

Fall 11-28-2021

## Leadership Rounding to Improve Patient Satisfaction in Pediatric Ambulatory Care

Tara J. Haskell

University of St. Augustine for Health Sciences, t.haskell@usa.edu

DOI: <https://doi.org/10.46409/sr.JDBR1371>



This work is licensed under a [Creative Commons Attribution 4.0 License](https://creativecommons.org/licenses/by/4.0/).

Follow this and additional works at: <https://soar.usa.edu/scholprojects>



Part of the [Nursing Administration Commons](#), [Pediatric Nursing Commons](#), and the [Quality Improvement Commons](#)

---

### Recommended Citation

Haskell, T. J. (2021). *Leadership Rounding to Improve Patient Satisfaction in Pediatric Ambulatory Care*. [Doctoral project, University of St Augustine for Health Sciences]. SOAR @ USA: Student Scholarly Projects Collection. <https://doi.org/10.46409/sr.JDBR1371>

This Scholarly Project is brought to you for free and open access by the Student Research at SOAR @ USA. It has been accepted for inclusion in Student Scholarly Projects by an authorized administrator of SOAR @ USA. For more information, please contact [soar@usa.edu](mailto:soar@usa.edu), [erobinson@usa.edu](mailto:erobinson@usa.edu).

**Leadership Rounding to Improve Patient Satisfaction in Pediatric Ambulatory Care**

Tara Haskell, MS, RN, CPN

School of Nursing, University of St Augustine for Health Sciences This

Manuscript Partially Fulfills the Requirements for the

Doctor of Nursing Practice Program and is Approved by:

Mary Brann, DNP, RN

Cathy Kleiner Ph.D., RN

Approved: November 28, 2021

### Abstract

**Practice Problem:** Low patient satisfaction has been linked to poor treatment compliance, patients leaving the practice, staff decreased job satisfaction, and high staff turnover (Haskard Zolnierek & DiMatteo, 2009; Prakash, 2010). Magnet reporting has identified wide discrepancies in ambulatory clinics, with some clinics reporting below benchmark patient satisfaction ratings.

**PICOT:** In pediatric ambulatory and primary care services, how will the implementation of leader-led customer service rounding, compared to current practice, increase family and/or patient satisfaction over 4 weeks?

**Evidence:** Key findings are that the rounding needs to be population-specific, intentional, and swiftly followed up when problems are identified. The body of evidence suggests that implementing leadership rounding in a setting such as pediatric ambulatory care could benefit the patients served by building trust and communication.

**Intervention:** Implementation of a leadership rounding survey modified from current hospital rounding tools on patients and families by nursing leaders.

**Outcome:** While post-data results did not have a statistically significant change from the predata results, several identified needs for the clinics were discovered. Clinical significance, in this project, addresses the family-identified needs for change, which will impact future care.

**Conclusion:** Rounding on families in pediatric ambulatory care is an integral part of the care that can identify patient satisfaction needs and practice differences between clinics, leading to more consistency in patient satisfaction in the future.

### **Leadership Rounding to Improve Patient Satisfaction in Ambulatory Care**

Pediatric medicine focuses on the family and creates a nurturing, healing environment for children in all care settings. However, families do not always have a positive pediatric experience. Healthcare organizations aim to continuously improve the quality of care and the patient's perceptions of care. The Institute of Healthcare Improvement (IHI) developed the Quadruple Aim that supports improvement in the patient experience, which consists of improving quality care and patient satisfaction, reducing costs, and enhancing the work-life balance of healthcare workers (IHI, 2020). These aims have been a driving force for organizations in improving their satisfaction scores. Additionally, multiple insurance agencies are starting to require patient satisfaction measurements as part of their reimbursement for care provided, pay-for-performance incentives, and specialists' board certifications (Agency for Healthcare Research and Quality [AHRQ], 2017).

The clear challenge to deliver high-quality care and meet patients' expectations is seen in all areas of medicine. An interprofessional team often cares for patients in ambulatory clinics, including nurses, medical assistants, technicians, and providers. From the time the family walks in the door until they go home, each interprofessional team member plays a part in the patient experience. The way the team interacts with each other and the patient impacts the family's satisfaction with care. Press Ganey (2017) identified three important factors in patient satisfaction, which are teamwork, careful listening by the providers, and the nurses remaining attentive to the patient's needs. Taking measures to improve patient satisfaction scores impacts quality clinical care and organizational success (AHRQ, 2017).

### **Significance of the Practice Problem**

The perceptions of the patient and family are often reflected in patient satisfaction surveys. For example, if patients perceive their provider did not spend enough time with them, they may indicate poor satisfaction even if they were diagnosed and treated accurately. Additionally, communication with the care team that is perceived as poor can lead to confusion about treatment, and the patient can lose trust in the team and care provided (Davis et al., 2017).

Dissatisfied patients are more likely to change physicians and be non-compliant with their treatment plan (Haskard Zolnierek & DiMatteo, 2009; Prakash, 2010). A Vitals (2018) survey stated that 20% of patients changed physicians due to long wait times, and 30% of patients walked out of an appointment due to long waits. The survey also correlated wait time to a physician's average rating (Vitals, 2018). Changing healthcare providers can often lead to inconsistency in care, but by having a consistent provider with effective communication skills, illness prevention, and improved self-care management can increase (AHRQ, 2020).

Poor patient satisfaction can have a significant impact on the healthcare system. Research findings have linked low patient satisfaction to decreased job satisfaction and high staff turnover (Haskard Zolnierek & DiMatteo, 2009; Prakash, 2010). It is estimated that a medical practice could lose up to \$200,000 annually due to the loss of a patient over dissatisfaction (Prakash, 2010). Another financial impact on medical practices is malpractice lawsuits (Levinson, 1997). It is shown that primary care physicians with high satisfaction scores and lower rates of malpractice lawsuits often spend more time with their clients (Levinson, 1997). As a result of the correlation between high patient satisfaction and lower malpractice lawsuits, the American Board of Medical Specialists certification is working to include patient satisfaction scores into their process;

additionally, several healthcare insurance agencies and healthcare plans incorporate patient experience ratings into incentives for providers (AHRQ, 2020).

Many countries around the world require patient satisfaction surveys. The World Health Organization's efforts to move the quality of care forward worldwide helped create the Framework for Person-Centeredness (Larson et al., 2019). This framework includes patient experiences as an essential part of quality care. Improving patient satisfaction is considered a necessary component of universal health coverage and meeting the Sustainable Development Goals (SDGs) worldwide (Larson et al., 2019). Countries are already using a variety of measures to look at patient experiences or patient satisfaction. In Germany, this data is used for benchmarking patient satisfaction and is made available to the public (Bitzer et al., 2012). Gamble (2012) completed a global patient satisfaction survey that showed the United States with a 77% satisfaction rating overall compared to a global rating of 66%, while Germany was at 72%. Out of the seven main countries surveyed, the United States had the highest rating (Gamble, 2012).

Several tools are used in the United States to measure patient satisfaction. The hospital in this DNP project used the NRC Health survey tool to track patient behaviors, preferences, wants, and needs (NRC Health, n.d.). The hospital reports the main patient-family experience rating publicly; for internal tracking purposes, each clinic and specialty area has separate reporting of patient satisfaction scores. The NRC survey tool has four nursing-sensitive measures that are reported to the Magnet designation cycles. This status is critical for this hospital as they have had Magnet status since 2005 (Children's Hospital Colorado [CHCO], 2015). Magnet status identifies hospitals that have reached the “gold standard” in care delivery, patient experience, and use of evidence-based care processes and procedures (American Nurses Credentialing Center [ANCC],

n.d.). Maintaining high patient satisfaction scores in the ambulatory departments is challenging.

Due to the nature of the specialty department, they each function differently and provide different services. These differences between departments can lead to patient and family satisfaction variances; for example, one department did not meet the patient satisfaction benchmark for the four nursing questions in all eight quarters reported, but others met the benchmark in all eight quarters.

### **PICOT Question**

The following population, intervention, comparison, outcome, and time (PICOT) question is used to guide this project. In (P) pediatric ambulatory and primary care services, how will the (I) implementation of leader-led customer service rounding, (C) compared to current practice, (O) increase family and/or patient satisfaction (T) over 4 weeks?

### **Evidence-Based Practice Framework and Change Theory**

This project used the Johns Hopkins Nursing Evidence-Based Practice Model (JHNEBP) framework (Dang & Dearholt, 2018). The framework can be applied in many nursing settings, from the bedside to leadership and academia (Melnik & Fineout-Overholt, 2019). Along with the JHNEBP framework, Kotter's eight-stage change process theory for leading change, guided project planning, and sustainability efforts (Kotter, 2012).

### **Johns Hopkins Nursing Evidence-Based Practice Model**

The JHNEBP model is a step-by-step process that is linear and guides evidence-based practice (EBP) implementation. The model has a process and tools available to help nurses implement EBP changes in healthcare settings (Melnik & Fineout-Overholt, 2019). The framework has three essential components that reflect using EBP in healthcare settings: inquiry, practice, and learning (Dang & Dearholt, 2018).

The first step in the 19 linear steps is identifying the practice question (Dang & Dearholt,

2018). Once the practice question was determined, an inquiry into the evidence was made, and the project leader completed the evidence grading. The evidence includes internal and external factors that might influence the project's implementation, such as change culture, resources, and current standards (Melnyk & Fineout-Overholt, 2019). Once all the evidence was compiled, a recommendation for change was made. The last phase in the JHNEBP is translation, which analyses the evidence to determine how feasible the project would be (Dang & Dearholt, 2018). Once the project was determined to be viable by the organization's leadership, an action plan was created to implement the change and evaluate the outcome. The final step in the JHNEBP is disseminating the findings to the organization's leadership and other professional organizations or journals.

### **Kotter's Eight-Stage Change Process**

Kotter's change model provides clear steps to follow, with an underlying concept that people need to be given a reason to feel like the change should happen (Melnyk & FineoutOverholt, 2019). The eight stages start with creating a climate for change, then progressing to enabling the organization, and finally sustaining change (Kotter, 2012). The driver for this project is that patient satisfaction should always be a consideration despite challenges. Having team members passionate about this change was an essential piece to help build urgency and encourage others to want successful change (Melnyk & Fineout-Overholt, 2019). Creating a climate for change was made through the first three stages of creating the sense of urgency, forming a coalition, and creating the vision (Kotter, 2012). Not only do people need to be invested in the idea, but also straightforward and easy-to-understand communication is vital for effective change (Kotter, 2012). Communicating this vision of change was met by sharing patient stories of both positive and negative experiences. The investment from the unit manager was



essential, by examining barriers; additionally, the Patient Family Experience representatives helped build the momentum and empowered the staff to change (stage five) (Kotter, 2012). Knowing how each stakeholder felt about the change before implementation, made the discussions of barriers such as training, time, and compliance, as well as, the importance of patient satisfaction improvement, be productive and guide the empowerment of the teams to sustain the new practice of rounding (Barrow et al., 2021).

