Hourly rounding: perspectives and perceptions of the frontline nursing staff

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Aims To gain knowledge of a nursing staff’s perspectives and perceptions of hourly rounding in an acute care hospital setting.

Background Research has shown hospitals that have successfully implemented hourly rounding have significant decreases in adverse patient events with improvements in patient and staff satisfaction. More recent studies and clinical observations by the author are revealing barriers and difficulties in translating this evidence-based practice to the bedside.

Method An original survey was distributed to direct care staff on six inpatient units. Descriptive analysis of each survey item and subanalysis of the registered nurse ($n = 52$) and patient care assistant ($n = 15$) responses was reported and aggregated according to demographic data and Rogers’ Theory of Diffusion of Innovation.

Results Findings varied considerably between job category, shift worked, unit worked on and educational level of the registered nurses. Overall only 25% ($n = 13$) of the registered nurses felt a sense of ownership of the hourly rounding initiative and only 23.1% ($n = 12$) agreed that completion of the hourly rounding paper documentation tool was a true indication that hourly rounding was actually being done.

Conclusions and implications for nursing management Results from this study may give nursing leadership and educators’ insight on how to lead and sustain a new initiative or evidence-based practice.

Keywords: hourly rounding, Rogers’ Theory of Diffusion of Innovation, rounding with purpose, Studer Group

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that were harming and even killing thousands of patients throughout the USA (Institute of Medicine 1999). This report was followed by the 2001 IOM series, ‘Crossing the Quality Chasm…’, espousing on the hospitalized patient experience and their right to safe, high-quality, patient-centred care that is more proactive than reactive (Institute of Medicine 2001). In 2003, the Agency for Healthcare Research and Quality (AHRQ) worked with the Centers for Medicaid and Medicare Services (CMS) to develop a standardized tool to assess patient’s satisfaction. The IOM identified eight domains of care: respect for patient’s values, preferences and expressed needs; coordination and integration of care; information, communication and education; physical comfort; emotional support; involvement of family and friends; transition and continuity; and access to care (Institute of Medicine 2001). After meeting with key stakeholders the final revised patient survey focused on six areas of patient care: nursing services, doctor communication, physical environment, pain control, communication about medications and discharge information. The survey was named the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (2007).

In 2007, hospitals were being incentivized to publicly report their HCAHPS scores. As part of the value-based care strategies of the 2010 Affordable Care Act, the HCAHPS will be included as a measure of the incentive payments for patients discharged from hospitals beginning in October 2012. The patient experience is one of 13 measures used by CMS to calculate 850 million dollars in payments (McEwen & Dumpel 2010, CMS 2012). Hospital administrators and financial officers had been clamouring for different methods and strategies to improve their publicly reported patient satisfaction scores. Being the largest workforce in health care, nursing became the focus of many initiatives. In response to the need for hospitals to improve their HCHAPS patient satisfaction scores, the Studer Group, a hospital consulting firm, developed the concept of hourly rounding, or rounding with a purpose, which has now been implemented in several hospitals across the country and worldwide (Studer Group 2007, ). The purpose of this study was to gain knowledge and understanding of a direct care nursing staff’s perspectives and perceptions of the pre- and post-implementation phases of hourly rounding.

Background

Patients tend to correlate satisfaction and quality care with the nursing staff’s availability, visibility and proficiency to meet their needs in a timely and efficient manner (Meade et al. 2006). In the words of the insightful Florence Nightingale: ‘Apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion’ (Nightingale 1898). Effective hourly rounding relieves the uncertainty and anxiety that is often associated with a vulnerable patient’s hospital experience. Woodard (2009) defined the concept of ‘help uncertainty’ as the patient’s inability to predict when care would be delivered and when someone would be available to assist them with care. Hourly rounding studies have shown that regulating and increasing the time a registered nurse spends at the patient’s bedside decreases patient anxiety, improves perception of satisfaction with care and decreases adverse patient outcomes (Fitzsimmons et al. 2011).

