

The University of San Francisco

USF Scholarship: a digital repository @ Gleeson Library | Geschke Center

Doctor of Nursing Practice (DNP) Projects

Theses, Dissertations, Capstones and Projects

Fall 12-17-2021

Purposeful Nurse Hourly Rounding: Plan to Decrease Patient Falls During a Pandemic

ROBBIE MASANGKAY

rmasangkay@dons.usfca.edu

Follow this and additional works at: <https://repository.usfca.edu/dnp>



Part of the [Other Nursing Commons](#)

Recommended Citation

MASANGKAY, ROBBIE, "Purposeful Nurse Hourly Rounding: Plan to Decrease Patient Falls During a Pandemic" (2021). *Doctor of Nursing Practice (DNP) Projects*. 276.

<https://repository.usfca.edu/dnp/276>

This Project is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Doctor of Nursing Practice (DNP) Projects by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.

Purposeful Nurse Hourly Rounding: Plan to Decrease Patient Falls During a Pandemic

Robbie Masangkay

University of San Francisco

Committee Chair: Jim D'Alfonso, DNP, RN, PhD(h), NEA-BC, FNAP, FAAN

Committee Member: Robin Buccheri, PhD, RN, FAAN

TABLE OF CONTENTS

Section I: Title and Abstract

Title	1
Abstract	5

Section II: Introduction

Background	7
Problem Description	7
Setting	9
Specific Aim	9
Available Knowledge	11
PICOT Question.....	11
Search Methodology	12
Integrated Review of the Literature	13
Summary/Synthesis of the Evidence	17
Rationale	17

Section III: Methods

Context	20
Interventions	20
Gap Analysis.....	22
Gantt Chart	23
Work Breakdown Structure	23
Responsibility/Communication Plan	24
SWOT Analysis	24

	3
Budget and Financial Analysis	25
Study of the Interventions	26
Outcome Measures	26
CQI Method and Data Collection Instruments	29
Analysis	29
Ethical Considerations	30
Section IV: Results	31
Section V. Discussion	
Summary	44
Interpretation	47
Limitations	49
Conclusion	50
Section VI: Funding	54
Section VII. References	55
Section VIII: Appendices	
Appendix A. Evidence Evaluation Table.....	63
Appendix B. Non-Research Approval Statement of Determination.....	76
Appendix C. Letter of Support from Agency	81
Appendix D. Gap Analysis	82
Appendix E. GANTT Chart	84
Appendix F. Work Breakdown Structure (WBS)	86
Appendix G. Responsibility/ Communication Matrix	87
Appendix H. SWOT Analysis.....	89

Appendix I. Budget and Financial Analysis	90
Appendix J. Continuous Quality Improvement (CQI) Method	91
Appendix K. Purposeful Nurse Hourly Rounding (PNHR) Tool	92
Appendix L. PNHR Pre-Implementation Survey Questions	93
Appendix M. PNHR Post-Implementation Survey Questions.....	96
Appendix N. PNHR Education Materials	98
Appendix O. Patient Fall Rate Table	106

Section I: Abstract

Problem: Patient falls remain a critical and persistent safety problem in healthcare today. The prolonged impact of the COVID-19 pandemic raises leadership concerns regarding the safe care of high-risk COVID patients and mitigating the increased stress and potential risks of infection to clinical staff.

Context: This Doctor of Nursing Practice (DNP) scholarly project details implementation of an evidence-based purposeful nurse hourly rounding (PNHR) pilot project designed to decrease the incidence of patient falls on a designated COVID-19 unit.

Measure: A modified PNHR rounding tool was implemented to guide focused elements for key nurse/patient interactions.

Interventions: PNHR strategies were further augmented by innovative quantum caring healthcare leadership (QCHL) principles intended to support team engagement and enhance a culture of safety. The transformational leadership approach and theoretical foundations of QCHL were viewed as pivotal enculturation tactics and were aligned to sustainability goals. The project aim was to decrease the incidence of adult patient falls by 10% over baseline data during a four-month pilot on a designated COVID-19 nursing unit.

Results: The post-implementation outcomes highlight a 58% reduction in patient falls from 4.29 to 1.79 falls per 1,000 patient days.

Conclusions: Quantitative and qualitative findings support a proactive leadership approach to patient safety and staff engagement that utilizes an evidence-based, structured, timely, and sustainable nurse hourly rounding strategy.

Dissemination: Low costs, improved clinical outcomes, and positive impact on patient safety and employee engagement increase the potential for spread of this scholarly project to non-COVID care units across the organization and to other systems.

Keywords: Nurse, hourly rounding, fall prevention, patient safety, COVID-19, quantum caring healthcare leadership

Section II: Introduction

Background

The global pandemic brought about by the coronavirus (COVID-19) further exacerbates an existing problem with patient falls in the acute hospital setting. Patients infected by COVID-19, especially older adults, present with higher acuity health conditions accompanied by more complications, and require heightened attention from the entire care team (Harrison et al., 2020). SARS-CoV-2, the virus causing the disease, does not discriminate and can potentially infect anyone with sufficient exposure to it (CDC, 2021). The lethality of the virus in combination with the many unknowns about how the disease manifests and can be treated, has made COVID-19 central to decisions about quality of care and patient safety. This scholarly project describes an approach to purposeful nurse hourly rounding adopted by a COVID-19-designated acute care unit of an urban not-for-profit hospital in Northern California to ensure staff and patient safety during the pandemic. The pilot program has the specific aims of reducing patient falls on the targeted unit and mitigating staff and patient anxieties related to delivering safe care.

Problem Description

The COVID-designated pilot nursing unit has an increasing problem with patient falls. From May 2020 to October 2020, 22 patient falls were reported yielding a fall rate of 4.29 falls/1000 patient days, which is above the national average benchmark rate of 3.44 falls/1000 patient days on general medical, surgical, and medical-surgical units (Venema, Skinner, & Nailon, 2019). This alarming rate of patient falls on the target pilot nursing unit raised quality and safety concerns amongst the nursing leadership team, which inspired the project lead to designate *fall prevention* as the focus of this scholarly project. The pandemic healthcare crisis, along with the rising patient fall rate on the pilot nursing unit, was a stressful period but also

served as a rallying point and became an opportunity for the team to find greater meaning and purpose in aligning oneself to the organization's mission, vision, and values.

Health systems were caught off-guard in early 2020 by the surge of COVID-19 patients and the complexity of treating patients stricken with such a highly infectious and poorly understood contagion. In a COVID-19 designated unit of an acute care hospital in northern California, strict infection control protocols were quickly put in place—and promptly put to the test. Frontline staff were immediately confronted with uncertainty surrounding safely caring for patients while protecting themselves from exposure to the virus. The nursing staff lacked confidence about the organization's ability to deal with the virus, including the availability of personal protective equipment (PPE) and the adequacy of hospital procedures in place to keep them safe. Hospital leadership was challenged to quickly implement measures to ensure that staff, patients, and families felt safe in the short term as hospital safety and infection control protocols were repeatedly revised in response to the continually evolving knowledge and unremitting nature of the pandemic that led to prolonged health and safety restrictions.

The overwhelming stress and increased workload imposed on the care teams by the pandemic made the task of effectively communicating new protocols for fall prevention more difficult. The unforeseen emergence of the global pandemic propelled many sudden changes that challenged the entire healthcare team to self-reflect upon the organization's mission of "Caring, healing, teaching, serving all" (Alameda Health System, 2021). In the COVID-19 nursing unit, the leadership team had to address the fears and anxieties of the frontline staff first. This was accomplished by the unit leadership team conducting huddles with frontline staff every shift to promote transparency and timeliness of communication and address all questions/concerns appropriately. Once staff felt reassured regarding their personal safety, they became more open

and receptive to supporting a new evidence-based pilot project involving purposeful nurse rounding with a focus on fall prevention.

Setting

The setting for the purposeful hourly nurse rounding pilot project was a 28-bed COVID-19 designated acute care nursing unit in a northern California not-for-profit urban hospital. The unit is comprised of approximately 70 registered nurses (RNs) working 12 hour shifts and 30 certified nursing assistants (CNAs) working 8 hour shifts in either full-time, part-time or per diem staffing equivalents (FTEs). The RNs and CNAs are critical to ensuring that rounding and safety checks are done hourly from 7 am to 10 pm, and every two hours from 10 pm to 6 am. Decreasing the frequency of rounding during nighttime hours is intended to minimize potential disruptions to essential sleep patterns. The PHNR pilot was conducted between November 2020 and February 2021.

Specific Aim

The specific aim statement for this scholarly project was to reduce the occurrence of patient falls by 10% over four months in all adult patients admitted to the pilot COVID-19 nursing unit from a baseline of 22 incidents between May 2020 and October 2020.

During a global pandemic, the acute care hospital setting is undeniably beset with chaos and disruption. This project is designed to demonstrate how evidence-based interventions in communication, collaboration, and standardized workflows, when focused on a shared or common purpose, can achieve improved patient safety, quality of care, and patient experience. The PNHR project seeks to reinvigorate and reconnect nurses and care teams with the moral imperative to prevent injury, promote safety, and advocate for “at-risk” patients, families, and care team members.

A secondary goal of the PNHR project, though it will not be part of the outcome measures, was to demonstrate to teams that during unprecedented times of chaos, stress, and complex care demands, the commitment and “Esprit de corps” (Study.com, 2020) of professional care teams and frontline staff to employ evidence-based interventions consistently has the potential to not only improve but sustain clinical outcomes and transform healing environments. Durant et al. (2015) articulated how the integration of caring science in their respective health system across administrative, operational, and clinic areas helped promote a positive and collaborative relationship between leaders and frontline staff through a keen focus on core values of caring, compassion, empathy, and kindness.

In tough times, purpose-driven leaders are frequently described as leading by example. A situation such as the global pandemic calls for transformational leaders to inspire others to persevere and achieve extraordinary outcomes. According to St. Thomas University (2014), transformational leaders demonstrate the following characteristics:

- they are inspirational- able to empower other people to be innovative and search for ways to attain objectives and succeed;
- they are mobilizers- able to activate and organize people into groups to accomplish a common purpose;
- they are morale boosters- able to enrich the well-being and the level of enthusiasm of a team through genuine solid professional relationships.

Leaders must consider that engaged, awakened nurses, and teams can only enhance and support the goals of collective greatness and exceptional outcomes. American Nurses Foundation (2017) expressed that the importance of effective collaboration is well-documented in studies and high-performing groups and institutions. Effective teamwork and how the team approaches

the work to be done can have a significant and positive impact on both the quality and quantity of the work being done.

A global pandemic brings with it uncertainty and elevated levels of stress for the entire healthcare team. It is the leader's responsibility to show authentic care and compassion for the nurses and the entire care team to help address and uplift the frontline staff's morale and foster well-being. Watson et al. (2018) describe the intersections of caring science with quantum leadership theory called Quantum Caring Healthcare Leadership (QCHL). In this model, the moral-philosophical-ethical-theoretical ideologies of caring science converge with established quantum leadership approaches. Quantum caring leaders (QCL) discover creative ways to adapt and thrive amid uncertainty, chaos, and unstable situations. They understand that innovation and ingenuity are best cultivated during the "tough times." Quantum caring leaders envision various conceivable scenarios or potential perspectives and explore diverse means of resolution by connecting with and eliciting direct feedback from as many people as possible, while remaining authentically caring, compassionate, and empathetic. This convergence, emergence and amalgamation of values and principles in QCHC offers invaluable insight and outlines critical aspects of evolved caring leadership necessary to overcome and flourish during extreme situations such as those encountered during a global healthcare crisis.

Available Knowledge

PICO(T) Question

The PICOT question for this scholarly project is: For patients admitted to the target adult inpatient nursing unit in an acute care setting (P), does nurse hourly rounding (I) compared to no nurse hourly rounding (C) decrease the incidence of falls (O) over a four-month time frame (T)? This PICOT question's objective is to guide the scholarly review of current literature to identify

successful evidence-based interventions in other hospitals and acute care settings, outline potential facilitators and barriers, and to integrate this information into the design and implementation strategy of an evidence-based pilot project with the highest potential to reduce patient falls. This project is named *Purposeful Nurse Hourly Rounding* (PNHR) because the primary goal of the project is for nurse hourly rounding to be more *intentional and meaningful* for nurses, connecting the project's purpose and goals with added value to the patient and care team while increasing the probability for enhanced engagement, support, and sustained success. The intent is for the care team to integrate purposeful hourly rounding into their daily clinical practice and experience *authentic connection and meaning* in the process, recognizing that individual and collective efforts make a measurable and positive difference in reducing falls, thereby preventing harm to patients. While there is an abundance of research on nurse hourly rounding, it is imperative to identify those interventions and outcomes that align best with the organizational culture, staff readiness, and target patient population of the identified patient care unit.

Search Methodology

A scholarly literature review and synthesis of available nursing research and evidence-based findings were conducted through the University of San Francisco's online Gleeson library. Keywords in this literature review included *nurse, hourly rounding, fall prevention, patient safety, COVID-19, and quantum caring healthcare leadership*. Relevant search findings appeared within the following databases: CINAHL, Scopus, AHRQ, Cochrane, Guidelines Clearinghouse, and PubMed. The initial literature review parameters included English-only publications, which yielded (without additional advanced filters) a total of 186,928 articles. Additional filters included narrowing publication dates between 2015 to the present and published in academic

journals narrowed the search to 865 relevant articles. An additional "peer-reviewed" journal filter resulted in a final yield of 33 items. The project lead then conducted a manual review of the 33 articles and selected ten scholarly articles aligned to the PICOT and defined objectives for the scholarly project. The articles selected were further appraised using the Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal Tool (Dearholt & Dang, 2019). A summary of the literature review is presented below. See Appendix A for the Evaluation Table related to this evidence.

Integrated Review of the Literature

Hourly Rounding Outcomes on Fall Rate, Hospital-Acquired Pressure Injuries (HAPIs), and Patient Experience

Bosley and March (2015) conducted a quasi-experimental study to gauge the outcomes related to the application of nurse hourly rounding in the acute hospital setting. The population included patients admitted to a 24-bed medical-surgical unit in an acute hospital setting. This study highlighted improvements to patient experience ratings from 48.6% to 72.2% post-implementation of the nurse hourly rounding project. The incidence of falls decreased by 57.7%, while hospital-acquired pressure injuries decreased from four (baseline) within six months pre-implementation to zero post-implementation. Their findings identify how a structured nurse hourly rounding process, executed consistently, demonstrated a positive impact on outcomes related to patient experience, patient fall rate, and hospital-acquired pressure injury (HAPI) rate.

East et al. (2020) conducted a survey method using STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) guidelines to analyze patient experience with intentional hourly rounding and examine which aspects of care predict patient satisfaction. The population was patients in a public hospital in rural New South Wales, Australia. The study

highlighted the strongest predictors of patient satisfaction were: *I felt comfortable and safe during my time in this ward* ($p < 0.001$); followed by *the nurses were interested in my feelings about my care* ($p = 0.003$); then, *I was able to see a nurse when I needed to* ($p = 0.006$); and lastly, *I was able to get pain relief when I needed it* ($p = 0.033$). The study suggests that nurses' intentional hourly rounding improves nurse-to-patient relationships, enhancing the patients' perception of care. Hourly rounding allows nurses (and patients) to stay proactive instead of reactive, improving patient safety and the overall quality of care.

Al Danaf et al. (2018) conducted a study to analyze rounding interventions practiced at high-performing healthcare facilities. The population was 26 hospitals in the HCAHPS (Hospital Consumer Assessment of Health Providers and Systems) database. The common denominator for the top-rated and high-performing hospitals was the reporting of proactive nurse rounding as their primary rounding intervention (96%). The best practice shared by the top-performing hospitals in the HCAHPS database was proactive nurse hourly rounding.

Hourly Rounding Outcomes on Fall Rates

Hicks (2015) completed an integrative review to summarize independent studies' outcomes to determine nursing best practice guidelines. The integrative review included 14 separate studies from 24-bed to 64-bed nursing units. The review highlighted that 12/14 studies demonstrated decreased fall rates. In contrast, 2/14 studies showed fall rates unchanged. The top two studies with the most impactful outcomes yielded the following results. In study one, falls were reduced from 7.02 to 3.18 per 1,000 patient days; In study two, falls decreased by 39% during the study period. This integrative review of fourteen independent research studies reported overwhelmingly positive outcomes, including a correlation between nurse hourly rounding and reduction of patient falls in the acute hospital setting.

Spano-Szekely et al. (2019) conducted an evidence-based practice improvement project to appraise the hospital fall protocol that involved nurse hourly rounding. The population was patients in a 245-bed community hospital. The study highlighted the reduction of patient falls by 54%, from 2.51 to 1.15 falls per 1,000 patient days. The authors suggested that fall prevention is best accomplished when optimal interprofessional collaborations exist. An evidence-based fall prevention program focused on patient safety, staff feedback, and lessons learned from real-time discussions supported learnings and long-term viability.