Stage six of Kotter's change process is creating quick wins (Kotter, 2012). Small wins included gaining facility approval and setting a date for "go live." These small wins gave momentum and a sense of accomplishment for moving forward. Celebrating these small wins helped move the project into stage seven, which built on the change (Kotter, 2012). The last stage of Kotter's Change Theory is making it stick (Kotter, 2012). Sustainability is essential in any project to make a lasting impact; immediate success can fade to complacency. The transition of ownership was passed on to the directors for the ambulatory departments, who are passionate about improving patient satisfaction and building a culture to sustain the change to other clinics. Unfortunately, the sustainability phase has hit some barriers due to the staffing shortage related to COVID-19. Once the staffing shortage has improved and there are fewer barriers to rounding, the sustainability process will improve.

### **Evidence Search Strategy**

Following the JHNEBP model, the literature has been reviewed to critique and appraise the evidence-based practices regarding leadership rounding. The literature review was conducted using the search engines ProQuest, CINAHL Complete, PubMed, Nursing OVID, EBSCO, and Google Scholar. Inclusion criteria included the years 2006 to present and the English language. The search included the following keywords: leadership rounding, rounding, executive rounding,

intentional rounding, nurse leader rounds, patient rounding, purposeful rounding, patient satisfaction, patient experience, family experience, pediatric, NRC, ambulatory, and outpatient. Leadership rounding was also included in the literature findings, often with hourly rounding research or protocols. Articles with only hourly rounding were excluded, but only after screening for leadership rounding. Exclusionary terms used included nurse-physician rounding, bedside rounding, interprofessional rounding, pharmacy, disease-specific focus, pain, infection control, and staffing. Phrases were searched using Boolean operators “and,” “not,” and “or.” The purpose of this review was to support a proposed Doctor of Nursing Practice (DNP) project intervention of doing leadership rounding in ambulatory pediatric areas.

### **Evidence Search Results**

The searches produced more than 3,845 articles. A total of 115 were screened for inclusion and exclusion criteria, which excluded 77 articles initially. There were 38 articles that met the inclusion criteria. A full-text review was completed from these articles, and 12 articles were selected for their substantial contribution to this project and are included in the evidence table (see Appendix A). Articles excluded from the evidence table were lower evidence articles, including white papers, quality improvement projects, student evidence-based practice projects, and literature reviews, which are found in the Prisma Chart (see Figure 1).

The overall strength of the recommendations was determined using the JHNEBP model. Studies supporting the implementation of leadership rounding ranged from level I to V. This rating is dependent on the study design, with quantitative studies being level I and level V are a quality improvement or literature review (Dang & Dearholt, 2018). The recommendation is that only “A” and “B” level studies support EBP. The 12 most relevant studies were evaluated and appraised using the JHNEBP model (see Appendix A and B). This criterion means the articles

are categorized based on having consistent or reasonably consistent results, sufficient sample sizes, or comprehensive literature reviews, description of the specific technique, and transparency (Dang & Dearholt, 2018). This recommended criterion was used to evaluate the literature returned from the literature search. The studies in the evidence table that supported the implementation of leadership rounding ranged from level I to III with A or B ratings. This body of evidence is mainly in the acute care settings; however, there is enough evidence to suggest the potential benefit of leadership rounding in ambulatory care settings as well.

### **Themes with Practice Recommendations**

Hourly rounding is a foundational concept from which leadership rounding was established in many institutions. Much of the literature addresses leadership rounding being used in conjunction with hourly or bedside rounding. The literature review for this project looked at articles on rounding and specifically leadership rounding and its impact on patient satisfaction. Several themes come up in the literature: rounding, intentional rounding, quality of care, or leadership rounding on patient satisfaction.

### **Rounding**

Best practice on inpatient units has found that rounding on patients either hourly or every other hour has several positive benefits (East et al., 2020; Meade et al., 2006; Ogbolu et al., 2016; Rea et al., 2018; Rondinelli et al., 2012). Regularly interacting with a nurse or staff member such as a certified nursing aide leads to trusting relationships and can reduce anxiety in patients and families (Ogbolu et al., 2016; Rea et al., 2018). A study of 11 southern California hospitals determined that the act of rounding improved patient satisfaction scores (Rondinelli et al., 2012). A key component identified for successful rounding was that the rounding results need to be reviewed, and structures around results need to be reevaluated for better outcomes

(Rondinelli et al., 2012). Additionally, managers identified the need for flexibility with rounding timing and routine as staff and unit needs change for continued sustainability (Rondinelli et al., 2012).

In a systematic review of 28 articles looking at family-centered rounding, patient satisfaction was impacted positively, with families reporting having an increased understanding of information and confidence in the medical team (Rea et al., 2018). A study with 145 patients showed statistically significant improvement in patients' perception of care and satisfaction with care, as measured with the tools Perception of Quality Nursing Care Scale and the Patients' Satisfaction with Nursing Care Quality Questionnaire (Shin & Park, 2018). In a qualitative study in 11 California hospitals, the two main themes identified were hourly rounding, improved patient perception of being well cared for, and overall patient satisfaction. An extensive nationwide study with 27 nursing units was foundational for rounding, and patient satisfaction was statistically improved for hourly and two-hour rounding (Meade et al., 2006). However, the limitations in this study included the lack of raw data determined by each hospital's different survey vendors (Meade et al., 2006).

### **Intentional Rounding**

The literature suggests using intentional rounding is beneficial for patient satisfaction (Ayaad et al., 2019; Cody & Williams-Reed, 2018; East et al., 2020; Harrington et al., 2013; Kirk & Kane, 2016; Ogbolu et al., 2016; Rondinelli et al., 2012; Shin & Park, 2018). Intentional rounding is scripted, structured, and timely, and the literature shows that both nurses and patients respond positively to intentional rounding (East et al., 2020; Ogbolu et al., 2016). One userfriendly way identified for doing intentional rounding was using a digital tablet with rounding software and pre-scripted questions, leading to consistency in the delivery of patient rounding questions (Cody & Williams-Reed, 2018). Using a tablet for tracking and consistency

helped to balance out some of the negatives identified in the literature, such as extra workload, not enough time, lack of staff engagement, and variability in settings such as the emergency department

(ED) (Harrington et al., 2013; Kirk & Kane, 2016).

### **Quality of Care**

Despite some negatives, it is documented in the literature that rounding increases the quality of care, as supported in 9 of the 12 supporting articles for this project (Ayaad et al., 2019; Cody & Williams-Reed, 2018; East et al., 2020; Harrington et al., 2013; Kirk & Kane, 2016; Meade et al., 2006; Ogbolu et al., 2016; Rondinelli et al., 2012; Shin & Park, 2018). Some of the main benefits identified with rounding are reducing falls and using call lights (Harrington et al., 2013; Kirk & Kane, 2016; Meade et al., 2006; Rondinelli et al., 2012; Shin & Park, 2018).

Another positive aspect is improving the nurse-patient relationship, as it is reinforced by regular rounding and improves patient quality care (East et al., 2020; Shin & Park, 2018). Leadership rounding impacts quality, builds patient-nurse communication, trust, and monitors other quality aspects, such as hourly rounding (Cody & Williams-Reed, 2018; East et al., 2020). Another significant quality factor is cultural competency. Often, patients express complaints after leaving, making it hard to meet their cultural expectations (Ogbolu et al., 2016). Completing leadership rounds can help identify themes and needs to develop culturally competent care for diverse patient populations (Ogbolu et al., 2016).

### **Leadership Rounding and Patient Satisfaction**

Leadership rounding builds on the benefits of hourly rounding and supports the patient's needs further. Three studies specific to leader rounding demonstrated increased patient satisfaction related to nursing concern and being well cared for (Ayaad et al., 2019; Rondinelli et

al., 2012; Tan & Lang, 2015). Another benefit found in the research, was that leadership rounding can assess patient needs and trends in care to impact future care (Ogbolu et al., 2016; Rondinelli et al., 2012). A small systematic review with only three articles had weak evidence but still demonstrated improved patient satisfaction (Tan & Lang, 2015). A retrospective descriptive study done by Cody & Williams-Reed (2018) showed one negative score for “nurses listened carefully” and one positive score for “nurses explained things in a way you could understand,” this study did not demonstrate a statistically significant improvement in the overall mean of hospital patient satisfaction scores. However, the study had limitations, as it did not report what percentage of patients were rounded on, though the stated expectation was 90% of patients, and there were management changes in the middle of the research, who did not receive the same training (Cody & Williams-Reed, 2018).

### **Gap in the Literature and Recommendations**

There is an abundance of information that rounding on adult patients and inpatient departments impacts improving patient satisfaction. However, there is limited literature on pediatric ambulatory care rounding. Although not specific to leadership rounding, one article in the search did demonstrate that rounding on pediatric patients and families has a significant impact on perceptions of care, leading to better patient satisfaction (Rea et al., 2018). There is also limited literature specific to the ambulatory setting; however, the evidence synthesized demonstrates that leadership rounding can impact patient satisfaction and is more related to nurse-sensitive care (Ayaad et al., 2019; Cody & Williams-Reed, 2018; Rondinelli et al., 2012; Tan & Lang, 2015). Key findings are that the rounding needs to be population-specific, intentional, and swiftly followed up on when problems are identified (Ayaad et al., 2019; Cody & Williams-Reed, 2018; East et al., 2020; Harrington et al., 2013; Kirk & Kane, 2016; Meade et

al., 2006; Ogbolu et al., 2016; Rondinelli et al., 2012; Shin & Park, 2018). The body of evidence suggests that implementing leadership rounding in a setting such as pediatric ambulatory care could benefit the patients served by building trust and quality of care.

### **Setting, Stakeholders, and Systems Change**

Implementation of this project was in the ambulatory department in a large southwestern children's hospital, which serves a multi-state region for specialty care. The leadership team at this hospital is committed to high-quality, coordinated care using reimagined and realized care to improve child health. The hospital strives to build community trust and stand by its values in all services provided. Two units were pilots for the initial implementation of the leadership rounding tool and evaluation of outcomes. Both the Child Health Care (CHC) and the Digestive Health Institute (DHI) clinics serve pediatric patients from infancy to adolescence and have large volumes of visits monthly. CHC focuses on primary care, and DHI focuses on esophageal, intestinal liver, pancreatic, and nutritional specialties. A convenience sample of patients and their caregivers, who were willing to participate in the survey, was rounded on during the intervention period, with a goal of 20 or more patient families rounded per month per clinic. Rounding was planned to be performed by unit managers, associate clinical managers (ACM's), and the project leader; however, due to changes made necessary by the impact of COVID-19, only the project leader completed the rounds.

A gap analysis, and a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, were conducted to determine the department's needs. Ambulatory department directors were contacted regarding the unit's needs; this included both directors for Primary Care, Community Programs, and Ambulatory Specialty Care. It was identified that leadership rounding was being completed hospital-wide but was lacking in ambulatory care settings. Another need

identified was that there was considerable variability for some department scores for the nursesensitive questions on the internally shared NRC survey, as reported to the Magnet redesignation committee. The plan for this project was to address these needs.