Specific nursing measures of patient satisfaction assessed by the HCHAPS are: how quickly call lights are answered, communication quality and quantity, and how well the patient’s pain is managed (Bourgault et al. 2008). The Studer Group hourly rounding model chose to address four areas correlated with the HCAHPS and patients’ perception of being satisfied with care. These are referred to as the four P’s: pain assessment and management; potty or assistance with toileting; positioning for comfort and reduction of pressure ulcers; and personal items within reach or personal attention (Meade et al. 2006). Instead of randomly responding to call lights that cause disruptions and interruptions in care, the nursing staff would systematically round on all patients decreasing the need for the patient to use their call light for non-emergency reasons. The RNs would round on even hours between 06:00 hours to 22:00 hours and the PCAs would round on odd hours. During the hours between 22:00 hours and 06:00 hours, the RNs and PCAs would round together every 2 hours, only waking the patients when absolutely necessary (Meade et al. 2006, Culley 2008, Duffin 2010, Ford 2010).


Despite the growth and emergence in the use of hourly rounding and its researched benefits, few
studies have addressed the barriers and difficulties of integrating systematic rounding into everyday practice. Initiating any new evidence-based change into clinical practice is a challenging, complex process (Rycroft-Malone et al. 2004). New studies on hourly rounding are now investigating both the implementation and sustainability of hourly rounding in hospital settings (McEwen & Dumpel 2010, Deitrick et al. 2011, Tucker et al. 2012). According to Deitrick et al. (2011), implementation of hourly rounding has not always proven successful and in some cases the rounds have been found to be ineffective. Recent observations by the researcher, in two local hospitals that have implemented hourly rounding, have given the author an indication that these newer reports of negative findings may be more common as more hospitals are implementing the practice. There also seems to be a disparity between the nurse managers’ perceptions of hourly rounding and what the frontline nursing staff is actually doing. Some of the nurse leaders at the study site felt as though the staff was performing hourly rounding consistently and according to evidence-based practice, but the researcher observed staff randomly going in and out of patients’ rooms not purposefully addressing the required patient needs.

The results of this survey may give nursing leaders and educators the improved ability to prepare, lead and sustain evidence-based quality and safety initiatives, such as hourly rounding into their clinical setting.

**Theoretical framework**

Rogers’ theoretical framework of Diffusion of Innovation helped guide the development of the research survey and this project (Rogers 2003). This theory examines what qualities improve and hasten the spread of an evidence-based practice. The newly developed survey explored all aspects of diffusion of hourly rounding from pre-implementation to post-implementation. There are four concepts involved in the diffusioning of an innovation into an organisation. These concepts are the innovation itself, the communication channels, time and the social system (Murray 2009). This framework provides a practical approach for successful implementation of hourly rounding. Once a new idea or practice has been identified it needs to be evaluated to determine if it is in line with the values and preferences of the organisation and the adopters. The adopters or frontline nursing staff, in this case, need to understand all aspects of the innovation. Staff must accept that hourly rounding is an improvement over current practice and subsequently develop a sense of ownership of the process. When staff can visualize the benefits of a change, they are more likely to adopt the innovation. According to Rogers’ theory it does not matter how passionate the leaders in the organisation feel about a new process or change, if the frontline nursing staff does not believe in the initiative they will not become engaged in the process and it will most likely fail (Murray 2009).

Rogers’ innovation decision process involves five steps: knowledge, persuasion, decision, implementation and confirmation (Jasovsky et al. 2010). The knowledge stage includes awareness of the new innovation, guiding principles and rationale. The second step of the process is persuasion. In the persuasion stage, the adopter starts to form either a negative or positive opinion about the new practice. This stage is important in identifying the early adopters or champions of the project to help facilitate the diffusion of the initiative to their peers. The decision process occurs when decisions are made about aspects of the new process that the adopter may decide to accept or reject. The individuals are actively participating in the innovation in the implementation phase. Here, the adopters should be involved in deciding if the innovation needs modifications after being put into action. This important phase in the time line includes testing for fidelity of the practice and sustaining the initiative. The final stage in the decision process is confirmation where the adopters need support, reinforcement and validation that the decision to implement was warranted (Jasovsky et al. 2010).