Mitchell (2017) conducted a quasi-experimental study to gauge whether staff education and implementation of an evidence-based hourly rounding program would affect the number of patient falls. The population was 40 residents in a long-term care facility. The study reported a 55% decrease in falls post-implementation of purposeful nurse hourly rounding. The results of this study suggest a strong correlation between staff education and hourly nurse rounds with a reduction in patient fall rates in a long-term care facility setting.

Grillo, Firth, and Hatchel (2019) conducted a quasi-experimental study to execute timely and purposeful hourly rounds as part of fall prevention interventions. The population was patients on a 112-bed medical-surgical unit. The study reported a significant decrease in fall rate from 5.31 to 1.45 per 1,000 patient days. Evidence from this study suggests that a properly structured and timely nurse hourly rounding process executed consistently demonstrates a direct correlation with a significant decrease in patient fall rate in the acute care setting.

Spittle (2010) conducted a study to assess the efficacy of purposeful hourly rounding on the total number of falls on a medical unit in an acute care hospital. The population was patients in a 1300-bed hospital in North Carolina, USA. The study highlighted no significant change to the fall rates from pre-to post-implementation of nurse hourly rounding. This may have been due

to hourly nursing rounding being viewed as too substantial a change in the nursing staff's care, workflow, and culture in a short amount of time. The authors concluded that the short duration of the study (13-weeks) was insufficient to effectively embed, integrate or hardwire the process with the nursing staff, which resulted in a lack of consistency and compliance with the initiative that negatively impacted the likelihood of short or long-term sustainability.

The Literature on Hourly Rounding Surveys

Toole, Meluskey, and Hall (2016) conducted a literature review on 20 independent articles to identify a wide-ranging list of barriers that influence effective execution and long-term sustainability of nurse-driven hourly rounding in the acute hospital setting. The review highlighted six common themes: the heavy workload of the nurses, arduous hourly round sheets, shortage of staffing support, deficiency of procedures for long-term sustainability, challenging patient population, and the lack of education and training for staff. The authors concluded it is of utmost importance for unit leaders to identify and understand all potential barriers to the nurse hourly rounding project's success. This information can help proactively address the known and unknown variables mentioned and help facilitate successful project implementation and long-term sustainability.

Fabry (2015) conducted an original, tested, validated, and reliable 21-item paper survey, constructed with a five-point Likert scale that consists of hourly rounding components, to learn from the frontline staff's perspectives about hourly rounding in the acute hospital. The population was staff members (total survey respondents, n=64) working in a 186-bed hospital. The study highlighted that over 85% (n=54) agreed that they have enough education regarding hourly rounding and how to incorporate hourly rounding into their daily routines. Only 28.3% (n=18) of staff concluded that the rounding audit tool's execution is an accurate representation that

rounding is being accomplished. Ninety-two percent (n=58) of staff agreed that pain, position, and potty (the “3-P’s”) are being addressed during hourly rounding, but only 55.8% (n=35) agreed that pain management is being handled during hourly rounds. Sixty-nine percent (n=44) favored the account that hourly nurse rounds reduce the incidence of patient falls in hospitals. The study reveals gaps regarding perspectives from direct caregivers (RNs and CNAs) regarding perceptions of staff and their level of engagement in initiatives in which they were not engaged in designing, planning, implementing, and evaluating the initiative. Nursing leadership must utilize this information to proactively address these concerns and have a plan that includes a comprehensive project structure, including staff input, education, engagement, and training for all nursing staff.

Summary/Synthesis of the Evidence

The literature reinforces the importance of grounding this pilot project within a strong evidence base. There were consistent themes and consensus throughout the literature review about the strong correlation between education and proactive nurse hourly rounding and the reduction of patient fall rates in the acute care hospital setting.

Rationale

Two theories form the conceptual framework that guided this project: Lewin’s change theory (2016) and Watson’s theory of human caring (2020). Each of these theories will be discussed including how each one contributed to this project.

Change Theory

Lewin's change theory (2016) is part of the conceptual framework underpinning this nurse purposeful hourly rounding project. This theory provides actionable concepts to facilitate positive change in the identified pilot COVID-19 designated nursing unit that will be the

project's site. Burnes (2020) describes the importance of each phase of Lewin's change theory to any organization, analogous to how a block of ice undergoes significant changes of unfreezing, changing to a malleable state, and then transforming (refreezing) into the desired form. Amid a global pandemic, it is critical to assess the staff's readiness to absorb new information. As part of the project's plan, it is necessary to ensure adequate and consistent communication regarding the change rationale. A communication plan implemented during unfreezing will help ensure that the entire team affected by the change is engaged and aware of the program and its role. Another crucial aspect of the unfreezing phase is that there is an opportunity to address potential barriers, such as any questions or concerns about the proposed change. During the actual change phase, communication must remain consistent and allow for time to adjust to the change process. The refreezing period marks a crucial time when the new and evidence-informed norm is set as part of the new organizational culture of quality, safety, and service. A vital piece of this phase is ensuring that affected staff members are provided with the necessary training and support the team requires and promotes their ability to remain on track or sustain the improvements over time. It is also an integral part of leadership's responsibility to ensure that the changes occur as planned and the essential resources are provided to support change. Celebrating success with positive reinforcements will support achieving the desired state and attainment of project goals locally. This scholarly project, goals, interventions, and outcomes may provide opportunities for future spread and accelerated integration of defined best practices into other patient care areas and facilities outside the target organization.

Watson's Theory of Human Caring

A defined nursing theory that supported this DNP project was Dr. Jean Watson's theory of human caring. The purposeful nurse hourly rounding initiative was deeply rooted in principles of

caring, compassion, and the treatment of the whole person as an entire being “mind-body-spirit” as one in relation with the caring-healing environment at all levels (Watson, 2020). Successful implementation and sustainment of the PNHR project depended on the care team being united as a cohesive unit aspiring to achieve common goals and objectives. Watson’s theory served as the project’s moral and ethical foundation for nurses and other members of the care team as they embraced a methodology of purposeful professional practice that promoted positive, therapeutic, and meaningful relationships between staff, patients, and all entering the healing environment.

Watson’s theory provided nursing leaders with an essential concept that nurses are first and foremost unitary human beings that must be cared for, attended to, and appreciated. The self-esteem, safety, security, and overall welfare of the frontline care providers must remain a leader’s top priority. A team that achieves good morale and healthy working environments, which is positively united as one- can generate and achieve positive and impactful outcomes, as nurses and others act with consciousness, intentionality, and presence with a focus on informed moral praxis. One of the ten Caritas core values (Caritas Process 1) outlined in human caring theory aligns nicely with the PNHR project's goals. Caritas Process 1 reads, “Sustaining humanistic-altruistic values by the practice of loving-kindness, compassion and equanimity with self/others.” (Watson, 2020). Amid an evolving global health crisis, each team member's humanistic and altruistic values, synergized by attitudes of love, care, and compassion, allowed the team as a collective to find joy, meaning, purpose, and fulfillment in the work that they do. These attitudes and values may be viewed as intangible factors, not readily visible, or measured in defined quality metrics. Nonetheless, they played a vital role in the team’s ability to discover the moral imperative and cultivate the fortitude necessary to survive and thrive in very challenging circumstances (Watson et al., 2018).

Section III: Methods

Context

The key stakeholders for this DNP evidence-based project include the Chief Nursing Officer/ Chief Administrative Officer, Vice President of Patient Care Services, Nursing Directors, Nursing Managers, Clinical Education Department, Risk Management, Patient Experience Team, Falls Committee, Staff RNs, C.N.A.'s, Clerks, Unit leadership, patients, and families. These key individuals and teams all play a crucial role in the safe delivery and quality of patient care. When present, either in-person or via remote telehealth modality, family members who understand and follow CDC guidelines regarding COVID-19 precautions significantly contribute to safety, advocacy, and support for impaired or at-risk patients. Through interviews, conversations, and interactions with the project lead, the above-identified nursing leaders and frontline staff expressed awareness of the lack of a standardized nurse hourly rounding process throughout the entire health system.

Intervention(s)

The PNHR intervention is an evidence-based initiative to help decrease patient falls in acute care settings. All key stakeholders worked with patients and families as a team to drive the project forward. The primary RNs and CNAs are essential to ensure that hourly rounding is done effectively every hour from 7 am to 10 pm, then every two hours from 10 pm to 6 am. The decision to decrease the frequency of nurse rounding during the nighttime to every two hours instead of hourly was made to protect and preserve sleep and minimize interruptions to essential rest time for the patients. The hourly rounding tool utilized for this DNP pilot project was modified from the version originally developed by the Studer Group (2020). The reason for the modification is to add a “fifth P,” which stands for “Protect,” to emphasize the importance of

patient safety by preventing patient falls and keeping the environment of care safe and free of hazards. See Appendix K for the Purposeful Nurse Hourly Rounding Tool and Appendix N: PNHR Education Materials. The PNHR intervention consists of five essential elements called the “5 Ps,” which each nursing staff must assess in every patient interaction:

1. *Pain*- assess for pain or discomfort and intervene as necessary
2. *Potty*- assess for toileting needs and help the patient as needed
3. *Position*- assess for comfort or the need to reposition in bed
4. *Provide*- ensure to provide all necessary items within the patient's reach, such as call light, eyeglasses, hearing aids, dentures, food.
5. *Protect*- ensure that fall precautions are in place and that the environment of care is safe and free of hazards

Communication was equally important as the other proposed interventions. Each nursing staff member should greet every patient with a standardized greeting, introducing themselves by name and role and letting the patient know that they will be conducting hourly rounding during the day and every two hours during hours of sleep. Asking the patient, "is there anything else I can do for you before I leave," is essential to ensure that the patient is safe, comfortable, and has had all needs addressed. An existing evidence-based communication framework is also being utilized as a standard way of communicating to patients during purposeful nurse hourly rounds. Studer Group (2020) created a communication structure called “*AIDET*,” which stands for five communication activities:

1. *Acknowledge*- knock on the door; greet the patient using the patient’s preferred name; smile; acknowledge everyone present in the patient’s room.
2. *Introduce*- introduce self with name, title/skill, and professional experience.

3. *Duration*- provide an estimated timeframe for any tests, procedures, follow-up items, and next assessment/update.
4. *Explanation*- educate the patient regarding the plan of care, next steps, what to expect, and inform the patient of the best way to reach the staff, such as the nurse's phone or call button.
5. *Thank you*- thank the patient and family for their patience and cooperation.

It is important to note that AIDET is not a script but rather a standardized and evidence-based framework to achieve regularity in incorporating essential communication elements in every interaction with patients. This communication strategy was vital for the PNHR project to accomplish consistency, uniformity, and reliability in communicating with patients and families. In addition, it was necessary to understand that a script may complement but should not usurp the importance of authentic, compassionate, humanistic interactions that enhance trust and connection in a caring culture.

Gap Analysis

During the project's planning phase, unit leaders conducted interviews and discussions with the frontline nursing staff regarding their knowledge, perceptions, and thoughts regarding the nurse hourly rounding concept. The project lead solicited feedback from staff by utilizing a pre-implementation survey, which incorporated questions regarding baseline knowledge, potential barriers to successful implementation, and suggestions for the PNHR project implementation. Continual deliberations with other nurse leaders also transpired to elicit expert opinions and best practice recommendations from previous clinical and leadership experiences. Data from the MIDAS Safety alert system was examined to identify gaps in nursing performance and practice about patient safety. The gap analysis emphasized the necessity for baseline and

supplemental education amongst the nursing staff, unit leadership team, and other key disciplines about the purpose of nurse hourly rounding and its importance in maintaining quality and patient safety. An education plan to teach foundational PNHR concepts will be part of this project to address and bridge this defined gap. As identified previously, there was currently no standardized hourly rounding tool used throughout the entire organization. See Appendix D for details regarding the Gap Analysis.

GANTT Chart

The PNHR initiative will be implemented in three strategic segments. The first segment or phase will consist of assessing the current state, identifying the problem and proposed solution(s), and educating all key stakeholders--to ensure that teams are aligned with the go-forward strategy, objectives, and outcome priorities. The primary focus of the PNHR intervention is patient safety and quality care. The second segment or phase will be the actual implementation of the PNHR project, where the nursing staff will integrate and incorporate the findings identified during the education phase. The second segment is where unit leadership will assess project status, performance and identify opportunities to close potential gaps. The final process component will consist of a thorough data analysis to examine the interventions' overall effectiveness and identify any areas that may require focused attention or revision. This final phase will evaluate the potential integration of best practices and outcome improvements as part of the staff's standard work and culture of care, which further supports the sustainability and future spread goals for the project. See Appendix E for details regarding the Gantt Chart.

Work Breakdown Structure

The work breakdown structure (WBS) of the purposeful nurse hourly rounding project consists of four key project focus areas essential for design, implementation, and completion of

the project: project development, human resources, finance, and program evaluation. Each phase is interdependent and integral to the overall structure and success of the project. The most challenging aspect is to sustain the standard work methods after implementation via ongoing audits and the utilization of the existing plan-do-check-act (PDCA) continuous process improvement mechanism. Per the American Society for Quality (2020), the PDCA cycle is a four-step quality improvement model that allows for continuous assessment and evaluation of processes for constant development and improvement. See Appendix F for the detailed Work Breakdown Structure.

Responsibility/Communication Matrix

The purpose of the communication plan is to ensure that all essential individuals, groups, and teams involved with the PNHR project are aligned with project objectives and goals at every phase of the initiative. The plan is to communicate with stakeholders at key intervals and times to prevent information overload to key stakeholders while also soliciting valuable feedback and providing pertinent data, as close to real-time as possible, to the frontline nursing staff to ensure continuous process development and improvement throughout the pilot project. The communication matrix was created to strategically pace the communication's timing and content to facilitate smooth project implementation. The project coordinator will provide timely updates to all involved to be aware of the project status, allowing for opportunities to gather feedback and answer questions. See Appendix G for details of the Communication Matrix.

SWOT Analysis

The SWOT analysis of the unit's current state revealed areas that can be improved to help facilitate successful project implementation. Highlights are as follows: the strength identified is the strong teamwork and collaboration within the nursing team and amongst the interdisciplinary

teams. A weakness identified is the lack of a standardized hourly rounding tool and process on the unit level, compounded by the stressors due to the COVID-19 pandemic. The opportunity identified is the increased complexity of patients getting admitted to the hospital due to complications brought about by the prolonged global pandemic. It would be wise to leverage existing professional solid relationships and partnerships between nursing and other key disciplines to achieve project goals. The primary external threat identified is the possibility of a COVID-19 resurgence and the lack of a COVID-19 vaccine, increasing the burden to staff, which can negatively affect the PNHR project. See Appendix H for more details regarding the SWOT Analysis.

Budget and Financial Analysis

A proposed budget was established to sustain this DNP pilot project over a 4-month implementation plan. Costs associated with the PNHR pilot initiative encompassed project expenses that include education hours for all key stakeholders (staff RNs, staff CNA's, staff clerks, unit leadership team, charge nurses), project-related meetings, project supplies and materials, and labor cost to build the PNHR documentation tool in the EHR. The salaries of employees involved in the project were not incorporated in the budget proposal, as involvement in a unit-based pilot project is part of employees' duties and responsibilities to the organization. Program supplies and materials, including printing costs, were included. Per the delineated GANTT chart and work breakdown structure, the DNP pilot project was carefully planned, executed, and closely monitored to safeguard the timeliness and compliance within the proposed budget. (Appendix E: GANTT chart; Appendix F: WBS). Weekly project update meetings with key stakeholders will allow for ongoing and consistent communication amongst the project team

to enable the project lead to make necessary adjustments to the project strategy, as close to real-time as possible, to ensure that project timelines are accomplished.

According to Johns Hopkins Medicine (2015), the average cost of a fall with injury in the hospital is \$34,294. See Appendix I: Budget and Financial Analysis. The estimated cost of the entire Purposeful Nurse Hourly Rounding (PNHR) project is approximately \$15,530. The potential cost-avoidance savings from preventing one patient fall is \$34,294 (Johns Hopkins Medicine, 2015). The cost-avoidance savings from preventing ONE patient fall will more than cover the entire cost of the PNHR pilot project. Potential organization savings may be exponential depending upon the actual number of falls that can be prevented due to this DNP quality improvement project. According to Waxman (2018), it is crucial to the DNP/nurse leader's success and the organization's benefit to acquire operational, financial, and management skills. Similarly essential are the skills of balancing the challenges between quality and cost, negotiating with multiple stakeholders, presenting conflicting agendas, and implementing the processes needed to ensure high-quality individualized and compassionate patient care. There is also a positive learning opportunity for nurses and care teams to understand the impact and costs associated with a patient fall, both as good stewards in promoting healthcare affordability and preventing patient harm.