Other key stakeholders were included in the approval process, such as the vice president (VP) and medical providers of network of care (NOC), VP for Ambulatory Services, Child Health Clinic Clinical Manager and Associate Clinical Manager, Digestive Health Clinical Manager and Associate Clinical Manager, Ambulatory Care Patient Family Experience Chair, Rounds Plus (Rounds+) representative, and Family Advisory Council Chair. Other stakeholders for this project are patients, families, other clinic staff, physicians, dietitians, and nurse practitioners. Both ambulatory care directors approved and supported the project.

The sustainability plan included sharing the results with the ambulatory care leadership team and expanding leadership rounding to all clinics. Leadership rounding is expected to be incorporated with handwashing rounding to decrease barriers with time. The leadership rounding has been placed on hold because of extreme staffing shortages due to the global pandemic of COVID-19's impact on healthcare during 2020/2021. However, both directors for ambulatory care have stated they would like to implement rounds again as soon as staffing hits an adequate number. Different ambulatory departments are looking at other healthcare staff completing the rounding to assist the nurse leaders, such as orthopedic technicians in the orthopedic clinics. Interprofessional collaboration was needed during the implementation and will also be needed to support the sustainability of leadership rounding. The whole team needs to support patient rounding. Quality care begins at the initial interaction, through intentional scripted information that provides patients with an understanding of the importance of participation in leadership rounding and how it will provide support and improved care.



This project's focus was to have a sustainable specific population and macrosystem level change in the organization. The project involves healthcare professionals and patients from multispecialty clinics. The long-term effect of this project is for leadership rounding to be rolled out to many different ambulatory clinics and multiple sites across the broader organization. While this was not possible immediately after the project implementation, due to COVID-19 barriers, it is still planned. There is also potential to develop a new standard for pediatric ambulatory care rounding as the literature lacks this population area.

The SWOT analysis (see Appendix C) was completed for the ambulatory department and leadership rounding before implementation. Strengths at the time of the analysis, which was in the fall of 2020, included staff having a strong ethos for openness, commitment to patient satisfaction, and families being confident in the care received. Leadership rounding is already being supported and completed in the institution with established technology such as Rounds+ and smartphones. The Rounds+ software program records the patient's responses to the leadership rounding survey questions (see Appendix D). There were weaknesses identified, including inconsistencies in patient satisfaction scores for departments, staffing issues, and limitations on in person appointments due to COVID-19 restrictions. These limitations have increased the use of telehealth and eliminated nursing from these visits as patients often call directly to speak to the provider. Opportunities that exist include increasing patient satisfaction scores and improving community trust, with potentially higher clinic ratings for clinics that are lower performers. Another opportunity is the potential of financial savings and meeting national standards for Magnet and the American Nurses Association. Utilizing the Rounds+ platform is also an opportunity to advance technology use. The external threats to this department and project are economic slowdown, COVID-19 restrictions, altered communication due to

facemasks, insurance changes, and resistance to rounding from staff and patients. There are reported prior challenges to access data with NRC and Rounds+ data in a timely manner, and rounding outcomes can be challenging to quantify and put into statistical measures. This project's main objectives (see appendix F for all objectives) were to improve the overall patient satisfaction scores, increase nursing respect, and care team communication through reported percentage numbers from NRC surveys, in two ambulatory clinics for 4 weeks after the implementation of leadership rounding.

### **Implementation Plan with Timeline and Budget**

#### **Implementation Schedule**

These aims will be accomplished following the JHNEBP process and using Kotter's Change Theory. Following the JHNEBP, after the evidence was collected, the project moved into the translation phase, with stakeholders being notified and support was sought. Under Kotter's Change Process, the vision of the project was communicated, and buy-in was obtained. The project leader obtained the support of the directors for ambulatory medicine, as well as other stakeholders. Implementation started in August 2021, after the approval from the University of St. Augustine for Health Sciences Doctor of Nursing Practice Evidence-Based Practice Review Council (EPRC) review and the hospital's Evidence Based Practice/Quality Improvement (EBP/QI) Council committee. See Appendix E for more detail on the schedule for this project.

Rounds+ software has the leadership rounding survey questions loaded into the program and records patient responses for data collection. The implementation period lasted 4 weeks. The rounding during the 4 week period, aimed to collect at least 20 to 25 patients and family responses, using the leadership rounding survey questions for each family. This goal was established using the current handwashing surveys aim. This aim is so that both surveys can be

combined for efficiency and sustainability. The rounding is a modified intentional rounding survey adapted to the ambulatory care setting from the current rounding tools used at the facility (see Appendix D). These leadership rounding surveys have been in use for several years and have face validity, as leaders have used them for some time. The surveys are widely accepted in the hospital in multiple departments, including emergency and urgent care outpatient settings, inpatient settings, and general use. The survey length was a challenge in the ambulatory setting and has been condensed for sustainability.

The directors of the ambulatory departments and nursing research department have all verified face validity for the survey. The leadership survey has been shown to have value by increasing patient experience knowledge. Two weeks into the intervention, the data from Rounds+ was tabulated, and the goal of a minimum of 20 rounds per clinic was obtained at this time. NRC reported patient satisfaction results once a month and was collected at the beginning of September 2021. The project manager collaborated in this data collection with the patientfamily experience chair for ambulatory patients who has access to the data management program in Rounds+. The intervention was completed at the end of August 2021, and the final data collection points were collected the second week of September 2021. After collecting the NRC survey data and Leadership Survey data from the Rounds+ application, the data was analyzed and summarized for final evaluation and dissemination.

### **Budget**

The budget for this project was minimal outside of the standard operating cost, and the directors approved the hospital's cost (see Table 1). At the end of this project, the cost for hospital-employed leaders was deleted as there were no ambulatory leaders who completed rounds and needed approved time for this activity. There was also no need for celebrations on the

unit as the project leader did the rounds. Hospital costs included time with the patient satisfaction team and the Rounds+ representative to build the survey and train the project leader on the use of the instrument. Other budget expenses included a statistician for the analysis of the data before dissemination.

### **Role of the Project Leader**

Throughout this project's phases, the project leader was involved in all aspects. Using Kotter's Change Process, the project started creating urgency and building momentum with the investment of a strong team. Transformational leadership skills align with the hospitals' values and is also supported by the American Nurses Credentialing Center and Magnet designation as required skills for EBP implementation (Everett & Sitterding, 2010). These skills include serving on interdisciplinary teams, including nurses, physicians, healthcare aides, patient family experience representatives, parents, and unit service specialists. A high-level system change requires a team of stakeholders and support from multiple disciplines. The project leader was responsible for updating the stakeholders regularly throughout the process. This communication was done with bi-monthly and monthly emails that consisted of critical updates as the project moved forward post approval from key stakeholders. The responsibilities also included ensuring the staff implemented the leader rounding and that it was completed as defined in the project. At the end of the implementation period, it was vital to perform a complete evaluation. The project's summary and the review of outcomes were delivered to key stakeholders by the project leader.

### **Results**

NRC Health was the survey tool used by this healthcare facility to evaluate patient satisfaction. This measurement tool is used to track patient behaviors, preferences, wants, and needs (NRC Health, n.d.). The NRC survey was delivered by NRC staff, after a patient had

completed a visit in the ambulatory care department and included questions about the responsiveness of the hospital staff, nursing communication, pain management, cleanliness, and patient education. The responses to the survey were reported monthly to the hospital and directors of the departments. This data was also posted on the hospital's internal SharePoint website. The overall patient satisfaction scores were reported and recorded by clinic name in the percentage of those surveyed who reported a 9/10 score. For reporting and running Chi-squared testing on data, the rate of patients reported a 9/10 was listed as a yes, and those who did not give the top rating were a no for the statistical analysis. Data from the CHC and DHI clinics were used and compared in this pilot project. This data was de-identified information from the NRC survey and was collected directly by NRC and then reported to the hospital with the satisfaction scores in aggregate form. The inclusion criteria were all patients or families who returned the survey to the NRC. The questions compiled from the NRC reports were “satisfaction with provider; would recommend facility; confidence and trust in nurses and nurses listened carefully.” These scores were compared to pre-and post-intervention data collection.

The project leader completed the leadership rounding for both pilot clinics, resulting in 21 rounding surveys conducted per clinic. This number met the minimum process measure goal of 20 per clinic during August 2021. Due to the unprecedented strains of the COVID-19 pandemic on the healthcare system and staffing in the hospital system, the nurse unit leaders could not implement the intervention themselves; therefore, the project leader stepped in to complete the leadership rounding. Although the nurse unit leaders were available if any patient concerns arose, the outcome measure for nurse leader satisfaction related to the rounding process could not be obtained, due to this change. The total number of leadership rounds completed was recorded in Rounds+ and saved in the system. Only pre-approved users can access this data with

a password. This collected information was retrieved from Rounds+ and saved on a passwordprotected hard drive in aggregate form with no patient identifiers for data analysis.

The data analysis was done using the collected data from the NRC report and leadership rounding surveys. The NRC tool is valid and reliable and is used in hospitals across the country. The collected measures are reviewed in Appendix F, including the goals for the measures, the statistical test used, and the type of data collected. Due to the small size group, nonparametric equality of medians tests or  $\chi^2$  (chi-squared) tests were conducted to compare each variable's pre-and post-groups; additionally, *p*-values of .05 or less are considered significant. Data analysis was performed with Intellectus Statistics online software (Intellectus Statistics, 2021). Qualitative data collected from the Rounds+ Leadership Surveys was evaluated for themes and reported descriptively.

The primary outcome measure was to determine if this intervention of leadership rounding improved patient satisfaction as measured by four satisfaction questions. The chisquare test results were not significant based on an alpha value of 0.05, with *p*-values reported in Table 2 for both pre-and post-intervention clinics. These results imply that the observed frequencies were not significantly different than the expected frequencies. Table 2 presents the results of the chi-square test for both clinics and the pre-and post-data collection.

**Table 2**

*NRC Survey Results from Pre-Post Intervention*

	Digestive Health			Child Health		
	Pre (July)	Post (Aug)	p-value*	Pre (July)	Post (Aug)	p-value*
Provider Satisfaction	92 (87.6%) (N = 105)	83 (85%) (N = 95)	0.957	70 (76.9%) (N = 90)	105 (81%) (N = 124)	0.416

Would recommend facility	55 (91.7%) (N= 60)	43 (87.8%) (N= 49)	0.500	55 (81.7%) (N= 67)	91 (83.5%) (N= 109)	0.811
Confidence and trust in nurses	56 (87.5%) (N=64)	43 (87.8%) (N= 49)	0.967	61 (65.6%) (N= 93)	75 (71.4%) (N= 105)	0.696
Nurses listened carefully	57 (87.7%) (N= 65)	46 (90.2%) (N= 51)	0.671	64 (67.4%) (N= 95)	75 (65.8%) (N= 114)	0.810
Note: *p-value calculated by Chi-Square Test						

The results are consistent with historical data for the different clinics, as the DHI clinic has consistently performed higher than the CHC clinic. The chi-square test results compared the clinic's pre-and post-intervention data and were significant based on an alpha value of 0.05, with *p*-values as reported in Table 3.