**Aims**

This survey, which has been based on Rogers’ (2003) innovation decision process, may help distinguish what qualities in the introduction and maintenance of the current process were successful or unsuccessful. The overall aim is to gain knowledge of nursing staff’s perspectives and perceptions of hourly rounding in an acute care setting. Specific aims of the project applied to Rogers’ theory:

- to evaluate the nursing staff’s perception of how effective and comprehensive the education process was before implementation of hourly rounding (Knowledge);
- to evaluate the nursing staff’s understanding of the benefits of hourly rounding (Persuasion);
- to gain information about factors that facilitate or inhibit the acceptance of hourly rounding (Decision Making);
to evaluate staff’s perception on the fidelity of the intervention and its impact on improving patient outcomes (Implementation);

- to evaluate the nursing staff’s perspective on support and feedback they received after the implementation of hourly rounding (Confirmation).

**Methods**

**Design and survey tool**

These cross-sectional, paper surveys were distributed to the nursing staff individually and collected over a 3 week period (Fawcett & Garity 2009). The paper survey is a five-point Likert scale made up of 21 positive statements on hourly rounding based on the author’s literature review, Rogers’ theory, and observations at various hospitals, including the study hospital. The participants were asked to strongly disagree (1), somewhat disagree (2), somewhat agree (4) or strongly agree (5). They also had the option to choose undecided (3). Survey responses were also categorized according to the five stages in the decision-making process of Rogers’ Diffusion of Innovation Theory: knowledge, persuasion, decision making, implementation, confirmation. The demographic data included years worked in current job title, current work status, shift most often worked, highest educational level and unit most often worked on. There was also a section for comments.

The validity of the survey tool was tested using various individuals and groups to review the questionnaire and provide feedback. There was testing of content validity to provide an assessment of how relevant the instrument is to hourly rounding and understandability of questions by experts in the field of research and those with varying degrees of knowledge of the study topic. These reviewers included nursing staff at the study hospital, performance improvement registered nurses, the associate dean of the research department for the university’s school of nursing, and faculty members in the university’s graduate school of nursing.

**Sample and setting**

The study was carried out in a 186-bed adult community hospital in Western New York, USA. The survey was distributed to 137 RNs and 47 PCAs on four inpatient units, one acute rehabilitation unit and the intensive care unit. The nursing staff from these six inpatient units were chosen because they were the only ones currently required to perform hourly rounding. Some of the participants were considered ‘floats’ and worked on more than one nursing unit. There was a 38% (n = 52) return rate for the RNs and a 36% (n = 15) return rate for the PCAs. Hourly rounding had been introduced to these inpatient settings approximately 1 year ago. According to the nurse managers on these nursing units, most felt as though the nursing staff were performing hourly rounds according to protocol on a regular basis. Some managers confirmed this by observation and others by randomly auditing the hourly rounding documentation tool that was to be completed by the staff.

**Ethical considerations**

This voluntary study was conducted in the summer of 2012. Before initiation of the study and recruitment of participants, approval for working with the hospital staff was obtained in April 2012 from the University at Buffalo Social and Behavioural Sciences Institutional Review Board and the hospital. The approval number is 4867. All participants were given information sheets which served as a verbal consent for participating in the survey. Confidentiality and anonymity were maintained as there was no personal identifying information on the surveys.

**Data analysis**

The statistical analysis was conducted using the 2011 SPSS version 19 (George & Mallery 2012). Analysis included descriptive statistics of frequency and percentages of agreement. Per cent agreement scores were calculated using the respondents’ score above the midpoint of the Likert scale (score 4 or 5). Subanalysis was also carried out according to job category, shift and nursing unit most often worked, highest education level and years worked in current job category. There were very few instances of missing data.

**Results**

Table 1 shows demographic characteristics of the sample. Fifty per cent (50%) of the RNs worked in their job category for 10 or more years with a range of 0.3–40 years and a mean of 13.8 years. A majority of the RNs worked full time and worked 12-hour shifts. Almost 53% of the RNs had a bachelor’s degree. All of the PCAs worked 8-hour shifts.

