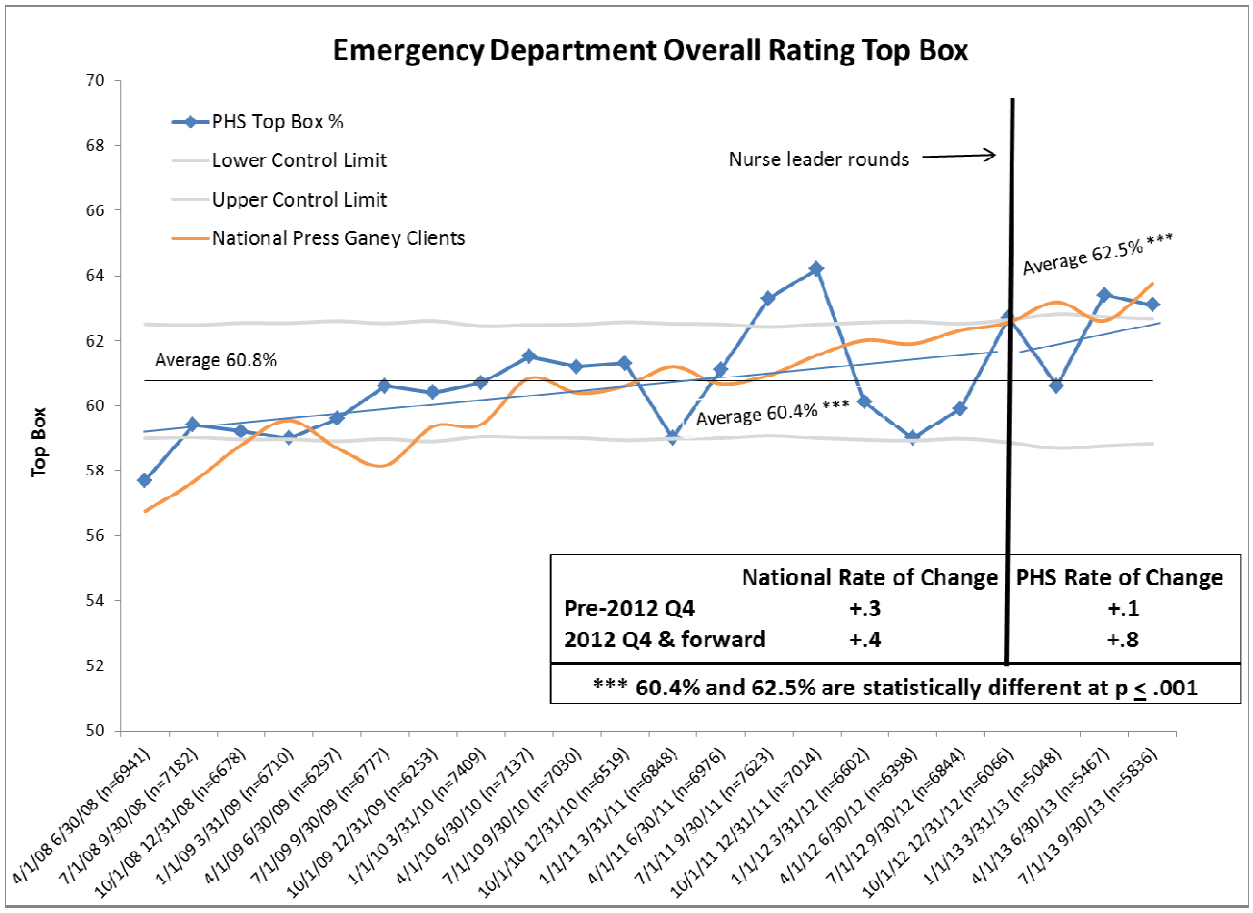
Figure 5 illustrates a similar pattern in percentile rankings as was seen in the inpatient setting. In all cases, percentile rankings for different aspects of care were much higher when patients reported receiving a nurse leader round compared to when they did not recall such a visit.