**Table 3**

*NRC Survey Results, Pre-Post Intervention, Clinics Compared*

	Clinics Pre			Clinics Post		
	Digestive Health July	Child Health July	p-value*	Digestive Health Aug	Child Health Aug	p-value*
Confidence and trust in nurses	56 (87.5%) (N=64)	61 (65.6%) (N= 93)	0.002	43 (87.8%) (N= 49)	75 (71.4%) (N= 105)	0.026
Nurses listened carefully	57 (87.7%) (N= 65)	64 (67.4%) (N= 95)	.003	46 (90.2%) (N= 51)	75 (65.8%) (N= 114)	0.001
Note: *p-value calculated by Chi-Square Test						

These continued differences suggest practice differences between clinics and that the leadership rounding could improve scores and ensure consistency. Other outcome measures

reported on the leadership rounding survey included the percentage of patients and families reporting that they received great care and that the communication between team members was consistent; both pilot clinics reported 100% satisfaction. Statistical analysis was not needed for these measures. This outcome met both goals for the leadership rounding data measures.

The clinical significance of improvements related to leadership rounding can be associated with the visual and qualitative information collected during data collection. This information can be used to improve processes and care for patients. One of the observed differences between DHI and CHC was that a nurse completed an intake questionnaire before the provider visit in the DHI clinic, but this was not observed in the CHC clinic. Another difference was that a nurse was assigned to all patients who received leadership rounding; however, many of the patients in the CHC clinic did not see a nurse for extended time frames or at all. These differences in nurse involvement could explain one area that impacts the nursing-related questions on the NRC survey. During leadership rounding, themes emerged when patients and families were asked if there were any recommendations or kudos to the team. Patients and families in the DHI clinic reported being seen early and that this was the best clinic they have ever been to, including other clinics at the same facility. Comments from families in the DHI included, “We have been to a lot of clinics, and DHI is the best managed and well run of them all” and “today has been great, we saw neuro last week and had to wait over two hours, so it was nice to get in and be seen on time today.” It was typical for the CHC clinic to hear praise from several families and complaints that the clinic often ran behind. One comment on this was, “It would be nice to have an update to reduce anxiety (while waiting).” No current complaints needed addressing during the rounding process; however, a few recommendations were made that have been passed on to the nurse unit leaders. These recommendations include; a request to



schedule more than two siblings at the same time for checkups; confirmation texts to include all children in the appointment; letting families bring siblings into the room as they sometimes do not have a choice but to bring them; adding a check-in option for non-binary patients, so they do not have to select “other”; and more translators in person.

### **Impact**

While statistical significance was not observed for the outcome measures, the clinical importance will address the shared patient concerns that were shared to improve patient and family satisfaction moving forward. Additionally, addressing the continued perceived differences from one clinic to the next can impact the perceived quality of care in the long run. The local community trusts that they will receive extraordinary evidence-based care when seen at any of the clinics within the organization. By comparing data between clinics, the lessons learned from one clinic to the next can be shared throughout the organization for consistency. For example, DHI has a nurse enter the room and perform an intact questionnaire; this initial contact and communication with a nurse can impact a patient's perception of nursing care. This practice is not done in the CHC clinic and could contribute to why nursing care is statistically lower for this clinic.

Since the initiation of this project, the face of healthcare has significantly changed because of the worldwide pandemic of the COVID-19 virus. A limitation of the project was that more patients were being seen remotely, which was not captured in the project design. Staffing within the entire facility has been dramatically impacted due to COVID-19, and fewer nurse leaders are available to perform rounding with families. It was necessary to have the project leader implement the rounding instead of clinic nursing leaders due to these limitations. Another constraint was that patient satisfaction only includes the highest satisfaction scores and only

families who take the time to fill the survey out. Families that were rounded on may not have completed the NRC post-visit survey and would not have been captured in the overall satisfaction for units. A further limitation, that will also have an effect on sustainability, was that the clinics in the organization do not all function the same, which will have an impact on rounding and patient satisfaction results.

The project's sustainability is that the leadership rounding survey has been created, and the ambulatory directors want to initiate this survey. The survey is readily available for use in Rounds+ when staffing issues are resolved, and clinic leaders have the availability to resume rounding. This project was a pilot project for only two clinics, but with many more clinics in the institution, the directors of ambulatory care want to see this rounding expanded to the other clinics. The survey only takes about two minutes to complete, which helps with the sustainability for a busy clinic leader. This time frame makes it possible for nurse leaders to round on several families in a short window of time each month. Clinic managers already pull patient satisfaction surveys monthly, and evaluation of the satisfaction surveys can be compared once the rounding is resumed. However, a barrier to sustainability is that the new staff hired to correct the current staff shortage will not be familiar with the project and may not have the same investment as the project team. There would need to be training and orientation to the tool once staff is hired for these leadership roles and project sustainability. Another barrier is that due to this project's limitations, statistical significance was not observed, and the lack of supporting data could limit future buy-in from staff.

### **Dissemination Plan**

Getting staff buy-in long-term will be impacted by appropriately disseminating the information to others. The project's findings were disseminated to the ambulatory directors. The

meeting was done via a virtual meeting with the directors from both clinics. This meeting included the project overviews, such as the time it took to complete the surveys and the results obtained. Plans for sustainability and rolling out the leadership rounding to all units have been placed on hold due to significant staffing shortages in all ambulatory clinics secondary to COVID-19's impact on healthcare. However, the clinic directors see the value and have buy-in for future implementation of the leadership rounding tool in the near future.

Publication of the project work and findings, while not statistically significant, can be used for other nurses to learn from challenges in implementing a project during a healthcare crisis. This project and the lessons learned from the challenges faced were presented at the University of St. Augustine's for Health Sciences Sigma Theta Tau chapter meeting in November 2021. Areas of potential future publication could be in the *Society of Pediatric Nurses Professional Journal*, the Beryl Institute's annual conference, and *The Rounds+ Software Journal*. *The Beryl Institute's Patient Experience Journal* is an appropriate choice for potential publication as it is a peer-reviewed journal focusing on expanding global evidence regarding patient experience. Project publication is also included in the Soar@USA database, a collection of all student and faculty work at the University.

### **Conclusion**

The patient experience is one of the four focal points of improving patient care, as stated in the Quadruple aim (IHI, 2020). Poor patient satisfaction has been linked to challenges with outcomes and retaining patients, and it can impact a facility's finances and the patient's health. Implementation of leadership rounding is one method for improving patient satisfaction. Seeing how a visit is going for a family during leadership rounding and intervening on any family needs immediately can quickly resolve poor experiences. Leadership has the respect to make a positive

impression and correct any issues that might lead to a poor patient experience. Performing consistent weekly leadership rounding can improve the patient experience by addressing these concerns. Leadership rounding can also help departments recognize patient identified concerns related to the facility, care, and processes. Nurse leaders are able to address both immediate and long-term needs that patients and families are concerned about in the clinic. The JHNEBP model and Kotter's Theory of change were guides for the implementation of this project. Through the guidance of the project leader, the ambulatory department at a children's facility was able to identify several key factors that needed to be addressed. The value in leadership rounding might not be consistently verified in numbers but is demonstrated through patient perceptions and the improvement of the patient experience through consistent communication and care between departments.

## References

- Agency for Healthcare Research and Quality. (2017). *CAHPS ambulatory care improvement guide*.  
<https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/qualityimprovement/improvement-guide/2-why-improve/cahps-section-2-why-improve-patientexperience.pdf>
- Agency for Healthcare Research and Quality. (2017, December). *Strategy 2: Communicating to improve quality*. Retrieved October 30, 2020, from  
<https://www.ahrq.gov/patientsafety/patients-families/engagingfamilies/strategy2/index.html>
- American Nurses Credentialing Center. (n.d.). *Why become Magnet?* American Nurses Association. Retrieved October 13, 2020, from  
<https://www.nursingworld.org/organizational-programs/magnet/about-magnet/whybecome-magnet/>
- Ayaad, O., Alloubani, A., Al-rafaay, M., Arideh, A., Abualeish, M., & Akhu-Zaheya, L. (2019). Impact of structured nurse leader rounds on satisfaction with nursing care among patients with cancer. *Journal of Nursing Scholarship*, 51(5), 526–536.  
<https://doi.org/10.1111/jnu.12503>
- Barrow, J. M., Annamaraju, P., & Toney-Butler, T. J. (2021). *Change management*. StatPearls.  
<https://www.ncbi.nlm.nih.gov/books/NBK459380/>
- Bitzer, E., Volkmer, S., Petrucci, M., Weissenrieder, N., & Dierks, M.-L. (2012). Patient satisfaction in pediatric outpatient settings from the parents' perspective - the Child ZAP: A psychometrically validated standardized questionnaire. *BMC Health Services Research*, 12(1). <https://doi.org/10.1186/1472-6963-12-347>

- Children's Hospital Colorado. (2015). *It's a threepeat! We achieved nursing's highest honor for the third time.* <https://www.childrenscolorado.org/about/news/2015/december-2015/magnet-redesignation/>
- Children's Hospital Colorado. (2021). *Patient-family experience at Children's Hospital Colorado.* Retrieved April 17, 2021, from <https://www.childrenscolorado.org/about/quality/patient-experience/>
- Cody, R., & Williams-Reed, J. (2018). Intentional nurse manager rounding and patient satisfaction. *Nursing Management*, 49(4), 16–19.  
<https://doi.org/10.1097/01.numa.0000531172.62599.ba>
- Dang, D., & Dearholt, S. (2018). *Johns Hopkins nursing evidence-based practice: Model and guidelines* (3rd ed.). Sigma Theta Tau International.
- Davis, J., Burrows, J. F., Ben Khallouq, B., & Rosen, P. (2017). Predictors of patient satisfaction in pediatric oncology. *Journal of Pediatric Oncology Nursing*, 34(6), 435–438.  
<https://doi.org/10.1177/1043454217717239>
- 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), 1365–1371. <https://doi.org/10.1111/jocn.15180>
- Everett, L. Q., & Sitterding, M. (2010). Transformational leadership required to design and sustain evidence-based practice: A system exemplar. *Western Journal of Nursing Research*, 33(3), 398–426. <https://doi.org/10.1177/0193945910383056>
- Flowers, K., Wright, K., Langdon, R., McIlwraith, M., Wainwright, C., & Johnson, M. (2016). Intentional rounding: Facilitators, benefits and barriers. *Journal of Clinical Nursing*, 25(9-10), 1346–1355. <https://doi.org/10.1111/jocn.13217>

- Gamble, M. (2012, April 30). *30 statistics on global patient satisfaction*. Becker's Hospital Review. <https://www.beckershospitalreview.com/hospital-managementadministration/30-statistics-on-global-patient-satisfaction.html>
- Harrington, A., Bradley, S., Jeffers, L., Linedale, E., Kelman, S., & Killington, G. (2013). The implementation of intentional rounding using participatory action research. *International Journal of Nursing Practice*, *19*, 523–529. <https://doi.org/10.1111/ijn.12101>
- Haskard Zolnierak, K. B., & DiMatteo, M. (2009). Physician communication and patient adherence to treatment: A meta-analysis. *Medical Care*, *47*(8), 826–834. <https://doi.org/10.1097/mlr.0b013e31819a5acc>
- Institute for Healthcare Improvement. (2020). *Triple aim for populations*. Retrieved September 27, 2020, from <http://www.ihl.org/Topics/TripleAim/Pages/Overview.aspx>
- Intellectus Statistics. (2021). *Intellectus Statistics* [Online software]. <https://analyze.intellectusstatistics.com/>
- Kirk, K., & Kane, R. (2016). A qualitative exploration of intentional nursing round models in the emergency department setting: Investigating the barriers to their use and success. *Journal of Clinical Nursing*, *25*(9-10), 1262–1272. <https://doi.org/10.1111/jocn.13150>
- Kotter, J. P. (2012). *Leading change* (1st ed.). Harvard Business Review Press.
- Larson, E., Sharma, J., Bohren, M. A., & Tunçalp, Ö. (2019). When the patient is the expert: Measuring patient experience and satisfaction with care. *Bulletin of the World Health Organization*, *97*(8), 563–569. <https://doi.org/10.2471/blt.18.225201>
- Levinson, W. (1997). Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *The Journal of the American Medical Association*, *277*(7), 553–559.