Overall 77.6% of the nursing staff (RNs and PCAs) agreed that their nursing unit carries out hourly rounding;
rounding consistently on all shifts according to recommended protocol. These results varied from 100% to 63.7% agreement depending on the nursing unit, shift worked and RN education level. Bachelors prepared RNs (BSN) had a 67.8% agreement score compared with the Associate Degree RNs (ADN) who had a 90.9% agreement score (Table 2).

Over 85% of the nursing staff had the perspective that they received enough education on hourly rounding and 88.1% understood how to incorporate the rounds into their daily assignments. Less than 60% of the nursing staff felt as though the education they received included current research on the hourly rounding benefit of decreased call light volume, yet 85% of the staff felt as though there was clear communication on the benefits of hourly rounding for the nursing staff. The BSNs felt as though there was less clear communication on the benefits of hourly rounding for the patients than other groups with the lowest agreement percentage of 67.9%. One BSN stated, ‘although we at … have been charged to perform hourly rounding for about a year now, virtually no education was provided as to the purpose, design, or script, other than to be told that this will decrease call light use’. Table 3 compares consistency of practice scores with education provided according to nursing unit most often worked and RN educational level.

Less than 30% of the nursing staff felt a sense of ownership or involvement in the planning process of the hourly rounding initiative. Only 28.3% agreed with the statement that completion of the hourly rounding documentation tool is a true indication that hourly rounding is being done (Table 4). One RN commented, ‘As an RN on a busy medical–surgical unit, I really don’t need a sheet of paper to tell me to hourly round’. Another stated, ‘I am in most rooms more than hourly and do not have time to document each event of interaction on the rounding sheet’.

Close to 90% of the nursing staff and over 94% of the RNs agreed that the patient’s pain, position, and personal needs were being addressed on rounds but only 55.8% of the RNs felt as though hourly rounds contributed to improved pain management. Seventy-six and 90 per cent of the RNs perceived hourly rounding as having a role in pressure ulcer prevention (Table 5).

Table 1
Demographics

<table>
<thead>
<tr>
<th></th>
<th>Registered nurses (n = 52)</th>
<th>Patient care assistants (n = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years worked in current job title</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–10 years</td>
<td>26 (50%)</td>
<td>10 (67%)</td>
</tr>
<tr>
<td>10+ years</td>
<td>26 (50%)</td>
<td>5 (33%)</td>
</tr>
<tr>
<td>Range (years)</td>
<td>0.3–40</td>
<td>1–30</td>
</tr>
<tr>
<td>Mean (years)</td>
<td>13.8</td>
<td>11</td>
</tr>
<tr>
<td>Current work status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>44 (84.6%)</td>
<td>11 (73.3%)</td>
</tr>
<tr>
<td>Part time</td>
<td>7 (13.5%)</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Per diem</td>
<td>1 (1.9%)</td>
<td>1 (6.7%)</td>
</tr>
<tr>
<td>Shift most often worked*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7a-7p</td>
<td>12 (23.1%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>7p-7a</td>
<td>16 (30.8%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>7a-3p</td>
<td>8 (15.4%)</td>
<td>7 (46.7%)</td>
</tr>
<tr>
<td>3p-11p</td>
<td>1 (1.9%)</td>
<td>4 (26.7%)</td>
</tr>
<tr>
<td>11p-7a</td>
<td>6 (11.5%)</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Other</td>
<td>9 (17.3%)</td>
<td>1 (6.7%)</td>
</tr>
<tr>
<td>Highest educational level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>na</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Some college</td>
<td>na</td>
<td>7 (46.7%)</td>
</tr>
<tr>
<td>Associates degree</td>
<td>22 (42.3%)</td>
<td>4 (26.7%)</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>27 (52.9%)</td>
<td>1 (6.7%)</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>1 (1.9%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Doctoral degree</td>
<td>1 (1.9%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Unit most often worked on</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unit A</td>
<td>11 (21.2%)</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Unit B</td>
<td>13 (25%)</td>
<td>4 (26.7%)</td>
</tr>
<tr>
<td>Unit C</td>
<td>9 (17.3%)</td>
<td>2 (13.3%)</td>
</tr>
<tr>
<td>Unit D</td>
<td>4 (7.7%)</td>
<td>1 (6.7%)</td>
</tr>
<tr>
<td>Unit E</td>
<td>10 (19.2%)</td>
<td>1 (6.7%)</td>
</tr>
<tr>
<td>Unit F</td>
<td>3 (5.8%)</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Float</td>
<td>2 (3.8%)</td>
<td>1 (6.7%)</td>
</tr>
</tbody>
</table>

