CE 1.5 CONTACT HOURS

HCAHPS Series Part 2

Does purposeful leader ro

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In part 1 of our 3-part HCAHPS series, we looked at the new Care Transition Measures. Join us this month as we examine whether leadership rounding improves HCAHPS scores.

The act of purposeful rounding, which occurs when nursing staff members demonstrate behaviors that offer empathy, deep listening, and understanding during their patient rounds, is a proactive way to promote quality care and patient safety. It's considered an effective method for building relationships and trust in addition to meeting a patient's physical needs. Studies have shown the positive benefits of frequent and purposeful rounding on patients by nurses every hour, including improved patient satisfaction, reduced incidents (such as falls), and reduced patient call light use.[1-3]

The measurement currently used to publicly report hospital performance and quality of care as perceived by patients is the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.[4] As you well know, HCAHPS is the standard by which many hospitals are evaluated and compared against each other regarding patient experience. There are many studies published on the benefits of nurse rounding; however, far fewer exist on the impact of leader rounding on patient satisfaction.

Leader rounding is performed by directors, managers, and supervisors, and promotes increased levels of teamwork and communication by transforming the entire organization into a cohesive team that's motivated to achieve the same goals. To make informed decisions, leaders need to know what's happening on the frontlines of their organizations. The best way to gather actionable information is to observe directly and hear firsthand from the patient. Leader rounds help build increased levels of trust by demonstrating to staff

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members and patients that the organization's leaders are interested in the day-to-day processes and quality of work being performed.

The purpose of this project was to implement leader rounding twice a week on all inpatients, and to evaluate the impact on patient satisfaction as measured by HCAHPS scores.

According to the literature...

One pair of researchers conducted a study to determine the relationship between leader rounding and discharge phone calls on patient experiences and satisfaction.[5] They found that patients who received postdischarge phone calls perceived their care and experience more positively than those who didn't receive a phone call. With regard to patient perception of nurse leader rounding, patients felt better about the nurses who took care of them. The researchers recommend postdischarge phone calls and leader rounding as best practices to improve patient experience. They also suggest that instead of treating rounds as a social visit, leaders round with a purpose by asking patients specific questions related to their experience, nursing care, and customer service.[5] These direct questions allow leaders to identify problems and alert the specific caregiver or department to resolve issues in real time. Leaders have the opportunity to almost instantly make a difference in their organizations by putting the patients first, and, at the same time, recognizing positive employee behaviors and enhancing the workplace environment.

Another study reported the use of information technology to create a meaningful monitoring and reporting system in conjunction with the implementation of two tactics, discharge phone calls and leader rounding, to improve patient satisfaction.[6] By using electronic logs of both nurse rounding encounters and discharge calls, it was possible to monitor compliance and conduct statistical analysis to determine the relationship with HCAHPS results. When nurses round regularly, call lights decreased by 37.8%, patient perception improved 12 mean points, falls decreased by 50%, and hospital-acquired pressure ulcers decreased by 14%.[3]

Leaders should round with a purpose by asking patients specific questions related to their experience, nursing care, and customer service.

Creating the leader rounds

This quality improvement project was conducted at a 95-bed full-service acute care hospital in North Texas. The hospital has approximately 242 nurses with three main nursing units: ICU (10 beds), progressive care unit (PCU, 16 beds), and acute care unit (ACU, 32 beds). Permission to conduct leadership rounds with specific focus on patient satisfaction was granted from the hospital's quality review committee and nursing research council, and the healthcare system nursing research council.

The total capacity for the three nursing units is 58 beds with an average occupancy rate of 90%. This equates to an average daily census (ADC) of 52.2. The estimated number of rounds completed in the project period was 2,506 (52.2 patients x 2 rounds per week x 4 weeks per month x 6 months). Some patients, however, were unable to participate in leader rounding because they were out of the room, sleeping, or unable to communicate at the time of rounding. All patients were included if they could understand English and answer leaders' questions.

Twenty-five members of the multidisciplinary leadership team, including supervisors, managers, directors, and senior executives, participated in leader rounding. These leaders were trained by the study investigator to interview patients using the Leader Rounding Form, created by the study's investigator. (See *Table 1*.) Each leader was assigned three rooms each month. Leadership rounds were conducted on Tuesdays and Thursdays of each week from 1:00 pm to 2:00 pm. This time was chosen because patients are typically resting in bed after lunch.

HCAHPS data were compared with baseline data from October 2012 to October 2013, focusing on questions within the following survey sections: your care from nurses, your experiences in this hospital, and overall rating of the

hospital. Results were trended and reviewed during the monthly service excellence committee, the people and service committee, and general staff meetings. In addition, any complaints and/or issues identified by the patient were escalated to the appropriate person and corrected as soon as possible. At the same time, patients were also given the opportunity to recognize staff members or share positive comments about their care. The completed surveys were turned in to the investigator for analysis.