Meade, C. M., Bursell, A. L., & Ketelsen, L. (2006). Effects of nursing rounds: On patients' call light use, satisfaction, and safety. *American Journal of Nursing*, *106*(9), 58–70.

<https://doi.org/10.1097/00000446-200609000-00029>

Melnyk, B. M., & Fineout-Overholt, E. (2019). *Evidence-based practice in nursing & healthcare: A guide to best practice* (4th ed.). Wolters Kluwer.

NRC Health. (n.d.). *Our purpose*. <https://nrchealth.com/our-purpose/>

Ogbolu, Y., Scrandis, D. A., Fitzpatrick, G., & Newhouse, R. (2016). Leading organizational cultural competency. *JONA: The Journal of Nursing Administration*, *46*(12), 627–629.

<https://doi.org/10.1097/mna.0000000000000417>

Prakash, B. (2010). Patient satisfaction. *Journal of Cutaneous and Aesthetic Surgery*, *3*(3), 151.

<https://doi.org/10.4103/0974-2077.74491>

Press Ganey. (2017). *The pediatric patient experience: One size does not fit all*. Retrieved April 17, 2021, from <https://www.pressganey.com/resources/articles/the-pediatric-patientexperience-one-size-does-not-fit-all>

Rea, K. E., Rao, P., Hill, E., Saylor, K. M., & Cousino, M. K. (2018). Families' experiences with pediatric family-centered rounds: A systematic review. *Pediatrics*, *141*(3), e20171883.

<https://doi.org/10.1542/peds.2017-1883>

Rondinelli, J., Ecker, M., Crawford, C., Seelinger, C., & Omery, A. (2012). Hourly rounding implementation: A multisite description of structures, processes, and outcomes. *JONA: The Journal of Nursing Administration*, *42*(6), 326–332.

<https://doi.org/10.1097/mna.0b013e31824ccd43>

Shin, N., & Park, J. (2018). The effect of intentional nursing rounds based on the care model on patients' perceived nursing quality and their satisfaction with nursing services. *Asian*



*Nursing Research*, 12(3), 203–208. <https://doi.org/10.1016/j.anr.2018.08.003>

Tan, M., & Lang, D. (2015). Effectiveness of nurse leader rounding and post-discharge telephone calls in patient satisfaction: A systematic review. *JBIR Database of Systematic Reviews and Implementation Reports*, 13(7), 154–176. <https://doi.org/10.11124/jbisrir-2015-2013>

Vitals. (2018, March 22). *9th annual vitals wait time report released*. Business Wire. <https://www.businesswire.com/news/home/20180322005683/en/9th-Annual-Vitals-WaitTime-Report-Released>

## Table 1

### *Budget*

<b>EXPENSES</b>		<b>REVENUE</b>	
-----------------	--	----------------	--

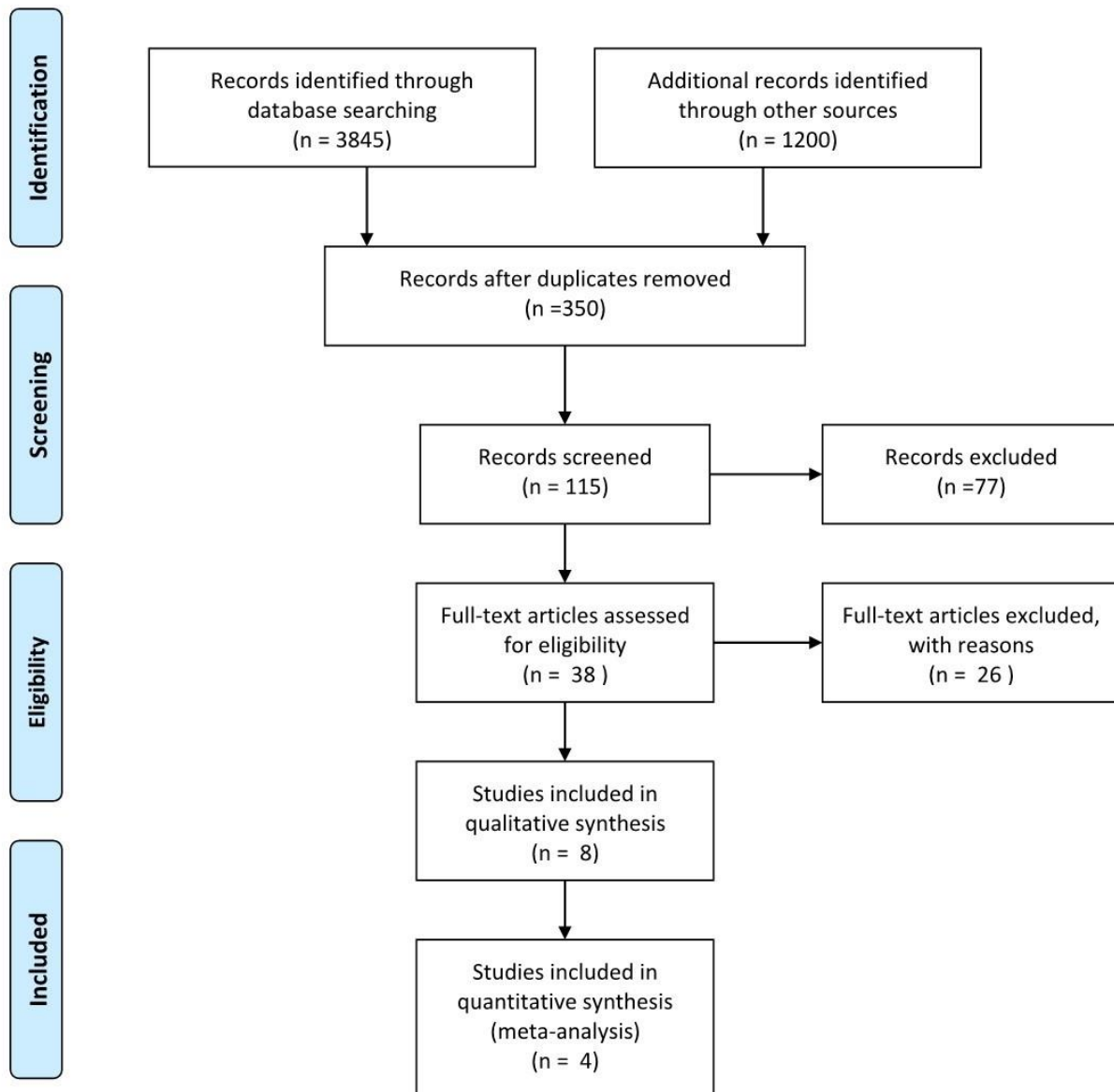
Direct		Billing	
Salary for Rounds+ representative in hospital (4hrs for developing questions)	\$200	Institutional budget support	\$200
Project Leader	\$0		
Services			
Statistician	\$100		
Celebration supplies	\$100		
<b>Total Expenses</b>	<b>\$400</b>	<b>Total Revenue</b>	<b>\$200</b>
<b>Net Balance</b>	<b>-\$200</b>		

**Table 2***NRC Survey Results from Pre-Post Intervention*

	Digestive Health			Child Health		
	Pre (July)	Post (Aug)	p-value*	Pre (July)	Post (Aug)	p-value*
Provider Satisfaction	92 (87.6%) (N = 105)	83 (85%) (N = 95)	0.957	70 (76.9%) (N = 90)	105 (81%) (N = 124)	0.416
Would recommend facility	55 (91.7%) (N= 60)	43 (87.8%) (N= 49)	0.500	55 (81.7%) (N= 67)	91 (83.5%) (N= 109)	0.811
Confidence and trust in nurses	56 (87.5%) (N=64)	43 (87.8%) (N= 49)	0.967	61 (65.6%) (N= 93)	75 (71.4%) (N= 105)	0.696
Nurses listened carefully	57 (87.7%) (N= 65)	46 (90.2%) (N= 51)	0.671	64 (67.4%) (N= 95)	75 (65.8%) (N= 114)	0.810
Note: *p-value calculated by Chi-Square Test						

**Table 3***NRC Survey Results, Pre-Post Intervention, Clinics Compared*

	Clinics Pre			Clinics Post		
	Digestive Health July	Child Health July	p-value*	Digestive Health Aug	Child Health Aug	p-value*
Confidence and trust in nurses	56 (87.5%) (N=64)	61 (65.6%) (N= 93)	0.002	43 (87.8%) (N= 49)	75 (71.4%) (N= 105)	0.026
Nurses listened carefully	57 (87.7%) (N= 65)	64 (67.4%) (N= 95)	.003	46 (90.2%) (N= 51)	75 (65.8%) (N= 114)	0.001
*p-value calculated by Chi-Square Test						