*7a-7p, 07:00–19:00 hours; 7p-7a, 19:00–07:00 hours; 7a-3p, 07:00–15:00 hours; 3p-11p, 15:00–23:00 hours; 11p-7a, 23:00–07:00 hours.

Table 2
Consistency of hourly rounding according to demographics

<table>
<thead>
<tr>
<th>Implementation</th>
<th>Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>My nursing unit consistently carries out hourly rounding on all shifts according to recommended protocol</td>
<td>77.6</td>
</tr>
</tbody>
</table>

RN, registered nurse; PCA, patient care assistant; ADN, associate degree RN; BSN, Bachelors prepared RN; 7a-7p, 07:00–19:00 hours; 7p-7a, 19:00–07:00 hours.
Only 69.2% of the RNs agreed with the statement that hourly rounds decrease patient falls in the hospital. One nurse in the ICU stated, ‘Falls can occur within minutes of leaving a room’ and another nurse stated, ‘If someone wants to get out of bed, especially if they are elderly, confused, and chronically ill, no amount of hourly rounding will solve this issue’. Table 5 compares consistency scores for improvement in pain management, prevention of patient falls and pressure ulcers according to nursing unit and job category.

Less than 19% of RNs on the 19:00–07:00 hours (7p-7a) shift felt as though there was continued support and resources available after implementation of hourly rounding compared with 75% of the 07:00–19:00 hours (7a-7p) RNs. Interestingly, more than half of the nursing staff (53.2%), including the 7p-7a RN staff (62.5%), did not feel as though having a resource person or unit-based champion on each shift would help improve the process. In relation to support and resources after implementation, overall the PCAs

Table 3
Nursing unit consistency, knowledge and persuasion (% agreement)

<table>
<thead>
<tr>
<th>Nursing unit/highest education level</th>
<th>Unit A (n = 14), %</th>
<th>Unit B (n = 17), %</th>
<th>Unit C (n = 11), %</th>
<th>Unit D (n = 5), %</th>
<th>Unit E (n = 11), %</th>
<th>Unit F (n = 6), %</th>
<th>ADN (n = 22), %</th>
<th>BSN (n = 28), %</th>
</tr>
</thead>
<tbody>
<tr>
<td>My nursing unit consistently carries out hourly rounding on all shifts according to recommended protocol (implementation)</td>
<td>71.4</td>
<td>76.4</td>
<td>90.9</td>
<td>100</td>
<td>63.7</td>
<td>83.3</td>
<td>90.9</td>
<td>67.8</td>
</tr>
<tr>
<td>The education I received included the current research that hourly rounding decreases patient call light use (knowledge)</td>
<td>64.3</td>
<td>76.4</td>
<td>45.5</td>
<td>60</td>
<td>36.4</td>
<td>50</td>
<td>45.5</td>
<td>60.7</td>
</tr>
<tr>
<td>There was clear communication on the benefits of hourly rounding for patients (persuasion)</td>
<td>78.6</td>
<td>100</td>
<td>90.9</td>
<td>60</td>
<td>45.5</td>
<td>66.7</td>
<td>90.9</td>
<td>67.9</td>
</tr>
<tr>
<td>There was clear communication on the benefits of hourly rounding for the nursing staff (persuasion)</td>
<td>85.7</td>
<td>94.2</td>
<td>90.9</td>
<td>80</td>
<td>63.7</td>
<td>66.6</td>
<td>100</td>
<td>75</td>
</tr>
</tbody>
</table>

ADN, associate degree registered nurse (RN); BSN, Bachelors prepared RN.