Data were entered into a spreadsheet for descriptive analysis. Responses from each question were converted into an ordinal level of measurement (always-4, usually-3, sometimes-2, never-1, and not applicable-0). A monthly average score was calculated for each unit. A radar diagram displayed results of each question group for each patient care unit. After 6 months of data collection, a descriptive analysis was completed to determine demographic information of the patients. The data were calculated using measures of central tendency, including mean, median, mode, and range.

Continuous variables were measured by calculating mean scores and standard deviations, and the categorical variables were measured by calculating proportions. Test statistics with an associated *p*-value of ≤.05 were considered statistically significant. Inferential statistical analysis was performed by a bio-statistician using a computer-generated statistical program.

Table 1: Crosswalk between HCAHPS and leader rounding questions

HCAHPS	Question number	Leader rounding	Question number
Rate hospital 0-10	H1		
Recommend the hospital	H2		
Nurses treat you with courtesy/respect	H3	Do you feel that you're being treated respectfully by everyone?	LR3
Nurses listen carefully to you	H4	Do you feel that your questions are answered?	LR4
Nurses explain in a way you understand	H5	Do you understand the explanations that are provided to you?	LR5
Responsiveness of hospital staff	H6	When you need help, do you feel that your needs are met in a timely manner?	LR6
Pain management	H7	Do you feel that your pain is managed appropriately? Does the pain medication work for you?	LR7
Staff tell you what your new medication is for	H8	Do you understand the information about the medications you're receiving?	LR8
Staff describe medication adverse reactions	H9	Do you know the adverse reactions of the medications that have been prescribed to you?	LR9

Results

The demographic distribution was based on HCAHPS surveys received from patients discharged from November 1, 2013 to April 30, 2014. Demographics of the patients rounded were presumed to be the same as those reported in the HCAHPS surveys because they were the same patient population. (See *Table 2*.) The HCAHPS survey was sent to a random sample of discharged adult patients; only a percentage of discharged patients were included.

There are 32 beds with an ADC of 28.8 in the ACU, with rounding conducted twice a week; the expected number of patients rounded on was 1,384 in the 6-month period. Similarly, the PCU has 16 beds, and the expected number of patient rounds was 691; the 10-bed ICU had an expected 432 patient rounds. However, due to the rounding time, quite a number of patients were unavailable or the room was empty because the patient was recently discharged or transferred. In the first 2 months, the compliance for leader rounding was low (35% to 40%). However, with reeducation, the following month compliance rose to between 61% and 82%.

The analysis from this project shows no correlation between how patients respond to the specific HCAHPS questions and how patients respond to the questions posed by the leader as they rounded in all areas. Although we were hopeful that leader rounding could be used to provide more real-time data related to patient satisfaction, the analysis shows that we can't rely on it to accurately predict how patients will complete their HCAHPS

survey. Additional factors, such as interactions with staff members or other hospital personnel that occurred after leader rounding was conducted, could cause the difference between what patients expressed during leader rounding and their HCAHPS survey.

Table 2: Demographics

Gender	Number	Percent
Female	469	66%
Male	242	34%
Age ranges		
<34	178	25%
35 to 49	102	14%
50 to 64	131	18%
65 to 79	218	31%
80 plus	83	12%
Race and ethnicity		
White (non-Hispanic or non-Latino)	590	83%
White (Hispanic or Latino)	46	6%
Black (non-Hispanic or non-Latino)	41	6%
Asian (non-Hispanic or non-Latino)	16	2%
Asian (Hispanic or Latino)	1	0
American Indian/Alaskan Native (Hispanic or Latino)	1	0
Other (non-Hispanic or non-Latino)	11	2%
Hawaiian/Pacific Islander (non-Hispanic or non-Latino)	1	0

Table 3: Relationships between HCAHPS and leader rounding questions

	ACU		PCU		ICU	
	Correlation	*p*-value	Correlation	*p*-value	Correlation	*p*-value
H3 vs. LR3	0.03	0.9565	0.37	0.4685	-0.39	0.4387
H4 vs. LR4	0.21	0.6860	0.26	0.6228	-0.28	0.5941
H5 vs. LR5	-0.14	0.7872	-0.20	0.6998	-0.41	0.4247
H6 vs. LR6	0.26	0.6200	0.26	0.6200	-0.50	0.3910
H7 vs. LR7	0.49	0.3287	0.60	0.2080	-0.10	0.8729
H8 vs. LR8	0.56	0.2278	0.71	0.1108	0.52	0.3733
H9 vs. LR9	-0.03	0.9572	-0.20	0.7471	-0.09	0.8717

What's the score?

So, what relationship exists between leader rounding and patient satisfaction scores? Spearman correlation coefficients and their corresponding *p*-values were calculated for each pairing of similar HCAHPS and leader rounding questions. Analysis was stratified by unit: ACU, PCU, and ICU. None of the correlations were statistically significant based on a significance level of 0.05. The highest correlation was between H8 (staff tell you what your new medication is for) and LR8 (do you understand the medications you're receiving) in the PCU at 0.71. Therefore, analysis from this project showed no correlation between how patients respond to the specific HCAHPS questions and how patients respond to the questions posed by the leader as they rounded. (See *Table 3*.)