Study of the Intervention(s)

Outcome Measures

The primary outcome measure for the PNHR initiative is the comparison of patient falls pre-and post-implementation. This data's primary source will be the MIDAS Safety Alert system, an anonymous patient safety reporting system administered by the Quality and Risk Management team. MIDAS is the organization's universal technological tool to encourage all hospital staff to

submit anonymous occurrence reports electronically regarding patient safety events for analysis and resolution. Adelman and Skae (2020) implemented the MIDAS patient safety reporting system in their respective healthcare facility and affirmed, "Some of our best insights arise when we examine why and how errors happen so that we can determine the best approach to an effective intervention." Similarly, at the project lead's hospital, when staff encounter or observe an error or near-miss event, staff members have been appropriately trained to electronically submit an occurrence report through the MIDAS Safety Alert System, which is accessible via the intranet from any computer in all facilities throughout the entire health system. Reports submitted through the MIDAS system are closely monitored, tracked, and trended by the Quality and Risk Management department.

Within the MIDAS Safety Alert System, various disciplines can exchange information and collaborate to resolve specific cases or occurrences. Pertinent data sourced from the MIDAS system are swiftly communicated, shared, and reported to unit leaders for prompt resolution, and in some cases, escalated to executive leadership for the construction of corrective action plans so risks and potential harm/damages can be mitigated promptly and prevent similar safety events. The MIDAS safety alert system is a simple yet effective tool to document safety occurrences, identify and trend for patterns, and resolve essential safety issues within the organization. As part of the organizational goal of supporting a "culture of safety," a non-punitive work environment is maintained. Staff members are encouraged to speak up whenever safety concerns are identified without fear of retaliation or reprimand. The primary focus of data collection and trending is to identify and prevent adverse safety events from happening. Leaders are responsible for ensuring that this vital principle remains part of consistent communication to teams. As a result, it

becomes second nature to staff's approach to standard work and empowered clinical practice, ultimately enhancing staff engagement, patient safety, and quality of care.

Patient fall (quantitative data) were monitored throughout the PNHR project implementation to determine if the purposeful nurse hourly rounding interventions are effective. Also, qualitative data were gathered from team surveys, staff feedback, narratives, and comments from the frontline nursing staff. A vital aspect of leadership inquiry for honest feedback is promoting a "speak up" culture to encourage and elicit correspondence in a safe and non-punitive approach. According to the Institute for Healthcare Improvement (2021):

An organization can enhance safety particularly when leaders are visibly committed to change and when they empower staff to share safety information openly. Unfortunately, when an organization does not have such a culture, staff members are usually reluctant to report unfavorable safety incidents and unsafe situations because they fear retribution or assume reporting will not result in any change. (para. 2)

The project lead considered including patient experience data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) database for this pilot DNP project; however, due to the impact of COVID-19 on strict family/relative visitation restrictions and associated infection control protocols (i.e., social distancing), HCAHPS scores have proven inconsistent, related to delayed reporting and unavailable or unreliable benchmarking scores during the pandemic. These limitations resulted in the exclusion of HCAHPS data may confound project results. The HCAHPS survey is the first survey nationally recognized as the gold standard for measuring the patient's perception regarding their hospital care and experience (CMS, 2020). The Centers for Medicare and Medicaid Services (CMS) designed and implemented the HCAHPS survey in 2006, and since then, the publicly reported

HCAHPS data has been made available to the public to allow for transparency and objective comparisons amongst hospitals and healthcare systems (CMS, 2020). Patient falls were identified as the primary project metric as patient safety and prevention of falls remain the initiative's central goal.

CQI Method and/or Data Collection Tools

Key unit-based nurse leaders, such as charge nurses and assistant nurse managers, received thorough education and training on performing random chart audits to ensure continuous quality and process improvements. Random chart audits were conducted by the trained unit leadership team to achieve long-term sustainability and successful integration of the purposeful nurse hourly rounding standard work as part of the routine care delivery of frontline nursing staff. Based upon audit findings, the unit leadership team provided constructive feedback and coaching to the staff members, as close to real-time as possible, to support the process of continuous quality improvement (CQI). See Appendix J: CQI Method.

Analysis

Baseline data were cross-checked with post-implementation results to evaluate the efficacy of the intervention over a period of four months. Descriptive statistics were used to evaluate changes in patient fall incidence. The P-value was obtained to determine if changes are significantly related to the intervention or a random occurrence. The specific aim is a ten percent decrease from baseline in patient falls at four months from initiation of the PNHR intervention.

The purposeful nurse hourly rounding (PNHR) quality improvement project found that the number of falls per month post-intervention (mean, 1.50 ± 1.29) was significantly lower ($p=0.006$) than pre-intervention (mean, 3.60 ± 0.82). Pre-intervention, the pilot nursing unit had an average of 4.29 falls per 1,000 patient bed days. Post-intervention, the average number of falls

decreased to 1.79 falls per 1,000 patient bed days. See Appendix O (Patient Fall Rate Table) for more details. The project goal of a ten percent decrease in patient falls from baseline was notably exceeded. The pilot project results demonstrate alignment with outcomes from similar initiatives found in evidence-based literature regarding the correlation of nurse hourly rounding with the reduction of patient fall rates. Thus, the findings from this DNP quality improvement project are consistent, significant, and support previously documented nurse rounding interventions cited from other scholarly articles regarding its positive impact on patient safety.

Qualitative data from staff surveys, discussions, and feedback were analyzed. All staff responses were reviewed, which helped inform the DNP project. Due to a large number of responses, the project lead randomly selected free-text responses to include in the DNP project report. Data were then integrated into the PNHHR project as part of the PDCA continuous improvement process.

Ethical Considerations

This evidence-based DNP change project aligns with the American Nurses Association's Code of Ethics (2015): The nurse promotes, advocates for, and protects the rights, health, and safety of the patient (para. 15). This is an overarching principle that is acknowledged and valued by nurses and all members of the care team.

Silva and Ludwick (1999) reinforced the importance of the concept of nonmaleficence, which means to “do-no-harm,” as it pertains to the moral and ethical imperative of nurses to protect and advocate for human beings they serve, especially elderly adult patients who are vulnerable and at a higher risk for injury, fall, isolation, confusion, and death, during this global pandemic crisis.

The moral-ethical-theoretical principles of Watson's theory of human caring serves as a moral compass for frontline nursing staff to maintain increased and sustained awareness, engagement, consciousness, intentionality, accountability to "do-no-harm," and provide the care, compassion, and kindness that all humans deserve. One of the ten Caritas Processes is: Creating a healing environment at all levels (Caritas Process 8); a quiet environment for a positive energetic, authentic caring presence (Watson, 2020). This core value is well aligned to this DNP pilot project as it is one of the most important guiding principles of the PNHR project- that every patient must be treated with courtesy, dignity, and respect- regardless of a person's background, race, culture, gender, religion, and socioeconomic status. This moral principle is often expressed as the common maxim known as "The golden rule" whereby, healthcare workers treat patients and families the way they would like to be treated themselves. No identifiable or protected patient health information was used as part of the analysis or final written DNP project.

The core principles of the PNHR initiative also support Ignatian values and the Jesuit idea of *cura personalis* or "care for the entire person." This concept embodies the respect for every human being's individual intellectual, physical, and spiritual well-being (USF, 2019).

The project did not require a local institutional review board (IRB) approval and was conducted according to the guidelines of an exempted quality-focused and evidence-based nursing project. See Appendix B for the Non-Research Statement of Determination.

Section IV: Results

This DNP pilot project highlights a reduction of patient falls by 58% from 4.29 to 1.79 falls per 1,000 patient-days for four months during a global health pandemic. According to the MIDAS safety alert system, the number of patient falls in the pilot COVID-19 nursing unit throughout the project were as follows:

- May 2020= 3 (Pre-intervention data point)
- June 2020= 3 (Pre-intervention data point)
- July 2020= 3 (Pre-intervention data point)
- August 2020= 4 (Pre-intervention data point)
- September 2020= 4 (Pre-intervention data point)
- October 2020= 5 (Pre-intervention data point)
- November 2020= 3 (Post-intervention data point)
- December 2020= 2 (Post-intervention data point)
- January 2021= 1 (Post-intervention data point)
- February 2021= 0 (Post-intervention data point)

The downward trend of patient falls in the pilot unit is noteworthy given the very challenging circumstances of the COVID-19 resurgence during this time. The modified version of the PNHR rounding tool highlighted the “fifth P,” which stands for “Protect,” to reinforce the importance of keeping the environment of care safe and free of hazards. This added feature was part of the evolution of the nurse hourly rounding process whereby frontline nursing staff proactively address the vital components (*Five Ps: Pain, Position, Potty, Provide, and Protect*) of the PNHR process as part of their routine clinical practice. Although nurse rounding concepts have been utilized in healthcare for decades, the unprecedented global pandemic altered how healthcare is delivered, presenting unique challenges to the team to maintain safe patient care. As a result, healthcare leaders had to swiftly adjust to the many unknowns of the global healthcare crisis, balancing ways to financially keep hospitals open for service while maintaining safe patient care delivery.

There was a time when the supplies of personal protective equipment were running low throughout the organization; the frontline staff's level of anxiety was high. It was a period when the nursing leadership's mental fortitude, grit, and focus were tested. The positive professional relationships and harmony amongst the hospital leadership team and frontline staff enabled prompt funneling of vital communications across all levels. Adequate and timely communication was crucial to ensure that frontline staff members were kept abreast of all changes and updates regarding hospital policies, procedures, and protocols.

According to Reddy and Gupta, success in the containment of COVID-19 pandemic also mandates effective communication and interpersonal skills of health care workers that include the capacity to gather data to promote accurate diagnosis, proper advice for isolation and quarantine, provide clinical advice on how to develop relationships with patients (2020). Through this good communication, the team collaborated effectively and efficiently to operationalize the PNHR process measures.

The key stakeholders, i.e., registered nurses, certified nursing assistants, unit educators, and the unit leadership team, were educated and trained using a standardized method based upon the PNHR guidelines and the project's conceptual framework. Due to the pandemic, nursing staff shortage became an issue. As a result, supplemental agency nursing staff were on-boarded and trained on the PNHR process. During this chaotic time, there were consistent and continuous communications to the team regarding unceasing efforts to report all safety events via the MIDAS safety alert system so that proper data tracking and trending could continue.

Other challenges related to the pandemic made it arduous for staff to carry out the PNHR tasks. Elderly patients with existing comorbidities infected with COVID-19 presented with higher acuity and required more complex care and increased staffing demands. The surge of

COVID-19 patients also presented another challenge, as there were a limited number of negative-pressure rooms on the unit. As part of the organization's response, all patient rooms in the COVID-19 designated unit were converted into negative-pressure rooms with the help of the Engineering department. As the COVID-designated nursing unit became saturated with very sick patients infected with COVID-19, the "fairness of nurse-to-patient assignments" became a subject of concern. The unit leadership team had to pay close attention to ensure that unit charge nurses made fair nurse-to-patient assignments for staff and patient safety, which means the acuity of each patient had to be taken into consideration to ensure that the workload was distributed evenly amongst all nursing staff. With the advent of stringent infection control protocols and a surge of higher acuity COVID-infected patients, it became more physically and mentally exhausting for the nursing staff to perform their duties in the COVID-19 designated unit.

During this time, the open and honest communications between frontline staff and unit leaders helped mitigate the situation and provided the team with additional workforce resources, equipment, and supplies to assist with their heavy workloads. In addition, the organization had to modify its visitation policy to reflect community standards following CDC guidelines for physical distancing. According to the Center for Disease Control and Prevention, visitors to healthcare facilities should be limited in the context of the COVID-19 pandemic, regardless of known community transmission (2020). This change affected the morale of patients and staff, as the patients' family members could not be physically present with their loved ones in the COVID unit. It was a difficult adjustment but a necessary one given the dire status of the global health crisis. The pandemic brought many unintended barriers and challenges to the PNHR project, but the unit leaders and frontline staff maintained their resiliency as they worked together, faced, and resolved the difficulties as one united team. According to Baskin and Bartlett (2021), developing

resilience in nurses and other healthcare workers can protect against adverse consequences related to the job, including burnout, distress, anxiety, and depression, and can enhance patient outcomes.

A pre- and post-implementation survey was part of the study design to obtain baseline responses from frontline nursing staff and ascertain whether the purposeful nurse hourly rounding project impacted patient safety outcomes. The project lead developed the pre- and post-implementation surveys used in this DNP pilot project from nursing literature in collaboration with a panel of fellow nursing leaders who are masters prepared, experienced nursing educators, and researchers with defined experience in survey development. The surveys had not been previously tested and validated, but the questions included were identified by the panel as appropriate, targeted, and relative to the pilot project outcomes and goals. According to the Institute for Healthcare Improvement, teams can utilize short surveys to gather vital feedback to help guide if the project is going in the intended direction and beneficial as part of the continuous quality improvement process (2021). See Appendix L and Appendix M for more details on the pre- and post-implementation surveys, respectively.

The pre-and post-implementation surveys were distributed via work email through a secure link to Qualtrics, a dynamic online survey development suite that offers data collection, aggregation, and analysis tools. Qualtrics is used for quantitative and qualitative research designs and contains mechanisms for survey collaboration and distribution (The Center for Instruction and Technology, 2016). Survey responses were kept anonymous, as no demographic information was gathered other than the person's role, i.e., R.N. or C.N.A. The pre-implementation survey had a response rate of 73% (n = 100), while the post-implementation survey had 86% (n = 100). Therefore, the return rate for both surveys represents an appropriate majority of staff on the

targeted unit. The pre-implementation survey was administered upon the completion of staff education and training but before the implementation of the quality improvement project.

Pre-Implementation Survey Results

Ninety-five percent ($n = 73$) of those surveyed indicated affirmatively to the No Pass Zone question that they would not pass a call light, regardless of their position or job title. This is an encouraging sign because one of the top teaching points during staff education and training is that everyone has a responsibility to answer call lights and address the patient's needs, regardless of whether a particular patient is assigned to the staff member.

Ninety-six percent ($n = 73$) of those surveyed indicated affirmatively to the question regarding the definition of purposeful nurse hourly rounding, including the concept of five P's: pain, potty, position, provide, and protect. Again, this demonstrates an understanding of the quality improvement project's central doctrine to enhance patient safety, quality of care, and patient experience.

Ninety three percent ($n = 73$) of those surveyed answered affirmatively to the question that Purposeful Nurse Hourly Rounding (PNHR) is an evidence-based intervention that enhances patient safety by decreasing patient falls and proactively identifying and addressing the patient's needs. This is a positive indication of the nursing staff's knowledge and understanding of the project's objective and goals. 100% ($n = 73$) of those surveyed answered "yes" to this question: *If you or a loved one is admitted to a hospital, would you like the hospital nursing staff to perform consistent, purposeful nurse hourly rounding and implement a "No-pass zone" for you or your loved ones?* According to the staff's perspective, all survey respondents' 100% unanimous response to this question is a powerful affirmation that the PNHR and No-Pass zone initiatives are positive, helpful, and beneficial.

The latter part of the pre-implementation survey consists of two open-ended questions that staff members can input "free-text responses," which means that they can type their responses in a narrative format without any restrictions.

Below are random samples of staff free-text responses to the pre-implementation survey open-ended questions:

What do you think are potential barriers that can hinder the success of the project?

- With the many (almost daily) changes in hospital policies and protocols, we are swamped and may find it hard to consistently round every hour on patients.
- When we are short-staffed, we do not have enough C.N.A.'s, or we may not have a Resource/Break Nurse to help us with the very high acuity patients, which will affect our ability to round on all our patients per the hourly rounding schedule.
- Since our unit is the COVID-designated nursing unit in our organization, we hope there will be enough P.P.E.'s for the duration of this pandemic; otherwise, that will be a big problem!
- Hospital leaders also need to look out for our safety and well-being because it is scary out there! We are putting our lives on the line every day for these very sick patients.
- The communication between management and staff must remain transparent and timely so that we, the staff, will stay informed on keeping ourselves and our patients safe!
- From executive leadership to middle management to the frontlines, everyone must be on the same page if we want to be successful and safe.
- Because of the COVID-19 pandemic, patients are much sicker and require more complex care, which takes more time.

- Due to the frequency of going in and out of patient rooms, the supply of personal protective equipment (P.P.E.) may be an issue.
- I sure hope that we do not get sick because otherwise, there won't be any nurses to care for patients.
- There are too many things going on right now, so I am not sure how everyone will feel about starting a new project in the middle of a pandemic.
- For this project to be successful, the leadership team must alleviate the fears and anxiety of the frontline staff first. Once that is addressed, then people will listen.
- The main barrier I see is whether we as human beings can set aside our differences and work towards a common goal despite all the odds that look like they are against us.

Do you have thoughts/ ideas suggestions on implementing a successful PNHR initiative?

- Everyone will have to be educated and appropriately trained because we do have many staff members on this unit, and we must be all on the same page to make this work.
- Our unit consists of multi-cultural staff members who come from different parts of the world. It would be essential to ensure that everyone understands what they are doing and WHY they are doing it.
- All questions and concerns of staff members, including their fears and anxieties, will have to be addressed first and foremost before anything else.
- Leadership will not be successful in implementing any changes unless the staff members feel safe and secure.
- It will require complete buy-in from all frontline staff and the full support of the entire leadership team to make this work.