Table 4
Nursing unit consistency, ownership and completion of documentation tool

<table>
<thead>
<tr>
<th>Nursing unit/job category</th>
<th>Unit A (n = 14), %</th>
<th>Unit B (n = 17), %</th>
<th>Unit C (n = 11), %</th>
<th>Unit D (n = 5), %</th>
<th>Unit E (n = 11), %</th>
<th>Unit F (n = 6), %</th>
<th>RN (n = 52), %</th>
<th>PCA (n = 15), %</th>
</tr>
</thead>
<tbody>
<tr>
<td>My nursing unit consistently carries out hourly rounding on all shifts according to recommended protocol (implementation)</td>
<td>71.4</td>
<td>76.4</td>
<td>90.9</td>
<td>100</td>
<td>63.7</td>
<td>83.3</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>I feel a sense of ownership of the hourly rounding programme because I was involved in planning the initiative (decision making)</td>
<td>21.4</td>
<td>23.5</td>
<td>63.6</td>
<td>40</td>
<td>9.1</td>
<td>50</td>
<td>25</td>
<td>46.7</td>
</tr>
<tr>
<td>Completion of the hourly rounding documentation tool is a true indication that hourly rounding is being done (implementation)</td>
<td>14.3</td>
<td>23.6</td>
<td>27.3</td>
<td>40</td>
<td>45.5</td>
<td>33.3</td>
<td>23.1</td>
<td>46.7</td>
</tr>
</tbody>
</table>

RN, registered nurse; PCA, patient care assistant.
had a higher agreement percentage of almost 67% compared with the RNs who had an agreement percentage of less than 37%. In Table 6, each nursing units’ perception of the consistency of hourly rounding was compared to how supported the staff felt after implementation of the initiative. Table 6 also demonstrates the RN hourly rounding consistency scores on the 12-hour day and night shift, compared with their perception of the availability of support and resources after implementation. Agreement scores for the process being improved with the addition of a champion or support person was also included in Table 6.

### Discussion

Results of consistency of practice according to job category, shift, education level and unit most often worked were higher than the author anticipated. The BSNs had a lower agreement score on consistency (67.8%) compared with the ADNs (90.9%). Almost 80% of the BSNs worked on units A, B and E and the consistency scores were the lowest on these nursing units compared with other units (see Table 3). The reason for the difference in perception between the BSNs and the ADNs is not clear. However, there has been a
great deal of research on the differences in perception of practice between these two education levels of RNs. One study found that the BSNs were better able to see their practice and its limitations more globally than were the ADNs (Delaney & Piscopo 2004). These findings warrant further investigation on the differences in perspectives and perception between the BSNs and the ADNs. The staff from unit D had the perception that hourly rounding was being done consistently 100% of the time on their nursing unit. This 100% perception of consistency was different from the author’s perception and informal observations.

Consistency, knowledge, and persuasion

According to Rogers’ theory the end user needs to understand and visualize the benefits to change, to more readily accept the new concept (Murray 2009). Research has suggested significant decreases in call light volume with implementation of hourly rounding, which can be a distinct advantage for the nursing staff (Meade et al. 2006). Decreased call light volume has been shown to decrease disruptions in care and give nursing staff more time to complete other tasks (Ford 2010). In one of the larger studies on hourly rounding, the investigators found that call light usage was decreased by an average of 37.8% on 18 nursing units in 14 different hospitals. The decrease in call light volume led to the staff being more attentive and reactive to the call light because it was not part of the normal noise anymore (Meade et al. 2006). Other studies have found call light reductions of 65% (Wood 2008), 56% (Culley 2008) and 52% (Ford 2010) after implementation of hourly rounds.