In addition, monthly HCAHPS scores for the aforementioned questions were statistically analyzed. The preimplementation data were collected from surveys received from patients who were discharged between October 2012 and October 2013. Postimplementation data were collected from surveys received from patients who were discharged from November 2013 to April 2014. Typically, there could be a lag of 5 to 6 weeks before the surveys were returned; therefore, our report was run by discharge date as opposed to received date. The scores for these questions were compared and stratified by unit. Both the mean and standard deviations and median and interquartile range were provided. Comparison was performed with a Wilcoxon rank-sum test.

Although there was statistically no significant difference in the HCAHPS scores between the pre- and postleader rounding

implementation, the mean scores for H1 (rate hospital), H6 (response of hospital staff), and H7 (pain management) were lower during postimplementation in the ACU. Significant differences were found in H1 (rate hospital) and H2 (recommend the hospital) in the PCU. There was a marked decrease in the mean scores for questions H1 (rate the hospital), H2 (likelihood to recommend), and H8 (understanding about medication). On the other hand, all other questions' mean scores increased during the postimplementation period, albeit not statistically significant. In the ICU, there was a statistically significant difference in question H6 (staff responsiveness) with the mean score dramatically lower during the postimplementation period. Furthermore, the mean scores in the ICU were lower during the postimplementation period for every question.

Project lessons

During rounds, in addition to the seven other questions that the leader posed, the patient was also asked whether there were any issues or concerns he or she experienced. The leader then contacted the appropriate department manager to report the issues. Resolution of the issue was expected and tracked in a secure database for analysis and trending. There weren't many concerns logged during the project, and no common themes were identified. Those concerns expressed were resolved immediately. Some examples include:

- nursing care issues: I.V. pump alarms, questions about the care plan, questions about medication
- need for interpretive language services not initiated on admission
- staff member responsiveness to calls to use the bathroom
- construction noise
- nurse in the room taking care of the patient and getting a call to help another patient
- room temperature
- wait time for rooms.

As many hospitals across the country adopt leader rounding to improve patient satisfaction, the findings of this project are unexpected. There are limited articles published on leader rounding that support an improvement in patient satisfaction. The result of this project demonstrates that there was no relationship between leader rounding and HCAHPS scores in the ACU, PCU, and ICU.

Although these are concerning results, other variables may have impacted the HCAHPS scores for the period. Winter months are typically high census months for most hospitals, and this hospital is no exception. The hospital exceeded the actual patient days by 28.5% compared with the previous year's volume. The occupancy rate from December to April ranged from 90% to 92%, compared with other acute care hospitals at 75% to 80%. ED patients had to wait for inpatient beds for an average of 18 hours, and 56% of our inpatient admissions came from the ED. The high patient volume could be contributed to the yearly flu season marked with high-acuity patient population during this period and long lengths of stay. In the months of January and February, over 60% of the patients in the ICU were on ventilators with long lengths of stay. The average case mix index for the hospital has been steadily increasing since November 2013 from 1.15 to 1.35, indicating sicker patients. In addition, the hospital began construction in the middle of the study period and the noise from this made it very hard for the patients to rest.

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The bottom line

Leadership rounding has been advertised as a proven tool to improve quality, safety, communication, and patient experience. Rounding increases trust between staff members and patients because leaders are vested in the organization's outcomes and show an interest in the day-to-day operations. Rounding provides an opportunity for leaders to observe inefficiencies and opportunities for improvement and make necessary changes. Rounding also enables leaders to receive real-time feedback from patients and families. Although this project didn't show the expected results, the hospital believes leader rounding does have benefits and the

team intends to continue the practice, but to focus more on coaching staff to connect with patients and anticipate and meet patient needs. Also, the hospital believes that leadership rounds should be a team effort and include all leaders, not just nursing.

There's also inconsistency as to who actually completes the postdischarge survey; it could be the patient, a family member, or another caregiver. The thought of having representatives from the leadership team may be intimidating for some patients. To counteract this, perhaps a small dedicated group of staff members or volunteers could conduct the rounding. When there are issues, then the appropriate leader would be notified for follow-up rounding.

Lastly, there's always a question about customer sincerity in answering direct questions while still receiving the service. Concerns about "not wanting to get anyone in trouble" for fear of retribution could be a factor in not telling the truth, especially when the patient may have to stay for several more days. On the other hand, once the patient is discharged and the survey comes in the mail, it may be a different story. The bottom line is that improving the patient experience can be difficult, but identifying where to focus efforts is even tougher. NM

In the final part of our 3-part HCAHPS series, we discuss whether a leadership training program can improve HCAHPS scores.

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