- All staff on all shifts will have to be on the same page to maintain the consistency and rigors of the patient rounds.
- Unit leadership must consistently conduct routine rounds on staff and patients to validate and ensure that the rounds are happening as designed.
- To truly incorporate this into people's daily routines, they must understand these interventions' purpose, meaning, and benefits. If they feel they will benefit greatly, they will have better motivation to follow and do as told.
- It would be helpful to have visual cues, maybe in the break room or at the nurses' station, to help remind staff about the critical components of the hourly rounding.
- The staff must understand the WHYs behind the project to feel good about it and be self-motivated to make this part of their routine clinical practice.
- The unit leadership team must keep an open mind and be open to staff feedback, comments, and suggestions because we have many experienced and intelligent nurses who will have great ideas for improvement!
- Leaders will have to develop a mechanism for random auditing and coach staff members as needed so that the integrity of the process remains intact.

The project lead analyzed all pre-implementation survey responses. The findings were discussed with the unit leadership team to ensure that the comments and concerns were taken into consideration and address the issues proactively with staff to support the successful implementation of the quality improvement project.

The post-implementation survey was conducted one week after the conclusion of the DNP pilot project.

Post-Implementation Survey Results

Ninety-five percent (n = 86) of survey respondents answered "yes" to this question: *In your honest assessment, do you believe that Purposeful Nurse Hourly Rounding (PNHR) helped improve patient safety and quality of care for the patients we serve?* The solid affirmative response to this question indicates that staff members fully understood the rationale and actual value behind the quality improvement project and its impact on safe and high-quality patient care.

Ninety-four percent (n = 86) of survey respondents answered "yes" to this question: *Do you feel that you have been adequately educated, trained, and supported regarding the PNHR pilot project?* The affirmative majority response to this question is a good indication from the leadership team's perspective. One of the leading project objectives is to ensure that all staff members receive adequate education and training and continuous leadership support to be consistent in clinical practice regarding the PNHR-specific tasks.

Ninety-eight percent (n = 86) of survey respondents answered "yes" to this question: *Do you believe you have the necessary knowledge and tools you need in order to perform the PNHR tasks effectively?* The high rate of an affirmative response to this question is an excellent achievement by the unit leadership team because the staff needs not only knowledge but also the tools in order for them to execute the project objectives accordingly.

Eighty-five percent (n = 86) of survey respondents indicated *strongly satisfied* with the PNHR project; 7% (n = 86) indicated *slightly satisfied*; 3% (n = 86) indicated *neither satisfied nor dissatisfied*; 2% (n = 86) indicated *slightly dissatisfied*; and 1% (n = 86) indicated *strongly dissatisfied*. This question used a 5-point Likert scale, with options of: strongly dissatisfied, slightly dissatisfied, neither satisfied nor dissatisfied, slightly satisfied, and strongly satisfied. The high rate of overall strong satisfaction with the PNHR project is a positive indication for

both the unit leadership team and staff members, as the unity and teamwork of the entire group were tested and proved resilient during a challenging global pandemic.

The latter part of the post-implementation survey consists of one open-ended question that staff members can input "free-text responses," which means that they can type their responses in a narrative format without any restrictions.

Below are random samples of staff free-text responses to the post-implementation survey open-ended question:

In your opinion, what went well and what did not go well during the PNHR project implementation? Please explain.

What went well:

- Leadership did an excellent job in educating and training staff about this project.
- I felt prepared to have the knowledge and tools necessary to do my part in the project.
- Even though many registry (external agency) nurses got onboarded during the pandemic, they were also educated and trained adequately regarding the PNHR activities.
- The consistent huddles at the beginning of every shift were very helpful in disseminating vital information to the frontline staff.
- The leadership team did a great job addressing the fears and anxieties that we staff members felt very strongly about. We needed that to focus on doing a great job for the patients and each other!
- We felt the care and compassion from the unit leaders, that we were all in it together, and that they were genuinely looking out for our safety and well-being.
- I felt that there was good buy-in from the majority of frontline staff regarding this project.
- Unit leaders were very supportive throughout the entire project, from beginning to end.

- Patients appreciated that everyone seemed proactive with the care being provided and the extra attention by all staff.
- Unit leaders did their best to conduct audits to ensure that the hourly rounds were being done and provided as-needed constructive coaching to staff.
- There was good mutual communication from both sides (between staff and leadership) regarding the many questions, issues, and concerns that came up during the implementation of this project.
- Leadership listened well to staff feedback, which made a massive difference because we (the staff) knew the solutions to the many challenges we were facing. It was just a matter of whether the leaders will listen to us, and we are glad they did!

What did not go well:

- The COVID-19 pandemic made patients sicker, and the overall acuity of patients was higher than usual, which required extra care and attention from all healthcare workers, making it very challenging for us to stay consistent with the hourly rounding schedule.
- There was a shortage of isolation gowns at one point, so it was hard to do the frequent hourly rounds.
- Our unit (COVID designated nursing unit) was full of patients infected with COVID-19, so the workload for every nurse was very heavy, which made it very tough for us to round every hour during the day.
- Many frontline staff went out on leave either because their family members got sick, or they got sick. This contributed to the unit being short-staffed.
- There were so many rapid changes and updates in hospital policy, especially regarding Infection Control, that it was overwhelming for us staff to keep up.

- It was sad that family members could not be there physically with their loved ones who were very sick in the hospital due to the strict visitation policy.
- Sometimes the EVS (environmental services) staff were not communicating well with the nursing staff, so the rooms were not cleaned fast enough for the new patients. This was causing many delays in patient care.
- The pandemic changed a lot of how nursing and the hospital operates. It was very challenging to do this project while also learning and adapting to the many changes in processes throughout the hospital and organization.
- It was definitely a high-stress period of time to be part of a big project in the middle of a global pandemic because we were apprehensive about our safety too!
- It is tough to be working in a COVID-designated unit. Let alone do another big project on top of that.
- We got scared when the PPE supplies were running low in the organization.
- We feared for our safety and the lives of our loved ones to be in a COVID unit dealing with all patients infected with COVID-19.

All responses from the post-implementation survey were analyzed by the project lead and discussed with the unit leadership team. A post-implementation debriefing was also done to thank the staff members, recognize their hard work and efforts throughout the 4-month quality improvement pilot project, and debrief their experiences, challenges, and concerns. Ugwu et al. (2020) indicated that debriefing allows a healthcare team the opportunity to re-examine the clinical experience, review individual and team activities, identify deviations, and promote performance improvement approaches through thoughtful learning methods. The post-implementation project outcomes were also shared with the team to highlight the positive impact

that the team accomplished in terms of patient safety, quality of care, and overall patient experience.

Section V: Discussion

Summary

The DNP quality improvement pilot project highlighted many vital findings. The COVID-19 pandemic has increased the strain on frontline nursing staff and made the provision of safe patient care more challenging. The prolonged nature of this healthcare crisis remains physically and emotionally taxing for healthcare workers. Amid an unprecedented global pandemic, situations may seem dire, and it is natural for human beings to feel concerned, anxious, and fearful for their safety and overall health and well-being in these circumstances. However, the project demonstrated that a united team for a common purpose could accomplish great things even in the most challenging situations, as the team successfully achieved the project objectives.

According to the World Health Organization (2021), to be effective, both the response to COVID-19 and the rehabilitation necessitates the steady commitment of everyone, and we must come together - equally as important as the procedures put in place by the health experts are our individual and community actions and behaviors. It was also crucial that the leadership team listened to the staffs' questions, comments, and concerns before anything else because, as the staff members stated, until their fears and anxieties are addressed, they probably will not listen to whatever the leaders tell them. Hence, this became a top priority for the leadership team to understand the staff members' thoughts and feelings prior to starting the pilot project. The pre-implementation survey helped immensely, gathering the staff's thoughts and feelings about the project, which proactively facilitated the resolution of identified concerns before the project

started. Once the staff members felt more at ease about their safety and well-being, they became more receptive to the PNHR education and training. According to the American Medical Association (2020), the most reliable means to learn what health care professionals are most concerned about is to ask them.

Another important factor that positively contributed to the change process is when the nurse leaders followed the innovative quantum caring healthcare leadership (QCHL) principles and genuinely lived them through their interactions with members of the care team. When staff members observed that leaders were exerting their best efforts to keep them safe and advocate for their health and well-being, staff members reciprocated those efforts by giving their full buy-in to the PNHR project. At that point, the mutual, two-way communication between leaders and staff became seamless so that messages from leaders were received affirmatively and staff concerns were being heard and addressed promptly.

One particular strength of the project is the good foundational teamwork and rapport between the unit leadership team and the frontline staff that previously existed prior to the pilot project. Sifaki-Pistolla et al. (2020) indicated that interprofessional collaboration in healthcare environments is a valuable means of enhancing patient management. In addition, literature has highlighted the importance of trust in establishing effective healthcare teams. This became especially important when situations got more challenging, as the unit leaders were able to "rally the troops," so to speak, and facilitate open, honest, and transparent communications for fast resolution of issues during a fast-paced dynamic and constantly evolving situation such as the pandemic.

As far as lessons learned, the project highlights the importance of the leaders' tone for the team and the value of positive working relationships, timely and transparent communications,

mutual understanding, and good teamwork. According to Liu et al. (2021), in global pandemic circumstances, nursing leaders have an elevated obligation to support nursing staff in persisting at their jobs and feeling secure, strengthening safety systems, providing adequate equipment and personnel training, and proactively leading nursing staff. When leaders lead by example by backing up their words with genuine actions, that is when forward progress becomes a smoother process even in a rapidly changing, challenging environment. Furthermore, change process implementation is highly complex without the support of the frontline staff.

According to De-la-Calle-Duran and Rodriguez-Sanchez (2021), given the positive impact of employee engagement and well-being on efficiency, productivity, organizational performance, and the current pandemic context, healthcare leaders must address these factors to keep the firm competitive edge. Therefore, obtaining feedback directly from frontline staff is critical for process and outcomes development. Continuous quality improvement process requires ongoing two-way dialogue between leaders and staff. Through open discourse, brilliant ideas can be put into action and may become part of structured processes. That is why leaders must keep an open mind and not stop listening to staff feedback in order to facilitate the continued positive evolution of process and quality improvement.

New possibilities emerged due to the quality improvement project, as exceptional safety outcomes were achieved even in the direst situations. Implications of this project for advanced nursing practice are that nursing should incorporate transformational and compassionate leadership in nursing leadership education, training, and orientation processes, as it is a type of leadership that can help drive and implement changes successfully in challenging situations.

Dr. Jean Watson et al.'s quantum caring healthcare leadership theory and principles may offer a new nursing model for organizational leadership development. The integration of caring

science and quantum science leadership concepts can promote and strengthen future leaders who are conscious, flexible and adaptable in complex health care environments, supporting teams to thrive in even the most challenging situations and optimize positive clinical and operational outcomes. During challenging times, Watson's human caring principles provide a moral-ethical foundation for compassionate and conscientious professional nursing practice. Frontline staff deserve compassion, empathy, and support from hospital leaders. Addressing staff stress and anxiety about their own safety and well-being is an essential precursor to education and training for process and practice changes. The safety, security, well-being, and concerns of frontline staff members must remain a priority for healthcare leaders. It is only when these vital components have been addressed that forward progress and positive patient outcomes may be realized.

Interpretation

Evidence in the literature and from this DNP quality improvement project suggests that a proactive, structured, and purposeful nurse hourly rounding process decreases the incidence of patient falls and falls with injuries in the acute care hospital setting. In addition, as demonstrated by the positive outcome of this D.N.P. pilot project, Purposeful Nurse Hourly Rounding guided by quantum caring healthcare leadership principles can contribute to developing infrastructure and standardized processes to prevent avoidable patient falls and create a standard work protocol for proactive and intentional nurse hourly rounding. When caregivers are intentional and proactive in addressing critical elements of patient care, positive outcomes are achieved as far as safety, quality, and service. The PNHR process is highly structured and systematic. When the PNHR interventions were being followed as planned, organically, better patient satisfaction and experience were evidenced. Staff members also reported increased satisfaction that positive safety outcomes were realized through solid teamwork and enhanced camaraderie.

The DNP pilot project results exhibit similar positive outcomes attained by other high-performing healthcare organizations that employed nurse hourly rounding as a primary intervention to enhance patient safety and care quality. The PNHR project is a testament that desired positive outcomes can be accomplished if evidence-based practice initiatives are planned and executed following a structured and well-developed implementation plan. In addition, the quality improvement project made a significant impact on patients, frontline staff, and leaders. Patient fall rates significantly decreased in the COVID-designated unit, which is the primary objective of the project. Secondary benefits of the project were frontline staff verbalizing improved communication amongst the team regarding continuity of care and better teamwork between the RN's and CNA's in making sure that the hourly rounding process remained consistent throughout the entire day. Leaders also felt renewed by connecting hearts and minds of the team by rallying and inspiring the staff toward a common purpose.

Due to the COVID-19 pandemic, the leadership team anticipated the challenges of implementing the pilot project. However, the positive project outcomes were objectively better than originally anticipated, given the contagion's resurgence during the project's implementation phase. The implication of these findings for the leadership of change is the importance of acting genuinely with care and compassion to back-up words and to lead by a good example. In addition, it is vital to maintain an open mind and take the time to authentically listen to others so that staff feel valued, appreciated, and empowered. Finally, change management requires a comprehensive strategic approach, timely interventions, and proper communication to ensure a complete understanding of the rationale for the change so it can be supported.

The pilot project's cost is minimal, as the cost avoidance analysis demonstrates that the prevention of a single patient fall would cover the entire cost of the PNHR project. The project

strategy was to utilize existing unit educators and the unit leadership team to educate and disseminate PNHR-related education and training materials to the entire frontline nursing staff. As cited in the financial analysis section, the organization has an excellent opportunity to save costs exponentially with every patient fall prevented.

The project findings support Lewin's change theory and Dr. Jean Watson's theory of human caring science. All phases of the change process had to be planned while remaining agile to respond to and implement changes during the project's implementation phase. Caring and compassionate transformation leadership also proved a vital role in the unit leadership team's success in obtaining the full support of staff even though the project was conducted in the middle of a global pandemic. Inference from this work confirms that the formula of a structured plan combined with full support from a unified leadership team with engaged frontline staff--will yield positive results. The PNHR project provides an effective evidence-based template that can be utilized and reproduced to support spread to other units and organizations. As far as implications for future professional and staff development, there is an excellent opportunity to imbed the PNHR process as part of new nurse orientation and unit-based orientation. It can also be integrated into the mandatory annual competencies so that nursing staff may continue to receive refresher education regarding this important safety initiative. Transformational quantum caring leadership principles should also be part of new leader orientation, training, and development.

Limitations

Results obtained in this relatively small DNP evidence-based quality improvement scholarly project with limited scope and timeframe (4-months) may have been affected by the staff's increased workload and strain resulting from the COVID-19 pandemic. The limited

timeframe of this project presents an opportunity to conduct a similar study with a longer duration. In addition, further safety measures put in place for the pandemic (e.g., personal protective equipment, physical distancing, visitation restrictions) may have affected the perception and response to PNHR by both patients and staff. The pilot was conducted in a designated COVID-19 unit that treats elderly, high-acuity patients with complex comorbidities. The severity of their conditions often requires more intense medical and nursing management, potentially skewing outcomes and limiting the generalizability and transferability of the results.

There was a 5% (n = 100) nursing staff turnover during the implementation phase of the pilot project, attributed to a variety of reasons, i.e., retirement, transfer, or termination. Nursing staff (both RN's and CNA's) shortages were also a factor during the project's implementation phase due to illness of staff or their family members. In addition, new employees were oriented to the PNHR process as part of the unit-based orientation. Consequently, nursing staff shortage, staff turnover, and the introduction of new staff members may have affected the continuity and consistency of the PNHR process in a fast-paced 24-hr COVID nursing unit. As outlined previously, variables such as HCAHPS scores were excluded, and others appropriately controlled to promote improved internal reliability and reduce variability where possible.

Part of the project's goal was to achieve long-term sustainability, maintaining a process that is not "people-dependent," which means that the PNHR methods are embedded in the unit's culture of safety, high-quality standard of care, and humane compassion of clinical nursing practice. In addition, this methodology will help ensure that the process will be less affected and remain intact even if leadership or frontline staff turnover occurs.

Conclusions

Aligned with the project's core principles and values of human caring, compassion, and loving-kindness and strengthened by evidence-based structured PNHR processes--it is possible to save lives, prevent injuries, and alleviate suffering while instilling hope and promoting joy and meaning for frontline healthcare workers, providers, and leaders alike. Uniting in a common workforce and operational goals, clinical teams may achieve increased resilience, morale, and engagement, along with improved patient outcomes, elimination of unnecessary/avoidable healthcare costs, enriched relationships among team members, enhanced teamwork and inter-professional communication, strengthening nursing practice accountability, and raising professional expectations for patient safety and quality of care for all patients.