Results demonstrate that nursing unit E not only had the lowest agreement percentage in consistently carrying out hourly rounds on all shifts (63.7%), but also had correspondingly low agreement percentages for the statements on education of decreased call light volumes (36.4%), benefits to patients (45.5%) and nursing staff (63.7%). Providing nursing staff with education during work time is extremely difficult. The variations in scores across shifts and nursing units could have resulted from different instructors providing variations in the educational content or the timing of the sessions for the staff that worked the evening or night shift. The ADNs felt that the communication of hourly rounding benefits in the education process was clearer than the perception of the BSNs. This could be because of differences in educational content, as mentioned earlier, but could also result from differences in perception of the quality of the education and possibly higher expectation of what was considered ‘clear communication’ by the BSNs. As one BSN RN commented, ‘The 3–4 Ps need to be explained and understood by staff. I did not know that this was the purpose until I studied this on-line’.

Decision making and implementation

For change to occur successfully, direct caregivers need to feel a part of the process and have a sense of ownership of the process. Staff will be more willing to adopt an innovation if they are engaged in the decision-making process and the innovation is in line with their values and beliefs (Schultz 2007). As previously mentioned, nursing unit E had the lowest agreement percentage in relation to consistent hourly rounding. Table 4 illustrates that this nursing unit also had the lowest score (9.1%) with regard to ownership of the programme and being involved in the planning of the initiative.

Another item on the survey associated with the implementation process is completion of the hourly rounding documentation tool. On some of the nursing units the documentation tool was taped to the patient door or to the wall in the patient room. On two of the nursing units the rounding tools were not readily available and staff were unclear if they were still supposed to be using them or not. The form differed between nursing units, but in all cases it was not a permanent part of the patient record and was used mostly for the nurse managers’ monthly audits. Table 4 also illustrates the scores for documentation tool completion. There was not much difference between RN groups and per cent agreement scores, but the PCA staff perceived the tool as a true indication of rounding almost 24% more than the RN staff did.

Even though most of the nursing staff agreed they addressed their patient’s pain level on rounds 89.5% of the time, they did not feel as though this resulted in any major improvement in the patient’s pain management. A possible explanation is that the nursing staff perhaps felt as they do a good job with pain management despite hourly rounds or asking a patient if they need something for pain every hour is overkill. One nurse stated that ‘Hourly rounding is not beneficial for all people, some don’t like to be bothered that much, (q2h-Every two hours) is more practical’.

Consistency and confirmation

One gap reported in the literature is the lack of staff champions or other support resources available once
the hourly rounding initiative has been implemented. Having these resources available to the frontline nursing staff provides ongoing educational and emotional support and helps ensure fidelity of the process (Deitrick et al. 2011, Olrich et al. 2012). In this confirmation stage of Rogers’ theory, only 43.3% of the nursing staff felt as though there was continued support and resources available to them. As shown in Table 6, unit E felt more strongly that an hourly rounding resource person or unit-based champion could help improve the process compared with the other nursing units. This unit, with the lowest consistency percentage, could have most likely benefited from some extra support after implementation of the process.

One surprising result was the compliance with scripting statements during rounding, such as, ‘Is there anything else I can do for you? I have the time’. Per cent agreement for nurses was over 92% and scores only varied slightly between the other groups and categories. Informal conversations with nurses at several area hospitals and journal articles and editorials have reported scripting as an insult to nursing autonomy. Some nurses have proclaimed that scripting is fake, artificial, and forced instead of therapeutic, caring or individualized to a specific patient (Halm 2009). McEwen and Dumpel (2010) pointed out that HCAHPS also surveys nurses on care provided to them by physicians, but physicians and other providers are not told when to visit their patients or what to say to them.

**Limitations**

To have valid survey results most sources recommend at least a 50% response rate, which was not achieved with this study. There were also 37 more RNs in the sample than PCAs. Owing to the small sample sizes on some of the nursing units generalizability is limited. It was difficult to categorize the overall responses according to shift because a majority of the RNs worked 12 hours and the PCAs worked 8 hours.