**Figure 1***PRISMA chart*

**Appendix A Summary of  
Primary Research Evidence**

Citation	Design, Level  Quality Grade	Sample  Sample size	Intervention  Comparison  (Definitions should include any specific research tools used along with reliability & validity)	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
<p>Ayaad, O., Alloubani, A., Al-rafaay, M., Arideh, A., Abualeish, M., &amp; AkhuZaheya, L. (2019). Impact of structured nurse leader rounds on satisfaction with nursing care among patients with cancer. <i>Journal of Nursing Scholarship, 51</i>(5), 526–536. <a href="https://doi.org/10.1111/jnu.12503">https://doi.org/10.1111/jnu.12503</a></p>	<p>RCT Level IA</p>	<p>total of 190 patients participated in the study to overcome the effects of participants withdrawing from the study</p> <p>Inclusion criteria; patients diagnosed with cancer, 18 years of age and older, conscious, oriented to the nursing care, and hospitalized in one of the four units for at least 3 days. Exclusion criteria were patients</p>	<p>Patient satisfaction was measured using the Patient Satisfaction with Nursing Care Quality Questionnaire, which was derived from the Patient Judgement of Hospital Quality Questionnaire.</p> <p>A scripted 5 min nurse leader tool was used to standardize the structured leader round as developed by Babaev (2015). Content validity of the scripted nurse leader tool was assessed by five expert nurse leaders.</p>	<p>Not clearly defined in the paper</p>	<p>Impact on satisfaction with nursing care among patients with cancer=The questionnaire was scored per item by calculating the means of patients' responses for each item using a 5-point Likert scale (1 to 5), where a score of 1 indicated that the perception of the item was "poor," and 5 indicated the perception of the item was "excellent." A total score was also determined as the sum of the patients'</p>	<p>Significant difference in the total score of patients' satisfaction between study groups (<math>t = -9.213</math>, <math>p &gt; .001</math>). Conversely, the structured leader round significantly impacts the patient's experience with nurse concern and caring (<math>t = -2.054</math>, <math>p = .042</math>).</p> <p>NLR has a significant impact on improving patient satisfaction in an oncology setting where patients receive care from many disciplines, such as surgical, medical, radiotherapy, and radiology.</p>

		<p>hospitalized in nontargeted units or for less than 3 days in targeted units. Assigned randomly; the first admitted patient and every other patient in each unit were assigned to the experimental group. The second admitted patient and every other patient in each unit were assigned to the control group.</p>			<p>responses regarding all items. These two methods capture the patients' perceptions of each statement as well as overall patient satisfaction with nursing care, respectively.</p> <p>Relationship among NLRs, patient satisfaction and demographical variables. The impact of demographic data on patient satisfaction was measured using a one-way analysis of variance.</p>	
--	--	--	--	--	--	--

<p>Cody, R., &amp; WilliamsReed, J. (2018). Intentional nurse manager rounding and patient satisfaction. <i>Nursing Management (Springhouse)</i>, 49(4), 16–19.  <a href="https://doi.org/10.1097/01.numa.0000531172.62599.ba">https://doi.org/10.1097/01.numa.0000531172.62599.ba</a></p>	<p>Retrospective descriptive study Level II B</p>	<p>Study participants were responders to the HCAHPS survey from a period of 9 months before the training and initiation of intentional nurse manager rounding and 9 months after the training and initiation of rounding</p>	<p>Nurse Manager rounding</p> <p>Intentional questions, less than 5 minutes</p> <p>The HCAHPS survey questionnaire was the collection tool. The surveys were obtained and reported by an outside corporation. This tool has been validated.</p>	<p>Not clearly defined</p>	<p>The independent variable in the study was the intervention of nurse manager rounding. The the dependent variable was patient satisfaction scores before and after the intervention. The scores to be evaluated were the overall hospital rating, the individual unit rating, and the nursing bundle</p>	<p>No statistically significant change in mean patient satisfaction scores. The only statistically significant difference was in response to one question on Unit B (“nurses listened carefully to you”) and Unit C (“nurses explained things in a way you could understand”), respectively. The score for Unit B was statistically significant in a negative direction.</p>
					<p>related to four specific HCAHPS survey questions: nurses treated you with courtesy and respect, nurses listened carefully to you, nurses explained things in a way you could understand, and you got help as soon as you wanted it.</p>	

<p>East, L., Targett, D., Yeates, H., Ryan, E., Quiddington, L., &amp; Woods, C. (2020). Nurse and patient satisfaction with intentional rounding in a rural Australian setting. <i>Journal of Clinical Nursing, 29</i>(7-8), 1365–1371.  <a href="https://doi.org/10.1111/jocn.15180">https://doi.org/10.1111/jocn.15180</a></p>	<p>CrossSectional quantitative          Levell III-A</p>	<p>Convenience sampling method was used to recruit nurse and patient participants from a rural Australian hospital. Patients were eligible to participate in the survey if they were aged 18 years or older, had at least an overnight stay in the hospital in one of the selected wards, During the data collection period, patients in the hospital were not ventilated or cognitively impaired as</p>	<p>Patient Satisfaction Survey (PSS)</p> <p>Responses to each statement is scored on a 5-point Likert scale ranging from “strongly disagree” (1) to “strongly agree” (5) with a mid-point of “neutral” (3).</p> <p>Nurses completed a modified version of the PSS. The questions were modified to refer to the care nurses provide to patients, as shown in the following example:          Patient: I was not kept waiting when I used my call bell.          Nurse: My patients are not kept waiting</p>	<p>Evidencebased leadership framework</p>	<p>The nurse and patient versions of the scale were summed to create a total satisfaction scale. Demographic data were analyzed using descriptive statistics (frequency, percent, mean, standard deviation), and PSS nurse and patient results were compared using independent sample t-tests.</p>	<p>Intentional rounding practices ensure that patients feel genuinely cared for by nursing staff while hospitalized and can improve nurse and patient interactions, satisfaction, and outcomes</p> <p>Both nurses and patients were satisfied with the nursing care provided and received through intentional rounding</p> <p>Patient satisfaction is predicted by being able to see a nurse when they needed to, the provision of pain relief when needed, feeling comfortable and safe, and the perception that nurses were interested in their feelings about their care</p>
---	--	--	--	---	--	---



		<p>deemed by the nursing staff. Nursing staff were eligible to participate if they worked in the hospital on the selected wards during the data collection period.</p>	<p>when they use the call bell. The survey instrument is valid and reliable (Gardner et al., 2009). A demographic section was added to the questionnaire to collect the following data: age, sex, years of clinical experience (nurses), length of stay (patients), ward stayed in (patients), and main ward nurses work on (nurses).</p> <p>The nine items of the PSS were found to be highly reliable (9 items; <math>\alpha = .93</math>).</p>			
--	--	--	---	--	--	--

<p>Flowers, K., Wright, K., Langdon, R., McIlwrath, M., Wainwright, C., &amp; Johnson, M. (2016). Intentional rounding: Facilitators, benefits, and barriers. <i>Journal of Clinical Nursing</i>, 25(9-10), 1346–1355. <a href="https://doi.org/10.1111/jocn.13217">https://doi.org/10.1111/jocn.13217</a></p>	<p>Descriptive Qualitative Level III-A</p>	<p>15 nurses A convenience sample of nine nurses who responded to an invitation extended by the research team through the Nursing/Midwifery Unit Manager (N/MUM) of their ward participated in two focus groups. A third</p>	<p>3 Focus groups  IR had been implemented approximately 12 months before the focus groups were conducted. The focus groups were digitally recorded and transcribed verbatim for analysis.  Two research team</p>			<p>Engaging all staff, encouraging ownership, and managing stability are critical factors in successfully implementing and maintaining IR. IR is flexible and robust enough to accommodate different patient types and acuity.  Patient outcomes associated with intentional rounding will vary dependent upon the clinical setting, with regular reporting and</p>
		<p>focus group consisted of six current and past N/MUMs and Clinical Nurse/Midwifery Educators (CN/MEs) from the participating wards.</p>	<p>members then independently reviewed the data and identified further codes. Clustering of the codes to main and subthemes occurred.  Textual data analysis tools such as NVivo were used to increase the transparency of the data analysis.</p>			<p>feedback to nursing staff on the impact of intentional rounding on patients being recommended.  Intentional rounding can be used as a management tool to encourage best practices and accountability for patient care.  Barriers: Some participants felt the implementation of IR was an insult to their professional practice as it may ‘take away from actual patient care.’ They felt the IR tasks should be undertaken as part of standard practice and that ‘if you’re doing your job properly, you don’t need these forms.’</p>

<p>Harrington, A., Bradley, S., Jeffers, L., Linedale, E., Kelman, S., &amp; Killington, G. (2013). The implementation of intentional rounding using participatory action research. <i>International Journal of Nursing Practice</i>, 19, 523–529. <a href="https://doi.org/10.1111/ijn.12101">https://doi.org/10.1111/ijn.12101</a></p>	<p>Qualitative-Participatory Action Research Level III B</p>	<p>Inclusion and exclusion criteria not defined in the article</p> <p>86 patients 138 nursing staff</p>	<p>Hourly or Intentional Rounding vs. conventional management responds to needs rather than anticipating or offering before needed.</p> <p>Patient Satisfaction survey (not defined)</p> <p>Staff satisfaction survey (not defined)</p>	<p>Participatory Action Research (PAR)</p> <p>The stages of revision and assessment incorporated by PAR includes four cycles: <i>assessment</i> (planning), <i>implementation</i> (action), <i>evaluation</i></p>	<ul style="list-style-type: none"> <li>• Increase patient care and satisfaction</li> <li>• Improve staff productivity and satisfaction with care delivery.</li> </ul> <p>Patient Satisfaction survey (not defined)</p> <p>Staff satisfaction survey (not defined)</p>	<p>The study's outcomes revealed a drop in call bell use, no observable threats to patient safety, nursing staff, and patient satisfaction with care provision.</p> <p>Future studies should consider staff skill mix issues, including the needs of newly graduated nursing staff as well as the cognitive status of patients when implementing intentional rounding on acute care wards</p>
				<p>(observation), and <i>reassessment</i> (reflection)</p>		

<p>Kirk, K., &amp; Kane, R. (2016). A qualitative exploration of intentional nursing round models in the emergency department setting: Investigating the barriers to their use and success. <i>Journal of Clinical Nursing</i>, 25(9-10), 1262–1272.  <a href="https://doi.org/10.1111/jocn.13150">https://doi.org/10.1111/jocn.13150</a></p>	<p>Qualitative Level III A/B</p>	<p>The sample of emergency department staff nurses was selected using a nonrandom, purposive sampling approach</p> <p>qualified staff nurses working within the same emergency department, variety of levels, and work experience for a range of answers</p>	<p>Questions asked during the interview “Could you please share with me your general experiences, thoughts, and feelings on the concept of hourly rounding in the Emergency Department, and if applicable, elsewhere?”</p> <p>“How well do you feel this model of nursing works in the Emergency Department setting? Please elaborate”</p> <p>“Do you feel there are any benefits to using such a model in the Emergency Department setting? Please elaborate”</p> <p>“Do you feel there are any limitations to using such a</p>	<p>“Framework” method of qualitative data analysis by Spencer et al. (2014). This method, which is well established as a tool for qualitative researchers</p>	<p>What are the barriers and facilitators, as perceived by qualified nurses, to the effective implementation of hourly intentional nurse rounding in the emergency department setting?</p>	<p>Staff felt the introduction of intentional rounding techniques could lead to improvements in patient safety and overall care experience, they also identified a range of difficulties and adaptations needed to ensure its success within this acute care environment</p> <p>Benefits=more open communication between staff and patients and potentially more timely response to patient needs positively impacts safety and satisfaction levels.                  Barriers =lack staff engagement and the environmental factors and pressures within the ED setting</p>
---	----------------------------------	--	--	---	--	---

			model in the Emergency Department setting? Please elaborate”			
Meade, C. M., Bursell, A. L., & Ketelsen, L. (2006).	Quasiexperimental	14 Hospitals (27 units)	1-hr rounding between 6 am-10 pm,	Cognitivebehavioral	Number of call lights over 6 weeks	Binomial test (1 hr group p=0.007) revealed reduction of