Although HCAHPs scores were not included as part of the DNP project metrics, the positive effect and impact on overall patient satisfaction and experience were observed and noted. Even though patients were very sick, they verbalized their appreciation for the staff's proactive and focused attention to their essential needs, seeking to ensure their safety and comfort throughout their stay in the hospital. In addition, given the many pandemic-related restrictions such as social distancing and visitation policy changes, patients still perceived that the staff members were united in their efforts to provide the highest quality of care and intensified safety measures amid challenging circumstances. The DNP quality improvement project also yielded a positive operational impact on employee satisfaction, joy in work, and renewed meaning and purpose in performing hourly rounding practices--which are often unexplored or otherwise intangible factors. However, the effects were evident amongst staff, with perceived camaraderie, accountability, and teamwork improvements. The pilot project had various secondary positive impacts even though they were not included as formal project metrics. Improvements in staff morale and professional relationships seemed to support staff

retention and recruitment. In addition, staff members demonstrated elevated perceptions surrounding consciousness, intentionality, and collaboration, which are foundational attributes that may positively impact other nurse quality indicators such as medication safety, worker safety index, sick calls, and overall productivity. There is a high degree of confidence that the DNP pilot project directly influenced the unit's culture, with a renewed focus on human caring values, informed moral practices, and conscious, intentional cultures of human caring.

The extensive work involved in the purposeful nurse hourly rounding quality improvement project was beneficial and worthy of the healthcare team's time, effort, and energy. The project objectives were met, and outcomes were exceeded, enhancing the pilot unit's safety, service, and care quality. Implications for practice strengthen the concept of teamwork that it takes consistent and unrelenting discipline and collaboration to maintain patient safety and high-quality service, even in the most challenging situations. The project goals could not have been achieved without full support from the frontline staff. The significance of adequate education and training for the entire team cannot be underestimated. It was a critical component of the staff's readiness for the project implementation with confidence that they had the necessary knowledge and tools to execute the project plan and goals successfully. Positive professional relationships and open and honest communication between the unit leadership team and frontline staff also proved to be a critical factor in the successful implementation of the pilot project, as that was a crucial determinant in facilitating mutual rapid responses and resolutions to issues during the project implementation phase.

The leadership team's commitment to adopt QCHL principles along with continuous quality and process improvement is also an essential piece of the project strategy employing random chart audits, rounding on staff and patients, and providing as-needed coaching and

reinforcements to ensure that the nurse hourly rounding process was done consistently per the project plan. In addition, there are future research opportunities for a similar nurse rounding intervention study during a pandemic covering a longer duration, i.e., greater than 12 months, for more extensive data aggregate to evaluate sustained positive outcomes.

For future sustainability, the quality improvement infrastructure must not be dependent on people but defined structured processes; that way, even if there is turnover in leadership or frontline staff, the initiative can be sustained for the long term if key stakeholders follow the integrity of the established process. The next step is the potential spread of the PNHR initiative to other non-COVID nursing units in the hospital.

This DNP project was completed on time, within budget, and demonstrated exceptional return on investment and increased potential for continued cost avoidance. As cited in the literature and evidence found in this DNP project, it makes perfect sense to include purposeful nurse hourly rounding in the standard daily work of clinical nursing practice to enhance patient safety, quality of care, and patient experience. In addition, it should be part of the routine hospital and unit-based orientation for new RN's and CNA's. The PNHR project demonstrates that transformational and compassionate leadership combined with good teamwork utilizing an evidence-based nurse rounding process can significantly improve safety and financial health. In addition, the cost of the entire PNHR project was less than the cost of one patient fall. Therefore, the return on investment was significantly favorable to the organization with potential exponential cost savings the more patient falls can be prevented using the PNHR guidelines. Furthermore, there are clear indications that leadership intends to expand this project and share outcomes with other units across the system. Finally, the project's positive results demonstrate

the potential spread of the evidence-based process to other nursing units and beyond to other healthcare systems.

With the proper theoretical-moral-ethical framework, guiding principles, and core values to guide the project, along with comprehensive strategies to proactively address potential barriers and issues, this DNP change of practice quality improvement project was received favorably by frontline staff who were well-positioned for successful implementation. A united vision and sound execution of project goals and objectives helped develop and establish the foundational infrastructure and standardized processes to prevent avoidable patient falls and sustain long-term standard work with future replicability to other healthcare organizations and systems.

Conflict of Interest Statement

The author declares that there is no conflict of interest.

Section VI: Funding

This project received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Section VII: References

- Adelman, J., & Skae, C. (2020). *MIDAS+ System Offers Anonymous Reporting to Improve Patient Safety*. Albert Einstein College of Medicine.
<https://www.einstein.yu.edu/departments/medicine/news/midas-anonymous-reporting-patient-safety.aspx>.
- Agency for Healthcare Research and Quality. (2018). *Fall Prevention in hospitals: Training Program*. <https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/index.html>.
- Al Danaf, J., Chang, B. H., Shaear, M., Johnson, K. M., Miller, S., Nester, L., Williams, A. W., & Aboumatar, H. J. (2018). Surfacing and addressing hospitalized patients' needs: Proactive nurse rounding as a tool. *Journal of Nursing Management*, 5, 540.
<https://doi.org/10.1111/jonm.12580>
- Alameda Health System. (2021). *Overview- A New Day in Health*.
<http://www.alamedahealthsystem.org/about-us/>
- American Medical Association. (2020). *Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic*.
<https://jamanetwork.com/journals/jama/fullarticle/2764380>
- American Nurses Association. (2015). *What is the Nursing Code of Ethics?* Nurse.org.
<https://nurse.org/education/nursing-code-of-ethics/>
- American Nurses Foundation. (2017). *Teamwork Can Change Everything: Journal of Infusion Nursing*. Infusion Nurses Society.
https://journals.lww.com/journalofinfusionnursing/Citation/2017/03000/Teamwork_Can_Change_Everything.2.aspx.

- American Society for Quality. (2020). *What is the Plan-Do-Check-Act (PDCA) Cycle?* ASQ. <https://asq.org/quality-resources/pdca-cycle>.
- Baskin, R. G., & Bartlett, R. (2021). Healthcare worker resilience during the COVID-19 pandemic: An integrative review. *Journal of nursing management*, 29(8), 2329–2342. <https://doi.org/10.1111/jonm.13395>
- Brosey, L. A., & March, K. S. (2015). Effectiveness of structured hourly nurse rounding on patient satisfaction and clinical outcomes. *Journal of Nursing Care Quality*, 30(2), 153–159. <https://doi.org/10.1097/NCQ.0000000000000086>
- Burnes, B. (2020). The origins of Lewin's three-step model of change. *Journal of Applied Behavioral Science*, 56(1), 32–59. <https://doi.org/10.1177/0021886319892685>
- Centers for Disease Control and Prevention. (2019). *Keep on your feet-Preventing older adult falls*. <https://www.cdc.gov/injury/features/older-adult-falls/index.html>
- Center for Disease Control and Prevention. (2020). *Managing Visitors*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/hcf-visitors.html#references>
- Centers for Disease Control and Prevention. (2021). *SARS-CoV-2 Transmission*. <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html>
- Centers for Medicare and Medicaid Services. (2020). *HCAHPS: Patients' Perspectives of Care Survey*. CMS. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS>.

- De-la-Calle-Durán, M. C., & Rodríguez-Sánchez, J. L. (2021). Employee Engagement and Wellbeing in Times of COVID-19: A Proposal of the 5Cs Model. *International journal of environmental research and public health*, 18(10), 5470.
<https://doi.org/10.3390/ijerph18105470>
- Dearholt, S., & Dang, D. (2019). *Johns Hopkins nursing evidence-based practice: Models and guidelines (2nd ed)*. Sigma Theta Tau International.
<https://www.hopkinsmedicine.org/evidence-based-practice/jhn%5Febp.html>
- East, L., Targett, D., Yeates, H., Ryan, E., Quiddington, L., & Woods, C. (2020). Nurse and patient satisfaction with intentional rounding in a rural Australian setting. *Journal of Clinical Nursing*, 29(7/8), 1365.
- Fabry, D. (2015). Hourly rounding: perspectives and perceptions of the frontline nursing staff. *Journal of Nursing Management*, 23(2), 200. <https://doi.org/10.1111/jonm.12114>
- Foss Durant, A., McDermott, S., Kinney, G., & Triner, T. (2015). *Caring Science: Transforming the ethic of caring-healing practice, environment, and culture within an integrated care delivery system*. The Permanente journal.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5293129/>.
- Grillo, D. M., Firth, K. H., & Hatchel, K. (2019). Implementation of purposeful hourly rounds in addition to a fall bundle to prevent inpatient falls on a medical-surgical acute hospital unit. *MEDSURG Nursing*, 28(4), 243–261.
- Harrison SL., Fazio-Eynullayeva E., Lane D.A., Underhill P., Lip G.Y.H. (2020). Comorbidities associated with mortality in 31,461 adults with COVID-19 in the United States: A

federated electronic medical record analysis. *PLoS Med* 17(9): e1003321.

<https://doi.org/10.1371/journal.pmed.1003321>

Hicks, D. (2015). Can rounding reduce patient falls in acute care? An integrative literature review. *MEDSURG Nursing*, 24(1), 51–55. DOI: 10.1097/NCQ.0000000000000086

Institute for Healthcare Improvement. (2021). *Develop a Culture of Safety*.

<http://www.ihl.org/resources/Pages/Changes/DevelopaCultureofSafety.aspx>

Institute for Healthcare Improvement. (2021). *Short Surveys*.

<http://www.ihl.org/resources/Pages/Tools/ShortSurvey.aspx>

Johns Hopkins Medicine. (2015, June 9). *Falls cost US hospitals \$34 billion in direct medical costs*. Johns Hopkins HealthCare Solutions.

<https://www.johnshopkinssolutions.com/newsletters/falls-cost-u-s-hospitals-30-billion-in-direct-medical-costs/>.

Liu, T. Y., Sun, J. J., & Hsiao, C. T. (2021). *Hu li za zhi The journal of nursing*, 68(2), 92–98.

[https://doi.org/10.6224/JN.202104_68\(2\).12](https://doi.org/10.6224/JN.202104_68(2).12)

Mitchell, R. (2017). *Hourly rounding: A fall prevention strategy in long-term care*. No. 3708.

[Doctor of Nursing Practice Dissertation] Walden University.

<http://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=4811&context=dissertations>

Oliver, D., Healey, F., & Haines, T. P. (2010). Preventing falls and fall-related injuries in hospitals. *Clinics in geriatric medicine*, 26(4), 645–692.

<https://doi.org/10.1016/j.cger.2010.06.005>

Online Journal of Issues of Nursing (OJIN). (2016). *A Case Review: Integrating Lewin's Theory with Lean's System Approach for Change*. The Online Journal of Issues in Nursing.

<https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/O>

[JIN/TableofContents/Vol-21-2016/No2-May-2016/Integrating-Lewins-Theory-with-Leans-System-Approach.html](#).

Reddy, B. V., & Gupta, A. (2020). Importance of effective communication during COVID-19 infodemic. *Journal of family medicine and primary care*, 9(8), 3793–3796.

https://doi.org/10.4103/jfmprc.jfmprc_719_20

Sifaki-Pistolla, D., Melidoniotis, E., Dey, N., & Chatzea, V. E. (2020). How trust affects performance of interprofessional healthcare teams. *Journal of interprofessional care*, 34(2), 218–224. <https://doi.org/10.1080/13561820.2019.1631763>

Silva, M., & Ludwick, R. (1999). Ethics: Interstate Nursing Practice and Regulation: Ethical Issues for the 21st Century.

<http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume41999/No2Sep1999/InterstateNursingPracticeandRegulation.html>.

Spano-Szekely, L., Winkler, A., Waters, C., Dealmeida, S., Brandt, K., Williamson, M., Blum, C., Gasper, L., & Wright, F. (2019). Individualized fall prevention program in an acute care setting: An evidence-based practice improvement. *Journal of Nursing Care Quality*,

34(2), 127–132. <https://doi.org/10.1097/NCQ.0000000000000344>

Spittle, S. (2010). *Evaluation of purposeful rounding on patient falls*. [Masters Thesis]. Gardner-Webb University. https://digitalcommons.gardner-webb.edu/nursing_etd/192

Staggs, V. S., Mion, L. C., & Shorr, R. I. (2014). Assisted and unassisted falls: different events, different outcomes, different implications for quality of hospital care. *Joint Commission*

journal on quality and patient safety, 40(8), 358–364. [https://doi.org/10.1016/s1553-7250\(14\)40047-3](https://doi.org/10.1016/s1553-7250(14)40047-3)

St. Thomas University. (2014). *What is Transformational Leadership? Ideas Produce Results*. St. Thomas University Online. <https://online.stu.edu/articles/education/what-is-transformational-leadership.aspx>.

Studer Group. (2020). *AIDET Patient Communication*. Studer Group A Huron Solution. <https://www.studergroup.com/aidet>.

Studer Group. (2020). *Daily Hourly Rounding Log*. https://az414866.vo.msecnd.net/cmsroot/studergroup/media/studergroup/pages/what-we-do/learning-lab/aligned-behavior/hourly-rounds/hourly_rounding_log_daily.pdf?ext=.pdf.

Study.com. (2020). *Esprit De Corps in Management: Definition & Explanation*. Study.com. <https://study.com/academy/lesson/esprit-de-corps-in-management-definition-lesson-quiz.html>.

The Center for Instruction and Technology. (2016). Qualtrics. <https://myusf.usfca.edu/sites/default/files/ETS-Qualtrics.pdf>

The Joint Commission. (2015). *Preventing falls and fall-related injuries in health care facilities*. Sentinel Event Alert. https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/sea_55pdf.pdf?db=web&hash=53EE3CDCBD00C29C89B781C4F4CFA1D7.

Toole, N., Meluskey, T., & Hall, N. (2016). A systematic review: barriers to hourly rounding. *Journal of Nursing Management*, 24(3), 283. <https://doi.org/10.1111/jonm.12332>

Ugwu, C. V., Meadows, M., Don-Pedro, D., & Chan, J. (2020). Critical Event Debriefing in a Community Hospital. *Cureus*, 12(6), e8822. <https://doi.org/10.7759/cureus.8822>

USF. (2019). *Our Values*. University of San Francisco. <https://www.usfca.edu/about-usf/who-we-are/our-values>.

Venema, D.M., Skinner, A.M., Nailon, R. (2019). Patient and system factors associated with unassisted and injurious falls in hospitals: an observational study. *BMC Geriatr* 19, 348 <https://doi.org/10.1186/s12877-019-1368-8>

Watson, J. (2020). *10 Caritas Processes*®. Watson Caring Science Institute. <https://www.watsoncaringscience.org/jean-bio/caring-science-theory/10-caritas-processes/>.

Watson, J. (2020). *Caring Science & Theory*. Watson Caring Science Institute. <https://www.watsoncaringscience.org/jean-bio/caring-science-theory/>

Watson, J., Porter-O'Grady, T., Horton-Deutsch, S., & Malloch, K. (2018). Quantum Caring Leadership: Integrating Quantum Leadership With Caring Science. *Nursing science quarterly*, 31(3), 253–258. <https://doi.org/10.1177/0894318418774893>

Waxman, K. (2018). Financial and business management for the doctor of nursing practice. In *Financial and business management for the doctor of nursing practice* (p. 340). New York, NY: Springer Publishing Company.

Wojciechowski, E., Pearsall, T., Murphy, P., & French, E. (2016). A case review: Integrating

Lewin's theory with Lean's system approach for change. *The Online Journal of Issues in*

Nursing, 21(2). DOI: 10.3912/OJIN.Vol21No02Man04

World Health Organization. (2021). *Only through unity can we come out as winners in this battle*

against COVID-19. [https://www.who.int/malaysia/news/commentaries/detail/only-](https://www.who.int/malaysia/news/commentaries/detail/only-through-unity-can-we-come-out-as-winners-in-this-battle-against-covid-19)

[through-unity-can-we-come-out-as-winners-in-this-battle-against-covid-19](https://www.who.int/malaysia/news/commentaries/detail/only-through-unity-can-we-come-out-as-winners-in-this-battle-against-covid-19)

Section VIII: Appendices

Appendix A

Evidence Evaluation Table

Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
APA Citation: Brosey, L. A., & March, K. S. (2015). Effectiveness of structured hourly nurse rounding on patient satisfaction and clinical outcomes. <i>Journal of Nursing Care Quality</i> , 30(2), 153–159. https://doi.org/10.1097/NCQ.0000000000000086								
To gauge the outcomes related to the application of nurse hourly rounding in the acute hospital setting	PARiHS framework was used for the project.	Quasi-experimental	One medical-surgical unit with 24 beds in one acute hospital setting	HCAHPS: overall patient experience Patient Fall rate: # of patient falls HAPI rate: # of hospital-acquired pressure injuries	Using statistical analysis	Baseline data were cross-referenced with post-implementation information to assess the effectiveness of the initiative.	Patient experience ratings improved from 48.6% to 72.2% post-implementation of the nurse hourly rounding project. The occurrence of falls decreased by 57.7%. HAPI rate reduced from four	Level of Evidence: Level II, per the Johns Hopkins appraisal tool Quality: Good Worth to Practice: Adequate, available evidence is encouraging Strengths: Positive data outcomes for all variables measured Weaknesses: Limited sample size and the short length of time for the duration of the study Feasibility: Adequate Conclusion/Recommendation: A structured nurse hourly rounding process executed consistently demonstrates positive outcomes for patient experience, patient fall rate, and HAPI rate.