With any research study using a psychometric response survey, such as a Likert scale, there is a risk of bias. Central tendency bias may occur when respondents avoid choosing the most extreme response, such as strongly agree or strongly disagree. Acquiescence bias occurs when participants tend to agree with all responses as presented. One method to avoid this bias is to include reverse key questions or negative connotation in the statements. This is something the author chose not to do but did take into consideration when analysing the results. In social desirability bias, respondents choose statement responses that would make their group or, in this case, their nursing units, appear superior to or better than others, even though the answers may not be entirely accurate. This type of bias may be more likely to occur at the study site because participants are asked to include their nursing unit and shift most often worked.

**Conclusion**

There has been a major shift in the business of running a hospital over the last decade. Hospitals are no longer being financially rewarded based on volume of services alone. Many payment programmes are based on certain areas of performance where hospitals can earn hundreds of thousands of dollars by improving patient satisfaction scores and patient outcomes. Hospitals can also be penalized for ‘never events’ which are preventable hospital acquired conditions that should never occur, such as falls with injury or hospital-acquired pressure ulcers. Hourly rounding may be a panacea for some hospitals. Hospital leaders in conjunction with the front-line nursing staff need to determine if hourly rounding is the right fit for the nursing staff and patient population. Nursing needs to have a say in how they deliver care but must also be open to new evidence-based practices.

**Implications for nursing management**

The concept of hourly rounding is gaining momentum nationally and internationally, as shown by recent studies in the UK and Australia (Gardner et al. 2009, Duffin 2010, Dean 2012). Patient safety and quality of care are at the forefront of governmental, hospital and consumer agendas. It is the nurse manager’s responsibility to ensure that hourly rounding is being done according to policy, and modified according to patient needs and staff preferences. To bridge the research to bedside gap, nursing leaders must have a sound plan and some knowledge of change theory before planning to introduce a new practice.

As nursing leaders and educators, we need to decide if the paper hourly rounding documentation tool is necessary. Only 28.3% of the nursing staff felt that the tool was a true indication of hourly rounding being done. As one RN commented, ‘I feel hourly rounding has always been done, it is just not documented. I found it bothersome to stop and chart what is a typical part of our job’. Staff accountability should not be measured by completion of a paper form and, as one nurse said, is often ‘charted all at
once at the beginning or end of the shift’. Some hospitals have a special hourly rounding dry erase board that can be viewed by the patient and family in each patient room. Going public with the initiative tends to make staff more accountable (Baptist Leadership Group 2012). Developing an annual hourly rounding competency checklist to be used either in a simulation setting or in a real patient scenario would improve the fidelity of the intervention.

It is also important that nurses feel supported after a new initiative or programme is implemented, especially on the evening and night shifts. There needs to be face to face educational efforts, two-way feedback and evaluation of new programmes by leaders in the organisation on all three shifts throughout the implementation process. Education should also be provided during the time preference of the staff, not the person doing the education. Most hospital educational programmes are scheduled on the day shift or at inconvenient times for the night shift. Offering educational programmes between 19:00 hours and 01:00 hours demonstrates to the night shift staff that they are appreciated and valued, which can help improve morale and retention of information (Campbell et al. 2008, Mayes & Schott-Baer 2010). Providing different educational methodologies for the evening and night shift nursing staff during hours they learn best, without distraction, is imperative and should be supported by hospital leaders and educators (Mayes & Schott-Baer 2010). Some nursing units would have benefited from having a staff champion available; however, the decision to have this support person available should be at the discretion of the unit staff.

Participation in decision making and planning of new initiatives will increase the likelihood of adoption of new evidence-based practices. Some evidence-based practices need to be modified to fit the particular nursing unit and patient types. As one nurse told me, ‘If you have a 28-year-old patient who is two days post-op, you are not going to go in his room every hour and ask him if he has to go to the bathroom. There are some patients that are more independent than others and do not welcome the every hour intrusion’.

Patients deserve high quality, safe care that is based on evidence. Nursing leadership must keep pace with the rate of change in the nursing profession and not assume that introducing a new evidence-based practice will be automatically accepted, implemented and sustained by the frontline nursing staff. There must be careful planning and application of a well-tested theoretical approach to change.

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