Figure 5. Percentile Rankings for Different Aspects of the Patient Experience in the Emergency Department (when patients reported receiving a nurse leader round versus not)

Patient Survey Components (n=39,006)	Percentile Ranks		
	Yes	No/Not Sure	Difference
Arrival Composite	49	14	35
Nurses Composite	57	8	49
Doctors Composite	74	19	55
Tests Composite	50	15	35
Family & Friends Composite	64	19	45
Personal / Insurance Info Composite	54	13	41
Personal Issues Composite	21	2	19
Overall Composite	76	16	60
Likelihood to Recommend	77	21	56
Overall Survey	67	12	55

Figure 6 shows a statistically significant increase in the overall rating of care after nurse leader rounds was implemented in the emergency departments. Before implementing this leadership practice, Providence had a lower rate of improvement than that of the Press Ganey national database. Post-implementation, the rate of change exceeded that of the rest of the database.

Figure 6. Emergency Department Nurse Leader Rounding's Impact on ED Overall Rating of Care



Includes data from 25 emergency departments that were part of the system when the intervention began.
Shown quarterly based on discharge date
*** $p \leq .001$

Discussion and Conclusions

Patient perception data summarized in this article suggests that the implementation of nurse leader rounds is associated with increased levels of patient satisfaction in both inpatient and emergency department settings. It is hoped that this information will augment the previously published information about the impact of nurse leader rounds on patient satisfaction/loyalty.

A number of lessons related to the implementation of this approach have emerged as this leadership practice continues to be implemented across the system. These are summarized below.

Singular focus on implementing only one proven practice at a time increases the likelihood that the practice will be successfully implemented. In today's busy health care environment in which nurse leaders need to pay attention to multiple priorities on a daily basis, implementation success is optimized when there is a clear focus on performing a practice frequently and well to the point where it becomes habit. If too many improvement efforts are undertaken simultaneously, it is difficult to fully implement all of them.

Strong senior and staff leadership is required to successfully implement nurse leader rounds. Leaders at local and system levels need to be willing to persistently communicate expectations and hold individual leaders and teams accountable for achieving key milestones.

User-friendly toolkits, which can be locally customized help, ensure consistency of expectation and save time for busy local leaders expected to implement this practice.

Regular production of patient experience data is needed to support leaders and teams at all levels in assessing progress, recognizing improvements, and addressing gaps in performance. When senior and local leaders actively use feedback from patients to simultaneously inspire and hold leaders accountable for carrying out this part of their leadership role, implementation is accelerated.

Dual focus on quantity and quality of practice is key. Nurse leader rounds must be done with enough frequency to make a difference, and the quality of conversations that nurse leaders have with patients and their families must be substantive. Rounding conversations with patients provide real-time feedback to leaders about the care provided in units they are leading. Rounds provide information that assists leaders in recognizing staff providing great care and/or coaching staff that can further develop in their abilities to meet and exceed patient expectations.

Learning from those achieving goals and making solid progress was especially helpful. Nurse leaders facing daily operational challenges often figured out creative ways to increase the quantity and/or quality of nurse leader rounds. Some of the most valued sessions at the quarterly collaborative meetings were presented by nurse leaders who overcame various implementation challenges. Some of the local challenges encountered involved multiple demands on nurse leader time, leadership changes, reliable implementation of local monitoring systems, systematic follow-up on what was being learned during rounds, maintaining focus while simultaneously addressing major new priorities/demands (e.g. implementation of an electronic medical record system), and helping charge nurses to feel comfortable introducing themselves as nurse leaders.

Availability of on-site or virtual coaching provided additional support to facilities encountering implementation challenges.

Health care leaders are perpetually faced with many critical challenges, not the least of which is identifying how to create, improve, and/or maintain exceptional experiences for patients and families who visit their facilities. The experience and results summarized in this article suggest that the reliable implementation of nurse leader rounds represents one strategy that can be used to improve patient satisfaction and loyalty. This practice can be implemented successfully at hospital, emergency department, and system levels.

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