							(baseline) within 6-months pre-implementation to zero post-implementation.	
--	--	--	--	--	--	--	--	--

Definition of abbreviations:

HCAHPS= Hospital Consumer Assessment of Healthcare Providers and Systems.
 HAPU= Hospital-acquired Pressure Ulcer
 HAPI= Hospital-acquired Pressure Injury
 PARiHS= Promoting Action on Research Implementation in Health Services

Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
------------------------------	----------------------	-----------------	------------------	---	--------------------------------	---------------	----------------	---

APA Citation: Hicks, D. (2015). Can Rounding Reduce Patient Falls in Acute Care? An Integrative Literature Review. *MEDSURG Nursing*, 24(1), 51–55. <https://doi.org/10.1097/ncq.0000000000000086>

To summarize the outcomes of independent studies to determine current knowledge about the	N/A	Integrative Research Review, Meta-Analysis	14 independent studies; from 24 beds to 64-bed nursing units	Patient Fall rate: # of patient falls	A systematic review of statistical data from all 14 studies	The original search generated 2,856 results; however, only Four hundred thirty-five of these were	12/14 studies demonstrated decreased fall rates. 2/14 studies showed fall rates unchanged.	Level of Evidence: Level II, per the Johns Hopkins appraisal tool Quality: Good Worth to Practice: Adequate, available evidence is encouraging Strengths: Numerous independent studies demonstrate an extensive
---	-----	--	--	---------------------------------------	---	---	--	--

matter as a guide for nursing practice						journal articles. Out of all the articles examined, fourteen were identified to meet inclusion criteria.	The top two studies with the most impactful outcomes yield the following results: Falls decreased from 7.02 to 3.18/1,000 patient days; Falls decreased 39% during the study period.	decrease in the occurrence of patient falls Weaknesses: Studies included non-randomized samples, relatively small sample size, and short duration for the length of the studies Feasibility: Acceptable Conclusion/Recommendation: The integrative review study of fourteen independent research has shown overwhelming positive outcomes, and a correlation between nurse hourly rounding and the reduction of patient falls in the acute hospital setting.
--	--	--	--	--	--	--	--	---

Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
------------------------------	----------------------	-----------------	------------------	---	--------------------------------	---------------	----------------	---

APA Citation: Spano-Szekely, L., Winkler, A., Waters, C., Dealmeida, S., Brandt, K., Williamson, M., Blum, C., Gasper, L., & Wright, F. (2019). Individualized Fall Prevention Program in an Acute Care Setting: An Evidence-Based Practice Improvement. *Journal of Nursing Care Quality*, 34(2), 127–132. <https://doi.org/10.1097/NCQ.0000000000000344>

To appraise the hospital's fall protocol employing the evidence-based	Clinical Practice Guideline from the Institute for Clinical	Quasi-experimental/ Simulation experiment	245-bed community hospital	Patient Fall rate: # of patient falls	Using statistical analysis	Baseline data were cross-referenced with post-implementation information	The incidence of falls reduced by 54% from 2.51 to 1.15	Level of Evidence: Mixed method; Level III, per the Johns Hopkins appraisal tool Quality: Good Worth to Practice: Adequate, available evidence is encouraging
---	---	---	----------------------------	---------------------------------------	----------------------------	--	---	---

practice improvement model.	Systems Improvement Health Care Protocol on Prevention of Falls in Acute Care Institutions					to assess the effectiveness of the initiative.	falls per 1000 patient days.	Strengths: methodical approach of the CPG, using proven seven critical practices for effective fall prevention Weaknesses: None identified Feasibility: Adequate Conclusion/Recommendation: The positive outcomes regarding the significantly decreased incidence of falls are a reliable indicator that can help facilitate long-term buy-in and support from hospital leadership and frontline staff.
-----------------------------	--	--	--	--	--	--	------------------------------	--

Definition of abbreviations: CPG= Clinical Practice Guideline

Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
------------------------------	----------------------	-----------------	------------------	---	--------------------------------	---------------	----------------	---

APA Citation: Toole, N., Meluskey, T., & Hall, N. (2016). A systematic review: barriers to hourly rounding. *Journal of Nursing Management (John Wiley & Sons, Inc.)*, 24(3), 283. <https://doi.org/10.1111/jonm.12332>

To identify a wide-ranging list of the barriers that influence the effective execution and long-term sustainability of nurse-driven	N/A	Literature review	20 independent articles reviewed	Qualitative data: barriers & challenges to hourly rounding	Descriptive statistics	The hierarchy of Evidence for Interventional Studies was used to analyze the quality of each article	Six common themes were recognized: the heavy workload of the nurses, arduous hourly round sheets, shortage of staffing	Level of Evidence: Mixed method; Level V, per the Johns Hopkins appraisal tool Quality: Good Worth to Practice: Adequate, available evidence will help nurse leaders proactively address barriers to facilitate a successful implementation of the project Strengths: the article was able to synthesize the top six most
---	-----	-------------------	----------------------------------	--	------------------------	--	--	--

hourly rounding in an acute hospital setting							support, deficiency of procedures for long-term sustainability, challenging patient population, and the deficiency of education and training for staff.	common barriers from the frontline staff's perspective Weaknesses: lack of high-level evidence Feasibility: Adequate Conclusion/Recommendation: It is of utmost importance for the nurse managers to understand all potential barriers to the nurse hourly rounding project's success. This information can help address those barriers, as mentioned above, proactively, and help facilitate successful project implementation and long-term sustainability.
Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
<p>APA Citation: T Spittle, S. (2010). <i>Evaluation of Purposeful Rounding On Patient Falls</i>. http://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=edsbas&AN=edsbas.42337D2F&site=eds-live&scope=site&custid=s3818721</p>								
To assess the efficacy of purposeful hourly rounding on the total number of falls on a medical	Orem's Self-Care Deficit Model	Data obtained from the Risk Master occurrence reporting system	A 1300-bed hospital in North Carolina, USA	Patient Fall rate: # of patient falls	Using statistical analysis	Baseline data were cross-referenced with post-implementation information to assess the effectiveness	No significant change to the fall rates pre- and post-implementation of nurse hourly rounding.	Level of Evidence: Level III, per the Johns Hopkins appraisal tool Quality: Good Worth to practice: data from this study did not show any change in fall rates from pre- to post-implementation

unit in an acute care hospital						of the initiative.		<p>Strengths: transparency of data from the Occurrence reporting system database</p> <p>Weaknesses: lack of staff buy-in and support</p> <p>Feasibility: moderate</p> <p>Conclusion/Recommendation: The study recognized that purposeful nurse hourly rounding significantly changed the workflow and the current nursing staff's culture. The short duration of the study (13-weeks) was not enough time to hardwire the nursing staff process, which resulted in a lack of consistency and compliance with the initiative.</p>
--------------------------------	--	--	--	--	--	--------------------	--	--

Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
------------------------------	----------------------	-----------------	------------------	---	--------------------------------	---------------	----------------	---

APA Citation: Fabry, D. (2015). Hourly rounding: perspectives and perceptions of the frontline nursing staff. *Journal of Nursing Management (John Wiley & Sons, Inc.)*, 23(2), 200. <https://doi.org/10.1111/jonm.12114>

To learn from the staff members' standpoints and views of hourly rounding in the	Rogers' framework of Diffusion of Innovation	A 21-item survey consisting of hourly rounding components	186-bed hospital	Staff's perception of nurse hourly rounding	Using descriptive statistics	The agreement is credited to the score if a rating of 4 or 5 is chosen.	Over 85% agreed that they have enough education regarding hourly rounding.	<p>Level of Evidence: Level V, per the Johns Hopkins appraisal tool</p> <p>Quality: Good</p> <p>Worth to practice: data from this study is noteworthy as it highlights valuable perspectives of the frontline staff- who are the rounding.</p>
--	--	---	------------------	---	------------------------------	---	--	--

<p>acute hospital</p>							<p>85% agreed that they are knowledgeable on how to incorporate hourly rounding into their daily routines Less than 30% felt they were involved or engaged in the hourly rounding initiative's planning process. 28.3% concluded that the execution of the rounding audit tool is an accurate representation that rounding is being accomplished 92% of staff agreed that pain, Position, and potty are being addressed</p>	<p>ones performing the hourly rounding activities Strengths: well-formulated survey questions to elicit relevant information geared towards the success of the nurse hourly rounding project Weaknesses: lack of high-level evidence Feasibility: moderate Conclusion/Recommendation: The study is an eye-opener regarding direct caregivers' perspectives (RNs and CNAs). The nursing leadership must utilize this information to proactively address the concerns and have a better plan that includes a comprehensive project structure, education, and training for all nursing staff.</p>
-----------------------	--	--	--	--	--	--	--	--

							<p>during hourly rounding, but only 55.8% agreed that pain management is being addressed during hourly rounds. 69.2% favored the account that hourly nurse rounds reduce the incidence of patient falls in hospitals.</p>	
--	--	--	--	--	--	--	---	--

Definition of abbreviations: PCA= Patient Care Attendant (another term used for Certified Nurse Assistants)

Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
------------------------------	----------------------	-----------------	------------------	---	--------------------------------	---------------	----------------	---

APA Citation: Mitchell, R. (2017). *Hourly Rounding: A Fall Prevention Strategy in Long-Term Care*. <http://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=edsndl&AN=edsndl.oai.union.ndltd.org.waldenu.edu.oai.scholarworks.waldenu.edu.dissertations-4811&site=eds-live&scope=site&custid=s3818721>

To gauge whether staff education and	Kurt Lewin's change model	Quasi-experimental	40 residents in a long-	Patient Fall rate: # of patient falls	Using statistical analysis	Baseline data were cross-referenced	A 55% reduction of falls post-	Level of Evidence: Level II, per the Johns Hopkins appraisal tool Quality: Good
--------------------------------------	---------------------------	--------------------	-------------------------	---------------------------------------	----------------------------	-------------------------------------	--------------------------------	--

<p>implementation of an evidence-based hourly rounding program would affect the number of patient falls</p>			<p>term care facility</p>			<p>with post-implementation information to assess the effectiveness of the initiative for over three months</p>	<p>implementation of purposeful nurse hourly rounding</p>	<p>Worth to practice: data from this study is encouraging Strengths: well-formulated survey questions to elicit valuable feedback, geared towards addressing any potential issues and concerns regarding the nurse hourly rounding project Weaknesses: lack of high-level evidence Feasibility: moderate Conclusion/Recommendation: The study is an eye-opener regarding direct caregivers' perspectives (RNs and CNAs). The nursing leadership must utilize this information to proactively address the concerns and have a better plan that includes a comprehensive project structure, education, and training for all nursing staff.</p>
---	--	--	---------------------------	--	--	---	---	--

Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
------------------------------	----------------------	-----------------	------------------	---	--------------------------------	---------------	----------------	---

APA Citation: Grillo, D. M., Firth, K. H., & Hatchel, K. (2019). Implementation of Purposeful Hourly Rounds in Addition to a Fall Bundle to Prevent Inpatient Falls on a Medical-Surgical Acute Hospital Unit. *MEDSURG Nursing*, 28(4), 243–261.
<http://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=ccm&AN=138187887&site=eds-live&scope=site&custid=s3818721>

To Execute timely and purposeful hourly rounds as part of fall prevention interventions	Plan, Do, Study, and Act (PDSA) method	Quasi-experimental	112-bed medical-surgical unit	Patient Fall rate: # of patient falls	Using statistical analysis	Baseline data were cross-referenced with post-implementation information to assess the effectiveness of the initiative.	Fall rate significantly decreased from 5.31 to 1.45 per 1,000 patients days.	Level of Evidence: Level II, per the Johns Hopkins appraisal tool Quality: Good Worth to Practice: Adequate, available evidence is encouraging Strengths: Positive data outcomes regarding patient fall rate Weaknesses: Limited sample size and the short length of time for the duration of the study Feasibility: Adequate Conclusion/Recommendation: Evidence suggests that a properly structured and timely nurse hourly rounding process executed consistently demonstrates a direct correlation with a significant decrease in patient fall rate
---	--	--------------------	-------------------------------	---------------------------------------	----------------------------	---	--	---

Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
------------------------------	----------------------	-----------------	------------------	---	--------------------------------	---------------	----------------	---

APA Citation: East, L., Targett, D., Yeates, H., Ryan, E., Quiddington, L., & Woods, C. (2020). Nurse and patient satisfaction with intentional rounding in a rural Australian setting. *Journal of Clinical Nursing (John Wiley & Sons, Inc.)*, 29(7/8), 1365.

<http://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=edb&AN=142223753&site=eds-live&scope=site&custid=s3818721>

To analyze nurse and patient experience	None noted in the study.	STROBE guidelines. Survey method	One public hospital in	Patient and Nurse perspectives on Intentional Nurse Hourly rounding	Using descriptive statistics	A paper-based anonymous questionnaire about	The strongest predictor of patient	Level of Evidence: Level V, per the Johns Hopkins appraisal tool Quality: Good
---	--------------------------	----------------------------------	------------------------	---	------------------------------	---	------------------------------------	---

with intentional hourly rounding and examine which aspects of care predict satisfaction.			rural New South Wales (NSW), Australia, between April and June 2018			intentional rounding was made available to nurses who worked in the selected wards and given to all patients as well.	satisfaction was <i>I felt comfortable and safe during my time in this ward</i> ($\beta = .72, p < .001$), followed by <i>the nurses who were interested in my feelings about my care</i> ($\beta = .28, p = .003$), <i>I was able to see a nurse when I needed to</i> ($\beta = .26, p = .006$), and <i>I was able to get pain relief when I needed it</i> ($\beta = -0.18, p = .033$).	Worth to Practice: Adequate, available evidence is encouraging in terms of improved patient satisfaction while also helping to promote patient safety Strengths: Positive data outcomes regarding the nurse-to-patient therapeutic relationship Weaknesses: Limited sample size and the study was done in one rural facility with convenience sampling, so results cannot be used for the general population Feasibility: Adequate Conclusion/Recommendation: The study suggests that nurses' intentional hourly rounding helps to improve nurse-to-patient relationships, which enhances the patient's perception of care. Hourly rounding allows nurses to stay proactive instead of a reactive state, which improves the overall quality of care and patient safety.
--	--	--	---	--	--	---	--	---

Abbreviations: STROBE= Strengthening the Reporting of Observational Studies in Epidemiology

Purpose of Article or Review	Conceptual Framework	Design / Method	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
<p>APA Citation: Al Danaf, J., Chang, B. H., Shaeer, M., Johnson, K. M., Miller, S., Nester, L., Williams, A. W., & Aboumatar, H. J. (2018). Surfacing and addressing hospitalized patients' needs: Proactive nurse rounding as a tool. <i>Journal of Nursing Management</i>, 5, 540. https://doi.org/10.1111/jonm.12580</p>								
To analyze rounding interventions practiced at high performing healthcare facilities	None noted in the study.	Determine high performing hospitals in the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) database and examine their processes regarding proactive nurse rounding.	26 hospitals	HCAHPS: overall patient experience Domains of Staff responsiveness and nurse communication.	Using statistical analysis	Case studies were done for three of the top-performing hospitals within the Press Ganey database. To qualify for the study, the hospital must belong to the top 10 of the domains of staff responsiveness and nurse communication.	The common denominator for the top-rated and high performing hospitals reported proactive nurse rounding as their primary rounding intervention (96%).	<p>Level of Evidence: Level III, per the Johns Hopkins appraisal tool Quality: Good Worth to Practice: Adequate, available evidence is encouraging and further solidifies the evidence reinforcing the importance of proactive nurse hourly rounding towards patient experience and safety. Strengths: Positive data outcomes for all variables measured Weaknesses: none identified Feasibility: Adequate Conclusion/Recommendation: The common denominator and best practice shared by the top-performing hospitals is Proactive nurse hourly rounding. HCAHPS results demonstrate this fact. Appropriate structure, education, and training are essential for all key stakeholders: primary RN, Certified nursing assistants, unit</p>

								leader (charge nurse/manager), and chief nurse executive- for the long-term sustainability of the process.
--	--	--	--	--	--	--	--	--

Definition of abbreviations:

HCAHPS= Hospital Consumer Assessment of Health Providers and Systems;

RN= registered nurse;

CNA= certified nurse assistant

Johns Hopkins Nursing Evidence-Based Practice. Research Evidence Appraisal Tool (Dearholt & Dang, 2019)

Appendix B

Non-Research Approval Statement of Determination



Doctor of Nursing Practice Statement of Non-Research Determination (SOD) Form

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

General Information

Last Name:	MASANGKAY	First Name:	ROBBIE
CWID Number:	205-811-35	Semester/Year:	SUMMER/ 2020
Course Name & Number:	NURS 791E- PRACTICUM II FOCUS: MICROSYSTEM		
Chairperson Name:	DR. JIM D'ALFONSO	Advisor Name:	DR. JIM D'ALFONSO

Project Description

1. Title of Project

Reinvigorating Purposeful Nurse Hourly Rounding During the COVID-19 Pandemic: A Vital Approach to Patient Safety in

2. Brief Description of Project

Clearly state the purpose of the project and the problem statement in 250 words or less.