<p>Effects of nursing rounds: On patients' call light use, satisfaction, and safety. <i>American Journal of Nursing</i>, 106(9), 58–70. <a href="https://doi.org/10.1097/0000446-200609000-00029">https://doi.org/10.1097/0000446-200609000-00029</a></p>	Level IIA	<p>15 Experimental groups, nonrandom assignment of either 1hr rounding, 2hr rounding, or control; balance ensured between all hospitals by the primary investigator</p>	<p>2-hr rounding 24hrs/day, control group collected data on calls lights frequency and type but no prescribed rounding. Intervention groups had intentional actions based on best practice</p>	<p>and learning literature and theory; behavioral shaping</p>	<p>“ variation frequency of call light use by major reason category overtime”; type of call as predefined in study</p> <p>Patient Satisfaction (different hospitals used different scales: NRC, Press-Ganey, Professional Research Group) questioned overall nursing quality, which provided consistency despite different scales. Mean patient satisfaction was on a scale of zero to 100 (Likert type scales from 1-5 were converted to a 100point scale.</p>	<p>call lights for 1hr group except in weeks 3,4,5,6 for two categories room amenities and no/reason misc (p=0.06)</p> <p>Patient satisfaction= 1hr group went from a 79.9 score to 91.9 (t=736.58, p=0.0001); 2hr group went from 70.4 to 82.1 (t=657.11, p=0.001)</p> <p>Fall rates only had a significant drop for the 1hr group</p>
---	-----------	---	--	---	---	---

<p>Ogbolu, Y., Scrandis, D. A., Fitzpatrick, G., &amp; Newhouse, R. (2016). Leading organizational cultural competency. <i>JONA: The Journal of Nursing Administration</i>, 46(12), 627–629. <a href="https://doi.org/10.1097/nna.0000000000000417">https://doi.org/10.1097/nna.0000000000000417</a></p>	<p>Qualitative Level III A/B</p>	<p>The study sample included 8 CNEs from the hospital organizations of various sizes, locations, teaching and ownership status.</p>	<p>Organizational Selfassessment Qualitative Interview Guide to examine self-reported system antecedents and readiness factors associated with organizational adoption of the National Standards for CLAS (culturally</p>	<p>Not clearly defined in the article  The Transcultural Nursing Theory or Culture Care Theory by Madeleine Leininger w</p>	<p>Two researchers read each transcript in their entirety, identified key codes compared the codes with all the other interviews for similarities and collapsed codes into preliminary themes. The 2 researchers met to compare</p>	<p>Need to embed cultural competency with high-quality care will continue to increase and become an even greater priority for nurse leaders.  One of the most important recommendations noted by nurse leaders focused on improving the patient experience by rounding to identify issues, suggesting a</p>
			<p>and linguistically appropriate services)</p>	<p>ould fit this research</p>	<p>codes and reached a consensus on the final themes.</p>	<p>need for additional interventions supporting culturally sensitive care. Rounds may include other nurse leaders as champions in addition to the nurse manager to interact with patients and inquire about their experiences during all phases of care  Purposeful nurse leader rounding requires empathy and deep listening for understanding  Rounding is an effective strategy for building relationships and trust, all of which are necessary for the delivery of CLAS.</p>

<p>Rondinelli, J., Ecker, M., Crawford, C., Seelinger, C., &amp; Omery, A. (2012). Hourly rounding implementation: A multisite description of structures, processes, and outcomes. <i>JONA: The Journal of Nursing Administration</i>, 42(6), 326–332.  <a href="https://doi.org/10.1097/nna.0b013e31824ccd43">https://doi.org/10.1097/nna.0b013e31824ccd43</a></p>	<p>Social Action Research Qualitative Level III- B</p>	<p>Fourteen interviewees participated, representing Eight hospitals in the Southern California Kaiser Permanente the integrated healthcare organization, and 3 hospitals from different healthcare organizations in the area. Interviews occurred from December 2007 to August 2008. The</p>	<p>All codes were synthesized into themes, with each theme labeled and defined. Defined themes, along with sample exemplars, were sent to a voluntary group consisting of project leads, advanced practice nurses, and/or nurse scientists. This group independently validated whether the exemplars fit the assigned definition and if the definition fit the assigned theme</p>	<p>The Donabedian model of the structure, process, and outcome provides the framework for this study</p>	<p>For each interview, answers to openended questions were transcribed verbatim. All interview responses were searched for meaningful segments, referred to as exemplars. Manual indexing<sup>19</sup> was used to record exemplars, which were organized into code categories. Code categories were evaluated by 2 independent</p>	<p>The authors recommend the abandonment of routinization and the adoption of flexibility to sustain the successful implementation of hourly rounding.</p> <p>Unintended outcomes emerged during content analysis: patient perception of being well cared for, efficient nursing practice, expert nursing practice, and realization of both unit and individual practice culture.</p>
---	--	--	---	--	---	---



		<p>implementation time for hourly rounding in each facility ranged from 1 month to 1 year.</p>	<p>label. Using this process promoted clarity in capturing the implementation experience</p>	<p>coders, reaching an intercoder agreement of 79%. Coders collaborated on the remaining code categories to reach consensus on name and exemplar placement.</p> <p>Outcomes: Seeing the Benefits Designated Outcomes &amp; Patient falls &amp; Hospital-acquired pressure ulcers &amp; Patient satisfaction scores &amp; Volume of patient call lights &amp; Pain management scores &amp; No. of patient compliments vs. complaints &amp; Staff satisfaction &amp; Staff turnover &amp; No. of sitters &amp; Restraint use &amp; No. of patient requests made at the nurses' desk</p> <p>Unintended Positive Outcomes (Outcomes That Emerged From Interview Analysis)</p>	
--	--	--	--	---	--

					& Patient perception of being well cared for & Efficient nursing practice & Expert nursing practice & Realization of both unit and individual practice culture	
--	--	--	--	--	---	--

<p>Shin, N., &amp; Park, J. (2018). The effect of intentional nursing rounds based on the care model on patients' perceived nursing quality and their satisfaction with nursing services. <i>Asian Nursing Research</i>, 12(3), 203–208.  <a href="https://doi.org/10.1016/j.anr.2018.08.003">https://doi.org/10.1016/j.anr.2018.08.003</a></p>	<p>Quasiexperimental Level II-B</p>	<p>70 patients (experimental group) and 75 patients (control group). The Control group and experimental group were assigned according to the admission order, and experimental groups were allocated after the treatment of the control group with the time difference.</p>	<p>(1) hypothesis 1-The experimental group under intentional nursing rounds will reveal a higher level of perceived nursing quality than the control group without rounding service; This factor was measured in this study by adopting a tool called PQNCS. This tool consists of a set of 10 items measured on a fivepoint scale, and a higher score means a higher level of perceived nursing quality. The reliability of the scale, Cronbach's a, was obtained at .81 in their research and 0.94 in this research. (2) hypothesis- The experimental group</p>	<p>PPM Model based on Swanson's Care model  Theoretical development program involving six basic principles which are maintaining belief, knowing, being with, doing for, enabling, and patients' wellness</p>	<p>PQNCS (nursing quality); PSNSCQQ (satisfaction with nursing service);</p>	<p>Intentional nursing rounds based on the care model effectively improved the perception of quality nursing care and patients' satisfaction with nursing care.  Structured patient-oriented intentional nursing rounds based on the care model are expected to expand to a variety of clinical settings further.</p>
			<p>under intentional nursing, rounds will reveal a higher level of satisfaction with nursing services than the control group without rounding service.</p>			

Legend: Perception of Quality Nursing Care Scale (PQNCS) and the Patients' Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ).

Appendix B

Summary of Systematic Reviews (SR)

Citation	Quality Grade	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/Recommendation/ Implications
Rea, K. E., Rao, P., Hill, E., Saylor, K. M., & Cousino, M. K. (2018). Families' experiences with pediatric familycentered rounds: A systematic review. <i>Pediatrics</i> , 141(3), e20171883. <a href="https://doi.org/10.1542/peds.2017-1883">https://doi.org/10.1542/peds.2017-1883</a>	Level II-A	(1) What are families' overall experiences with the current model of FCR? (2) How do families perceive FCR? (3) What benefits or disadvantages do families see in FCR?	Following Cochrane guidelines  The informationist revised the PubMed search strategy and translated it across the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL; EBSCO), PsycInfo (EBSCO), Scopus (Elsevier), and Embase (Elsevier).	Inclusion criteria were as follows: being published in a peer-reviewed journal between January 2007 and February 2017 is written in the English language, having a study population including pediatric patients (0–21 years), and having measurement of a specific outcome of a family's experience with FCR (e.g., psychosocial outcomes, understanding of the plan and/or medical information, relationship with the medical team,	One author (K.E.R.) reviewed titles and abstracts of all results, and 2 authors (K.E.R. and P.R.) independently examined the remaining articles' full text for study inclusion and data extraction. Data extracted included sample size, participating medical unit, measures of family experience, and overall results.  Analysis of bias revealed that most researchers used an investigatordesigned	18 studies in the last 5  Overall, parents who attend FCR had high satisfaction but limited data to compare to standard rounding  FCR did not significantly reduce parents stress, but one study showed a reduction in anxiety  Disadvantages include non-English population satisfaction and poor communication when a translator was used. Families felt disempowered to speak up	Using medical jargon impacts PFX with FCR and should be avoided  Steps should be taken to ensure families understand FCR, such as a brochure, magnet on the door, and explanation  Limited research with adolescents' experiences  Implementing tools specific to children such as My CHATT tool are needed  Future research to look at the efficacy of implementing patient-centered communication and rounding preferences tools  Non-English families have decreased positive

				involvement in decision-making, prevention of adverse outcomes, length of stay).  Excluded if there was no outcome measure associated	parent satisfaction survey or qualitative interview rather than an established measure owing to the		experiences, and Spanish speaking providers positively impact it; the process needs to be standardized for translation services for improving communication
--	--	--	--	---	---	--	---

Citation	Quality Grade	Question	Search Strategy	Inclusion/Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/Recommendation/Implications
----------	---------------	----------	-----------------	------------------------------	------------------------------	--------------	--

				with family experience or if there was an FCR intervention.	lack of established measurements assessing family satisfaction in FCR. A comparison group was used in a little less than half (n = 13) of the studies. Parent reports alone were used in most studies (n = 22), although adolescent perspectives (n = 2) or direct observations of FCR (n = 5) were also used in a few studies. Explicit inclusionary and exclusionary criteria were used in most studies to explain data attrition and their sample, and a sample size of >30 was included in most studies (n = 18). Risk of bias the rating was assigned to each study based on the number of items endorsed during the analysis of risk		
--	--	--	--	---	--	--	--