Problem Statement:

The emergence of COVID-19 in early 2020 raises significant challenges in maintaining the health and well-being of a global community. The impact of this unprecedented pandemic has resulted in a critical strain on financial, operational, and human resources. Millions have been afflicted and directly affected by the spread and resurgence of COVID-19, including health care workers and their families. Amidst the complex care demands and stresses of the high volume of COVID-19 victims, patient falls remain a top safety concern in the acute care setting. The most recent Center for Disease Control and Prevention (CDC) data indicates 3 million older adults age 65 and older suffer from falls during hospitalization, and an estimated 30,000 falls result in death. A pilot project will be conducted on a designated COVID-19 Nursing Unit in a 28-bed acute care setting in Northern California, where 22 patients have suffered falls during a six month period (Sept 2019 to March 2020). This evidence-based project aims to reduce patient falls through increased staff engagement during the implementation of a Purposeful Nurse Hourly Rounding (PNHR) program, evaluating the impact of focused education and interventions, while exploring the feasibility of spread across the system and beyond.

3. AIM Statement: What are you trying to accomplish?

- What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well-defined, and at a minimum describe the target population, the desired improvement, and the targeted timeframe.
- To improve (your process) from (baseline)% to (target)%, by (timeframe), among (your specific population)

Complete this statement:

To increase / decrease: _____ (process/outcome)

from: _____ (baseline %, rate, #, etc.)

to: _____ (goal/target %, rate, #, etc.)

by: _____ (date, 3 - 6-month timeframe)

in: _____ (population impacted)

To decrease the incidence of patient falls from a baseline of 22 occurrences between the period of September 2019 and 1

4 Brief Description of Intervention (150 words).

4a. How will this intervention be implemented?

- Where will you implement the project?
- Attach a letter from the agency with approval of your project.
- Who is the focus of the intervention?
- How will you inform stakeholders/participants about the project and the intervention?

This evidence-based Doctor of Nursing project on purposeful nurse hourly rounding (PNHR) will be implemented on a designated COVID 19 nursing unit in a 28-bed not-for-profit acute care hospital located in Northern California.

The project employs various evidence-based methods of communication and education to engage and educate defined stakeholders and participants in the project plan and goals. Strategies include focused implementation by means of staff meetings, shift huddles, emails, flyers, posters, e-learning modules, and real-time coaching sessions. Part of the education/ coaching plan is to engage unit-based clinical educators to help reinforce learning and adoption of essential concepts with nurses and members of the care team.

The PNHR project has the potential to spread and be implemented on other inpatient nursing units and direct care areas across the organization. The organization's letter of support for this project is completed and attached for reference.

During a global pandemic, there is chaos and disruption in the acute care setting. This project aims to demonstrate how

5. Outcome measurements: How will you know that a change is an improvement?

- Measurement over time is essential to QI. Measures can be outcome, process, or balancing measures. Baseline or benchmark data are needed to show improvement.
- Align your measure with your problem statement and aim.
- Try to define your measure as a numerator/denominator.
 - What is the reliability and validity of the measure? Provide any tools that you will use as appendices.
 - Describe how you will protect participant confidentiality.

Baseline data from the designated COVID-19 unit and facility that is specific to patient falls will be obtained and assessed in collaboration with hospital Quality & Risk Management resources. All patient falls in the hospital are reported and documented in the MIDAS Safety Alert system and can be reported to the unit level. The project leader will collaborate closely with the Quality & Risk Management team to track and monitor the incidence of patient falls to evaluate and report the key indicators and results of the project.

According to the Agency for Healthcare Research and Quality (AHRQ), a patient fall is defined as an unplanned descent to the floor with or without injury to the patient. For every patient fall incident, a safety alert is entered and completed by the nursing staff/ unit charge nurse via the identified MIDAS Safety Alert system. The electronic MIDAS occurrence reporting system integrates templates specific to all reportable and targeted safety events. The patient falls template contains a standardized form that also serves as a patient fall and risk mitigation debriefing tool to identify all relevant factors involved in a patient involved incident.

A comparison of pre and post-project implementation data will be evaluated to assess the effectiveness of the PNHR interventions. All patient data compiled for this project will be de-identified and fully comply with HIPAA federal guidelines and organizational ethics and compliance policies. No personal health information will be used for the purposes of this project. The project does not require a local institutional review board (IRB) approval and will be conducted according to the guidelines of an exempted quality-focused and evidence-based nursing project.



DNP Statement of Determination Evidence-Based Change of Practice Project Checklist*

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

Project Title:

Reinvigorating Purposeful Nurse Hourly Rounding During the COVID-19 Pandemic:
A Vital Approach to Patient Safety in the Acute Care Setting

Mark an "X" under "Yes" or "No" for each of the following statements:	Yes	No
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	X	
The specific aim is to improve performance on a specific service or program and is a part of usual care. All participants will receive standard of care.	X	
The project is <u>not</u> designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does <u>not</u> follow a protocol that overrides clinical decision-making.	X	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does <u>not</u> develop paradigms or untested methods or new untested standards.	X	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does <u>not</u> seek to test an intervention that is beyond current science and experience.	X	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	X	
The project has <u>no</u> funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	X	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., <u>not</u> a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	X	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <i>"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."</i>	X	

Answer Key:

- If the answer to all of these items is "Yes", the project can be considered an evidence-based activity that does not meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files.
- If the answer to any of these questions is "No", you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: <http://answers.hhs.gov/ohrp/categories/1589>



**DNP Statement of Determination
Evidence-Based Change of Practice Project Checklist Outcome**

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

Project Title:

Reinvigorating Purposeful Nurse Hourly Rounding During the COVID-19 Pandemic:
A Vital Approach to Patient Safety in the Acute Care Setting

- This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). **Student may proceed with implementation.**
- This project involves research with human subjects and **must be submitted for IRB approval before project activity can commence.**

Comments:

Student Last Name: MASANGKAY **Student First Name:** ROBBIE

CWID Number: 205-811-35 **Semester/ Year:** SUMMER/ 2020

Student Signature: *Robbie Masangkay* **Date:** 08/02/2020

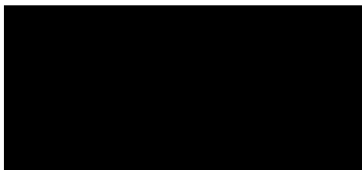
Chairperson Name: DR. JIM D'ALFONSO **Date:** 08/02/2020

Chairperson Signature: e-signed: Jim D'Alfonso, DNP, RN

DNP SOD Review Committee Member Name: _____

DNP SOD Review Committee Member Signature: _____ **Date:** _____

Appendix C
Letter of Support from Agency



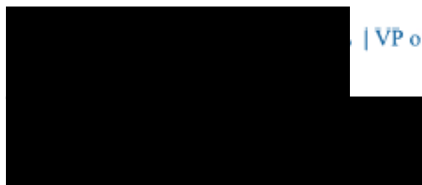
05/30/20

To whom it may concern,

This is a letter of support for **Robbie Masangkay** to implement his DNP Comprehensive Project-
Purposeful Nurse Hourly Rounding- at [REDACTED]

We permit him to use the name of our agency in his DNP Comprehensive Project Paper and future presentations and publications.

A handwritten signature in black ink, appearing to be 'R. Masangkay'.



| VP of Patient Care Services |

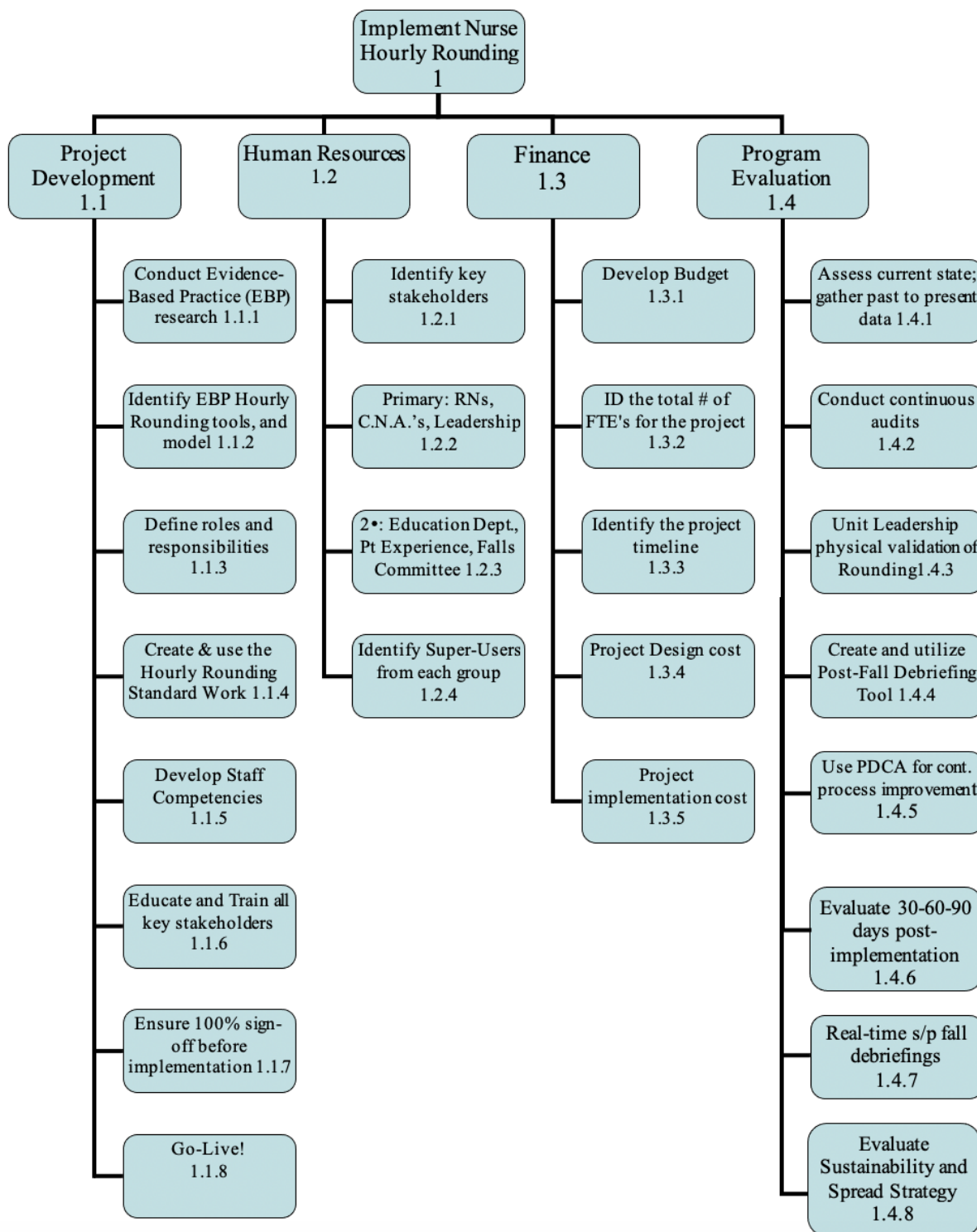
Appendix D
Gap Analysis

Current State	Future State	Gap	Action Plan
<p>Currently, there is no purposeful nurse hourly rounding being done on the pilot unit.</p>	<p>The pilot unit will implement the purposeful nurse hourly rounding initiative.</p>	<p>There is no identified standard for hourly rounding on the pilot unit. This gap leads to patient safety concerns.</p>	<p>In collaboration and with the support of all key stakeholders, the PNHR project will be trialed within the pilot unit to decrease patient falls and improve quality, safety, and service outcomes.</p>
<p>Through comprehensive and in-depth interviews and discussions between unit leadership and frontline nursing staff, a knowledge gap was identified by the unit leadership regarding the staff nurses' understanding of the importance of PNHR as it pertains to patient safety.</p>	<p>Unit leadership will identify and integrate best practices to address the learning and training needs and priorities of staff regarding PNHR.</p>	<p>There is a leadership knowledge deficit regarding frontline staff's learning and training needs on PNHR.</p>	<p>Develop a pre-implementation survey for the staff nurses to gauge their knowledge of PNHR and how it impacts patient safety.</p> <p>Subsequently, education and training will be designed and developed to address the identified learning needs of the staff.</p> <p>After completing education and training, another post-implementation survey will be conducted to evaluate the teaching effectiveness and identify any secondary learning needs.</p>

<p>There is a staff knowledge deficit regarding PNHR and its impact on patient safety and quality of care.</p>	<p>Staff will be knowledgeable of the PNHR initiative.</p>	<p>The lack of knowledge regarding the process of PNHR has resulted in an increased incidence of patient falls on the pilot unit.</p>	<p>Design education based upon the staff survey results and direct feedback regarding their knowledge gaps and learning needs.</p>
<p>There is no designated area or section in the electronic health record (EHR) to document nurse hourly rounding by staff.</p>	<p>A designated area or section where staff can document hourly rounding in the electronic health record (E.H.R.) will be implemented.</p>	<p>The absence of a universal area or designated section to chart hourly rounding in the EHR can result in inconsistencies in documentation</p>	<p>Collaborate with the EPIC (EHR) team to build and implement a universal designated area (mandatory field) in the EHR where staff may document hourly rounding.</p>
<p>There is a lack of awareness regarding the PNHR project, among inter-professional teams in the hospital, including physicians, therapists, and ancillary staff.</p>	<p>Inter-professional teams will be educated on the PNHR project and how their efforts can complement the nursing team and quality patient care goals.</p>	<p>There is an identified awareness and potential knowledge deficit regarding PNHR amongst other disciplines.</p>	<p>Invite other key departmental leaders, provide education regarding the PNHR project, and discuss how this collaborative initiative can positively impact patient safety and quality of care.</p>

Appendix F

Work Breakdown Structure (WBS)



Appendix G
Responsibility/ Communication Matrix

COMMUNICATION	PURPOSE	MEDIUM	FREQUENCY	AUDIENCE
Kick-off Meeting	Project synopsis and specifics	Skype	Twice- the second session is for people who could not join the first one	All key stakeholders: CNE, VP of Patient Care Services, Director of Nursing, RNs, C.N.A.'s, Clerks, Unit Leadership
Project Team Meeting	Project updates. Will ensure resources are available and barriers are identified and escalated to the proper chain of command to ensure success of the project.	Email/ Skype	Weekly	Unit Management Team, Unit Clinical Educator
Hourly Rounding Tool	Educate all stakeholders regarding the PNHR tool	Email/Skype	Weekly	Unit Leadership team, RNs, C.N.A.'s, Clerks
Go-Live	To ensure all key stakeholders are ready for Go-Live	Email/ Shift Huddles	Once	All key stakeholders: CNE, VP of Patient Care Services, Director of Nursing, RNs, C.N.A.'s, Clerks, Unit Leadership
Project Status Updates	Keep key stakeholders informed. Will ensure resources are available and barriers are identified and escalated to the proper chain of command to ensure success of the project.	Email	Monthly	CNE, VP of Patient Care Services, Director of Nursing, Unit Leadership team, RNs, C.N.A.'s, Clerks
Project Conclusion	Keep all stakeholders updated on project timeline	Skype/ Email	Once	CNE, VP of Patient Care Services, Director of Nursing, Unit Leadership team, RNs, C.N.A.'s, Clerks
Final Project Data results	Closed-loop communication to all key stakeholders	Skype/ Email	Once	Unit Leadership team, RNs, C.N.A.'s, Clerks
Frontline Staff Communication Feedback loop	To ensure all barriers are identified, escalated, and addressed in real-time	In-person/ Email/ Telephone	Real-Time/ As close to real-time as possible	Unit Leadership Team

COMMUNICATION	PURPOSE	MEDIUM	FREQUENCY	AUDIENCE
Unit Leadership Report	To provide frontline nursing staff and unit leadership team with key findings from on-going chart audits and rounding observations.	In-person huddles/ Email	Weekly	RNs, C.N.A. 's, Unit Leadership

Appendix H

SWOT Analysis

SWOT Analysis



PURPOSEFUL NURSE HOURLY ROUNDING

S	INTERNAL STRENGTHS
1	Strong teamwork within the nursing team
2	Solid collaboration with the interdisciplinary team
3	Staff are familiar with the concept of hourly rounding
4	Robust electronic health record system (EPIC) that is the universal medical record for the entire health system
5	Organization's mission: Caring, healing, teaching, serving all
6	
7	

W	INTERNAL WEAKNESSES
1	Lack of an established hourly rounding process on the unit.
2	Lack of an hourly rounding tool
3	High number of agency traveler RN staff due to COVID-19 pandemic
4	High level of stress on staff due to increased demands and health risk of COVID-19
5	Patients complain that the response time for nurses are too long
6	
7	

O	EXTERNAL OPPORTUNITIES
1	Increased complexity of patients getting admitted to the hospital due to complications brought about by the COVID-19 pandemic
2	Improved collaboration amongst multi-disciplinary healthcare teams
3	Reduction of grievances to regulatory and government bodies regarding patient falls
4	Reduction of penalty fees from regulatory agencies regarding the cost of injuries associated with patient falls
5	Significant financial savings through cost-avoidance and return on investment from decreasing the incidence of patient falls
6	
7	

T	EXTERNAL THREATS
1	Lack of support from frontline staff/ other key stakeholders/ Post traumatic stress of frontline staff working through the pandemic
2	COVID-19 resurgence/ lack of vaccine- resulting in increased burden to staff, which can affect the PNHR project
3	Nursing labor strike impacts work and professional relationships; causes disruption to the project plan as well as hospital operations
4	Financial challenges of organization/ limited organizational budget/ uncertain funding
5	Affordable care act/ uncertainty of healthcare economics
6	Nursing shortages affect how the nursing units are staffed; affects patient safety & quality of care
7	Access to Personal Protective Equipment (PPE)

Appendix I

Budget and Financial Analysis

PNHR Program Budget- Line Item

Item	Total in dollars
Education of Staff RNs - 1 hour	80 RNs x \$70 (ave. hourly rate) Total= \$ 5,600
Education of Staff C.N.A.'s - 1 hour	30 C.N.A.'s x \$35 (ave. hourly rate) Total= \$ 1,050
Education of Staff Clerks - 1 hour	6 Clerks x \$30 (ave. hourly rate) Total= \$ 180
Education of Unit Leadership Team (CN4's/ Charge Nurses) - 1 hour	10 RNs x \$70 (ave. hourly rate) Total= \$ 700
Stakeholder Meeting - 1 hour	Estimated cost: \$ 2,000
Project Supplies/ Materials	Estimated cost: \$ 2,000
Build of PNHR tool in the EPIC (electronic health record)	100 hours x \$40 (ave. hourly rate) Total= \$ 4,000
Total:	\$ 15,530

PNHR Program Budget- Cost Avoidance Calculation

Item	Total in dollars
Average cost of fall with injury in the hospital	\$34,294
Projected cost of the PNHR project (one-time cost)	\$15,530
Potential cost avoidance from preventing the FIRST patient fall as a result of this DNP project	\$18,764

***Cost avoidance is a potential savings/avoidance in costs related to increased hospitalization, surgery, potential fines, regulatory time, and possible litigation due to damages/injury incurred by the patient- which is dependent upon the number of falls that can be prevented via the process of purposeful nurse hourly rounding- not intended to reflect potential revenue.

Cost Benefit- Return on Investment (ROI)

Item	Total in dollars
Estimated cost of PNHR project	\$15,530
Cost benefit (to decrease incidence of falls by an estimated 10% throughout the duration of the project from a baseline of 22 falls)	\$75,447 (2.2 [10% of 22] x ave. cost of one fall [\$34,294])
Return on Investment (ROI)	\$59,917 (75,447-15,530)

***Average cost of fall with injury in the hospital= \$34,294: Source 2015 Johns Hopkins Medicine

Projection Chart: Estimated Cost Avoidance Savings per Fall Prevented

# of Fall Prevented:	Total cost savings in dollars:
1	\$34,294
2	\$68,588
3	\$102,882
4	\$137,176
5	\$171,470
6	\$205,764
7	\$240,058
8	\$274,352
9	\$308,646
10	\$342,940

***Potential organizational savings may be exponential based upon project implementation outcomes. (potential cost avoidance savings= \$ x # of falls prevented).

Appendix J

Continuous Quality Improvement (CQI) Method

Instructions: Continuous Quality Improvement (CQI) through randomized chart audits will be conducted by the unit leadership team. Criteria for “YES”= presence of documentation of hourly rounding in the EHR. Criteria for “NO”= absence of documentation of hourly rounding in the EHR.

Date	MRN	Performed Purposeful Nurse Hourly Rounding (Y/N)
Day 1		
Day 2		
Day 3		
Day 4		
Day 5		
Day 6		
Day 7		
Day 8		
Day 9		
Day 10		
Day 11		
Day 12		
Day 13		
Day 14		
Day 15		
Day 16		
Day 17		
Day 18		
Day 19		
Day 20		
Day 21		
Day 22		
Day 23		
Day 24		
Day 25		
Day 26		
Day 27		
Day 28		
Day 29		
Day 30		

Appendix K Purposeful Nurse Hourly Rounding (PNHR) Tool

Patient Name: _____

Hourly Rounding¹ Tool

Date: _____

Greeting: Start your hourly rounds by introducing your name and role, “I’m here to check on how you’re doing – someone from the nursing team will be checking in on you about every hour.”

Closing: Before you leave, ask the patient, “Is there anything else I can do for you?” Let the patient know, “I, or one of my colleagues, will be back in about an hour to check on you again. If you need anything before we come back, please use your call light.”

Time	Availability		Patient Needs (5 Ps)					Additional Notes	Initials
	Sleeping ²	Off Unit	Pain ³	Potty ⁴ (bathroom)	Position ⁵	Protect ⁶	Provide ⁷		
0700									
0800									
0900									
1000									
1100									
1200									
1300									
1400									
1500									
1600									
1700									
1800									
1900									
2000									
2100									
2200									
2300									
2400									
0100									
0200									
0300									
0400									
0500									
0600									

¹ Hourly rounding: Nursing staff will round on patients every hour from 0700-2200; every 2-hours from 2200-0600.

² If patient is sleeping, assess surroundings and ensure all personal items are within reach and the Environment of care is safe.

³ RN: “Do you have any pain right now?”; Nurse Technician/Assistant: “Do you have any pain right now? I can get your nurse if you’re in pain.”; put pain medication on nurse’s scheduled list of things to do for patients and offer the dose when due.

⁴ When applicable, ask the patient, “Allow me to assist you to the bathroom while I am here?”; check if the urinal is clean and at hand; check if the patient has been incontinent and if patient needs to be cleaned.

⁵ Check the patient’s position for comfort. For example, ask if he/she would like to sit up in bed or adjust his/her pillow or be repositioned in bed.

⁶ Ensure that Fall precautions are in place, per protocol.

⁷ Provide all essential items to the patient, such as call light, telephone, eye glass, dentures, hearing aid, food, etc., and make sure it is within reach.

Appendix L

Purposeful Nurse Hourly Rounding (PNHR) Pre-Implementation Survey Questions

Purposeful Nurse Hourly Rounding

Start of Block: Default Question Block

Q1 This survey is for Quality Improvement purposes for Patient Safety, Quality of Care, and Patient Experience. This survey is anonymous. Do not put your name on it. Thank you.

- I consent to take this survey. (1)
- I do not consent to take this survey. (2)

Skip To: End of Survey If This survey is for Quality Improvement purposes for Patient Safety, Quality of Care, and Patient... = I do not consent to take this survey.

Q2 What is your current role?

- RN (1)
 - CNA (2)
-

Q3 Select your best answer: What is the concept of No Pass Zone?

- No Pass Zone means nobody will pass on a call light. Regardless of the person's title or role, everyone has a responsibility to answer call lights and address the patient's needs IMMEDIATELY. If the task needed is outside the person's scope of practice, the staff can reach out to other co-workers who may help at that time. (1)
 - No Pass Zone is an area in the nursing unit that is off-limits to the public. (2)
-

Q4 Select your best answer: What is Purposeful Nurse Hourly Rounding?

- It is a meaningful task of rounding on patients in a defined frequency of time to address critical aspects of care such as the 5 P's: Pain (assess for pain), Potty (assist with toileting), Position (assist with repositioning), Protect (Keep patient and environment of care safe/ Fall precautions in place), and Provide (provide the patient with all essential items and make sure they are within reach)- to enhance patient safety, quality of care, and patient experience. (1)
 - It is a type of patient rounding that only applies to Registered Nurses and does not apply to CNAs. (2)
-

Q5 True or False? Evidence-based research suggests that Purposeful Nurse Hourly Rounding that is done consistently by the nursing staff- enhances Patient Safety by reducing falls and also improves overall Patient Experience by proactively identifying and addressing the patient's needs.

- True (1)
- False (2)
-

Q6 Theoretical case scenario: If you or a loved one is admitted to a hospital, would you like the hospital nursing staff to perform consistent Purposeful Nurse Hourly Rounding and implement a No Pass Zone process for you/your loved one?

- Yes (1)
- No (2)
-

Q7 What do you think are potential barriers (if any) that can hinder the success of the following initiatives: (Purposeful Nurse Hourly Rounding, No Pass Zone)? Please explain.

Q8 Do you have any thoughts/ ideas/ suggestions on implementing a successful Purposeful Nurse Hourly Rounding initiative?

Appendix M

Purposeful Nurse Hourly Rounding (PNHR) Post-Implementation Survey Questions

Purposeful Nurse Hourly Rounding

Start of Block: Default Question Block

Q1 In your honest assessment, do you believe that purposeful nurse hourly rounding helped improve patient safety and quality of care for the patients we serve?

- Yes (1)
- No (2)

Skip To: End of Survey If This survey is for Quality Improvement purposes for Patient Safety, Quality of Care, and Patient... = I do not consent to take this survey.

Q2 Do you feel that you have been adequately educated, trained, and supported regarding the purposeful nurse hourly rounding pilot project?

- Yes (1)
- No (2)
-

Q3 Do you believe you have the necessary knowledge and tools you need in order to perform the purposeful nurse hourly rounding tasks?

- Yes (1)
- No (2)
-

Q4 On a scale of 1 to 5, 1 is strongly dissatisfied, and five is strongly satisfied. Please rate your overall satisfaction with the purposeful nurse hourly rounding project.

- 1= Strongly dissatisfied = 1% (1/86)
- 2= Slightly dissatisfied = 2% (2/86)
- 3= Neither satisfied nor dissatisfied = 3% (4/86)
- 4= Slightly satisfied = 7% (6/86)
- 5= Strongly satisfied = 85% (73/86)
-

Q5 In your opinion, what went well and what did not go well during the PNHR project implementation? Please explain.

Appendix N
Purposeful Nurse Hourly Rounding (PNHR) Education Materials

Activity

Question 1:

What is Purposeful Nurse Hourly Rounding and what are the 5Ps?

Purposeful Hourly Rounding

- PNHR *is not* checking on a patient once an hour.
- PNHR *is* how you organize your work.

Typical Reasons to Go Into a Patient Room

- Give medication
- Recheck pain medication effectiveness
- Vitals
- Point of Care (POC) testing
- Respond to call light
- IV issues
- Hygiene needs
- Implement new physician order
- Bathroom need
- Change of shift and assessment

**All opportunities to
complete a Purposeful
Hourly Round!**

What Are The 5Ps?

- 1. Pain-** ensure that pain is assessed and addressed in a timely manner.
- 2. Potty-** assist with any toileting needs
- 3. Position-** ensure optimal comfort by helping with repositioning in bed/chair
- 4. Protect-** ensure that fall precautions are in place, i.e., bed is in the lowest position, side rails are up x2, bed is locked in place, patient is wearing non-skid socks, there is adequate lighting in the room, the environment of care is free of safety hazards.
- 5. Provide-** ensure that essential items are close to the patient, i.e., call light, eye glass, hearing aid, dentures, and bedside table

Summary of PNHR Approach

1. **Prepare patients** and family on admission or shift change to expect hourly rounding as our *commitment to very good care.*

2. **Cover the 5Ps** ensure *purposeful memorable rounds.*

3. **Follow up and close** to ensure the patient has what is needed.

“I or someone else from the nursing team will be back again in about an hour (or say, “two hours” if night shift) to do another round. Is there anything else you need before I go?”

“Excellent – Good Care”

- In Purposeful Nurse Hourly Rounding why do we tell patients we want to provide them with very good or excellent care?
- What is *very good care or excellent care* for each patient?
- Where do you record this?

Benefits of Hourly Rounding

Patients

1. Reduce patient falls

2. Reduce skin breakdown

3. Reduces patients anxiety and fear

4. Improves patient perceptions of their care -> **Improved Patient experience**

Nurses

1. Reduce call lights -> **Increased nurse efficiency and satisfaction**

2. Proactive rather than reactive nursing -> **Gives nurses more time for patient care tasks**

3. Reduced distance walked per shift -> **Reduced fatigue**

4. Improves patient perceptions of their care -> **Improved Patient experience**



All staff answering

All call lights

All the time

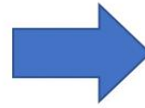
What is it and why?

- ✓ No Pass Zone is a **best practice**.
- ✓ Enlists every employee on a medical floor to answer a patient's call light.
- ✓ Many call light requests are non-medical and do not require a nurse
- ✓ Decreased call light response times are linked to **patient safety** and satisfaction.

No Pass Zone

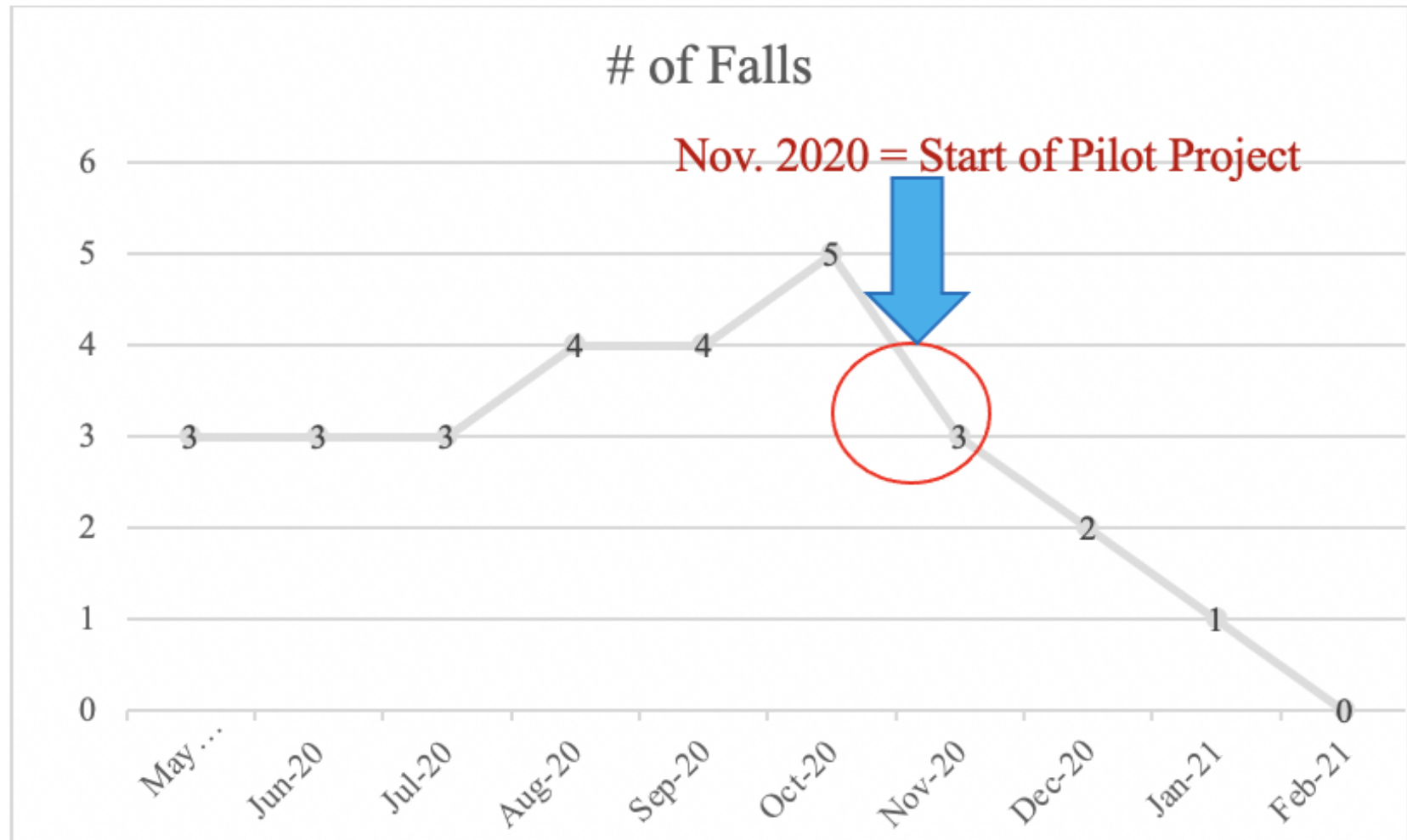


*A patient's feedback
belongs to the unit
and hospital, not to
an individual.*



Thus, **every** patient
is **everyone's patient**
It's a team effort!

Appendix O
Patient Fall Rate Table



*The Purposeful Nurse Hourly Rounding pilot project was conducted from November 2020 to February 2021