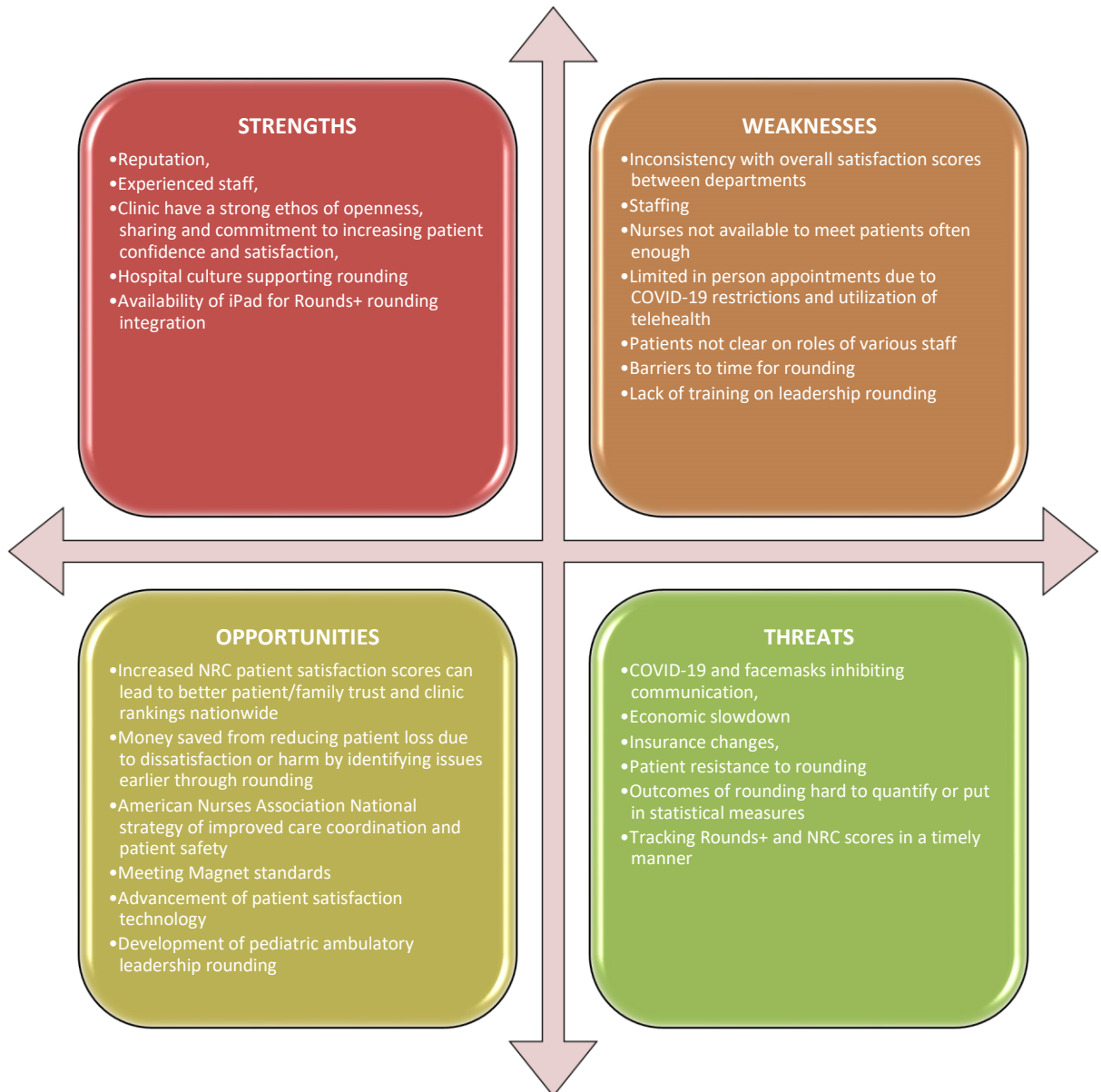
Citation	Quality Grade	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/Recommendation/ Implications
					(see Table 2: low = 1–2; moderate = 3–4; high = 5–6), and this rating is included in the summary of results table		
<p>Tan, M., &amp; Lang, D. (2015). Effectiveness of nurse leader rounding and postdischarge telephone calls in patient satisfaction: A systematic review. <i>JBIR Database of Systematic Reviews and Implementation Reports</i>, 13(7), 154–176. <a href="https://doi.org/10.11124/jbisrir-2015-">https://doi.org/10.11124/jbisrir-2015-</a></p>	<p>Grade II- B</p>	<p>Primary outcome: Patient satisfaction of nursing and hospital services, measured using any format described by the primary researchers, such as online surveys or questionnaires. No other outcomes were measured.</p>	<p>Published and unpublished English language studies from 2003 to 2013 were conducted in seven major electronic databases. Including Cochrane Central Register of Controlled Trials (CENTRAL), Scopus, Web of Science, MEDLINE, CINAHL, Embase, PsycINFO, and Mednar. A threestep search strategy was used, developing MeSH terminology and keywords to search and retrieve all</p>	<p>Inclusion: English, published or nonpublished 2003-2013 Exclusions: commentary article, review of postdischarge call, focus on advanced practice nurse rounds on skills, intervention on the ward round, bedside care, telephone calls for support at home, qualitative study, websites, non-studies, focus on communication, commentary articles, home visit follow-ups, nurse rounding to prevent falls, call lights, follow up calls for education after surgery, critiques, opinion papers, nurse director, abstracts only, retrospective</p>	<p>Two reviewers independently appraised the studies' methodological quality using the Joanna Briggs Institute's standardized critical appraisal instruments.  Data was extracted from the studies using the standardized data extraction tool. The authors of primary studies were contacted for missing information or data.</p>	<p>The interventions on nurse leader rounding and postdischarge telephone calls had increased patients' satisfaction with nursing and hospital services.</p>	<p>Hospitals could potentially use nurse leader rounding and post-discharge telephone calls to increase patients' satisfaction with nursing and hospital services.  Randomized controlled trials are needed to determine the effect of nurse leader rounding and post-discharge telephone calls on patients' satisfaction with nursing and hospital services.</p>



2013			relevant literature for the review	reports, post-discharge call, continuing education article,			
------	--	--	---------------------------------------	--	--	--	--

## Appendix C

### SWOT Analysis



## Appendix D

### Ambulatory Leadership Rounding Survey

1. Rounding taking place: Waiting room or exam room

#### GENERAL:

1. Good morning/afternoon, my name is \_\_\_\_\_. I am a (role) here at Children's Hospital. Thank you for choosing us to care for your child. I am visiting patients to ensure that we are providing great care.
  - a. Are we meeting this commitment?
  - b. Ask at least one of these:
    - i. Do you have any concerns right now that I can help address?
    - ii. We want to make sure all your needs are met. Can you tell me what matters most to you right now?
    - iii. As part of our caring community, we want to be sure to respect your family's needs. Are there any cultural practices or activities you would like us to observe when we come to Children's (or come to ..state clinic name)?
  - c. I see that \_\_\_\_\_ is your RN/Provider today. You are in excellent hands.
2. Were there any delays with being seen today? a. If yes, what reason was given for the delay?
  - a. Suggested wording for a long wait if in the waiting room:
    - i. We want to give each child the care they need. Because of this, we sometimes run behind schedule. We will make sure your child gets the time they need as well.

#### COMMUNICATION:

1. Has the communication between the care team been consistent and clear? a. If no, add comments:

#### RECOGNITION:

1. Any recommendations or kudos

#### Final Comment-

We want to be sure to provide you and your child with excellent care. At any time, if you do not feel you are receiving excellent care, please contact me at \_\_\_\_\_ (leave a business card).



**Appendix E  
Project Schedule**

Activity	NUR7801								NUR7802								NUR7803							
	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
Meet with preceptor	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Prepare project proposal	X	X	X	X	X	X	X																	
Create urgency by discussing with directors and managers the need for increased patient satisfaction and rounding			X																					
Literature Review			X	X																				
SWOT Analysis					X																			
Stakeholder Determination					X																			
Develop Leadership Rounding Tool						X																		
Metrics Development						X																		
Submit Project Proposal							X																	
Faculty Approval								X	X															
Preceptor Approval								X	X															
USA IRB/Project Approval										X														
CHCO Project Approval											X													





## Appendix F

## Measures and Results

Measure	Benchmark	Goal	Statistical Test	Data Type
<p><b>Outcome measure:</b> Overall patient satisfaction score -Percent positive Score (% of respondents selecting top response) (NRC Report)</p>	80% overall patient satisfaction	$\geq 75\%$	$\chi^2$	Ordinal
<p><b>Outcome measure:</b> Did nurses listen carefully to you? - Percent positive Score (% of respondents selecting top response) (NRC Report)</p>	80%	$\geq 75\%$	$\chi^2$	Ordinal
<p><b>Outcome measure:</b> Did you have confidence and trust in the nurses treating you? - Percent positive Score (% of respondents selecting top response) (NRC Report)</p>	80%	$\geq 75\%$	$\chi^2$	Ordinal
<p><b>Outcome measure:</b> Percentage of rounds responses that state they received great care. Denominator is the total number of rounds; the numerator is total # of yes responses on the Rounds+ rounding survey.</p>	80%	$\geq 75\%$	$\chi^2$	Ordinal
<p><b>Outcome measure:</b> Percentage of rounds responses that state the communication between the care team was consistent. Denominator is total number of rounds, numerator is total # of yes responses on the Rounds+ rounding survey.</p>	80%	$\geq 75\%$	$\chi^2$	Ordinal



<b>Outcome measure:</b> Rate of leader satisfaction with the rounding process. Measured with Likert scores of 0 not satisfied to 5 Very Satisfied	Satisfied	$\geq$ Satisfied	Paired ttest	Ordinal
<b>Process Measure</b> Total number of rounds completed weekly per clinic and per family or patient (depending on over or under 18 years of age)	20	$\geq 20$		Nominal
<b>Process Measure</b> Percentage of visits that had a nurse present for care. Denominator is total number of surveys and numerator is number of RN visits. Result is multiplied by 100.		$\geq 50\%$		Nominal
<b>Process Measure</b> Wait times for patient, defined as time to check in until time seeing the scheduled provider		$\leq 10$ minutes		Ordinal
<b>Balance Measure</b> Average time spent on rounding weekly. Total time spent Rounds+ Survey rounding/ total number of nurse leader participants	1 hour	$\leq 2$ hours/week		Nominal
<b>Financial Measure</b> Cost of nurse leaders' time	Salary for Manager X2 (4hr/month) Salary for ACM X2 (4hr/month) <b>Total= \$3360</b>			
<b>Financial Measure</b> Salary for Rounds+ representative in hospital (4 hrs for developing questions)	Total = \$200			

<b>Sustainability Measure</b> The total number of days per week rounding was not completed due to leaders' time constraints.		$\leq 3$		Continuous Data
---	--	----------	--	--------------------