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Patient Satisfaction and Patient Safety: Outcomes of Purposeful Rounding

By Virginia M. Ulanimo, M.S., R.N., C.C.R.N., special care unit and telemetry nurse manager,
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Routine purposeful rounding and nurse time at the bedside are significant aspects of our profession, both of which were begun by the founder of modern nursing, Florence Nightingale. The systematic literature review conducted for this paper, including a past *TIPS* article, "Participating in Proactive Nursing Rounds," highlights the importance of routine purposeful rounding to patient care and satisfaction.¹ The availability of a nurse and nursing presence at the bedside are among the predictors of patient satisfaction.²

In an era where health care transparency is evolving, patient satisfaction and patient safety are garnering greater and greater attention. How can nurses keep patients satisfied and ensure safety? One way is to implement routine purposeful rounding: Grounded in nursing's past, routine purposeful rounding is being used once again to increase patient satisfaction scores and decrease such things as patient falls, as noted in the studies discussed below.

Routine purposeful rounding is when a nurse goes to a patient's room every one to two hours to assess and meet patient needs; thus, emphasizing communication and nursing presence. If a family member is present, the nurse will endeavor to speak with them, as well as to ask the patient questions that can include:

- Are you having any pain?
- What is your pain level now? (If a pain medication was given earlier)
- Do you receive help as soon as you wanted?

If the answer to any of the questions is affirmative, the nurse will then provide the required care. In addition, the nurse will assess for patient safety and comfort by ensuring that the bed is locked and in its lowest position; the call light, telephone and other items are within the patient's reach; and that the patient is repositioned, if required. In this way, "anticipatory help" is brought to the bedside before the patient realizes a problem and requests assistance. A proactive approach to anticipated needs has been shown to increase patient satisfaction, because patients perceive their needs are being met in a timely manner. Numerous hospitals have implemented the purposeful rounding concept in various ways.

Studies Review

One study³ examined the effect of having an assistant in nursing (AIN) perform hourly comfort

rounding (another term for routine purposeful rounding) for eight weeks, 4 p.m. to 10 p.m., Monday through Friday, in an Australian surgical ward. Comfort rounding included assessing for the "3Ps" (pain management, positioning and personal needs), along with toileting. The outcome of the study showed no significant differences between the experimental and the control group's patient satisfaction scores, which researchers attributed to a small sample size and patients' unwillingness to complain; however, the nursing staff in the interventional group perceived that the quality of care was better because of the presence of the AIN. Additionally, the interventional group perceived improvement in resource availability and professional relationships amongst nursing staff.

In another study,⁴ purposeful (hourly) rounding was implemented by a nursing staff on each inpatient unit on three hospital campuses, also using the 3Ps. During their rounds, the nurses ensured that patients had easy access to call lights, telephones and garbage bags. Patient satisfaction scores improved. Examples of questions that demonstrated improved experiences in the surveys included:

- What is your overall rating of the hospital?
- Would you recommend the hospital?
- Did you receive help as soon as you wanted?

Routine purposeful rounding was also studied⁵ in a nursing staff that conducted it periodically from 7 a.m. to 10 p.m. in a 25-bed cardiac telemetry unit during several months. Patients were assessed for the 3Ps, as well as being assisted with toileting and provided other support, such as ensuring a call light was within reach. After the nursing care rounds program was implemented, researchers found that patient satisfaction scores increased; however, the promptness of response to call lights was statistically unchanged and staff identified workload as a barrier to rounding.

A study⁶ was conducted in an orthopedic surgical unit, hypothesizing that routine purposeful rounding would help nursing staff anticipate patients' needs; thus, increasing patients' perception of timely response and patient satisfaction scores. Overall, post-implementation patient satisfaction scores were higher and staff responsiveness was identified as the most important driver of patient satisfaction.

Twenty-seven nursing units were studied⁷ in 14 hospitals, focusing on the effect of conducting routine purposeful rounding each hour, versus

Research on Veteran Comprehension of VA Prescription Labels

By Maisha Mims, NCPS program analyst

Staff of NCPS and the VA Pharmacy Benefits Management Services (PBM) are conducting a study entitled “Improving Veteran Health-Literacy and Safety Through Implementation of a Novel, Evidence-Based, Patient-Centered Outpatient Prescription Label.”

The study is being led by two NCPS pharmacists: Keith Trettin, program manager, and Erin Narus. The goal is to better understand and evaluate how Veterans interpret current VA prescription labels.

The research includes an evidence-based and patient-centric evaluation model to ensure patient comprehension of prescription labels. Participants include veterans from various cultural, socioeconomic and educational backgrounds. VA pharmacists around the nation will also be surveyed as to the importance of specific information on prescription labels. This effort could lead to the creation of standardized patient-centric VA prescription labels nationwide.

Root Cause Analysis (RCA) teams at VA facilities around the nation investigate adverse events and close calls and enter their findings into NCPS’ Patient Safety Information System. This confidential, non-punitive reporting system is used by NCPS staff members to examine the root causes of these incidents. Though few RCAs have been found that concern patients misreading medication prescription labels, it is believed such incidents have gone under reported.

The US Food and Drug Administration (FDA) reviews accounts of such errors, documenting 250,000 per year; but actual rates may be much higher because of under reporting. A 2006 Institute of Medicine (IOM) report also credited poor patient comprehension and subsequent unintentional misuse of prescription drugs as a root cause of medication error, poor adherence and worse health outcomes.¹

Details on Selected Previous Studies

One study² addressed the need for prescription label redesign concerns. It is entitled “Improving Patient Understanding of Prescription Drug Label Instruc-

tions.” The research included in-person, structured interviews to test if explicit language for prescription labels could improve patient comprehension. Investigators measured the number of correct responses from 359 patients who were asked to state what information they found on 10 labels’ instructions. Four out of five patients (79 percent) misinterpreted one or more of the 10 common prescription label instructions.

Another study³ examined if the use of enhanced print drug warning labels could improve patient comprehension. In this study, entitled “Improving Prescription Drug Warnings to Promote Patient Comprehension,” nine drug warning labels were presented to 500 adult patients, each receiving one of three different types.

The three labels included: the current standard drug warning label; drug warnings with text rewritten in simplified plain language; and plain language and icons developed through patient feedback.

It was found that 80.3 percent of the patients correctly interpreted the standard drug warning labels, 90.6 percent correctly understood the simplified text, and 92.1 percent correctly interpreted the simplified text with icons. The results from the study concluded that simple, explicit language on warning labels can increase patient understanding. The addition of appropriate icons was also found particularly useful for adults with lower literacy skills; however, evidenced-based standards are still required.

The Current VA Study

In 2010, the VA administered approximately 258 million prescriptions via mail or in person at VA medical centers. Based on such a large volume of prescriptions and the diversity of the Veteran population, one of the major goals of the current VA study is to assess barriers patients face when trying to understand medication labels.

Veterans at a VA medical center in Puerto Rico participated in such an effort during the study: Participants who speak Spanish as their first language were asked if they encountered language

barriers when comprehending prescription labels. Veterans of Polynesian and Native American descent were also asked to participate to determine if they risked misunderstanding prescription labels due to cultural differences.

The study also interviewed Veterans from Detroit. The National Institute for Literacy⁴ estimates that 47 percent of adults (more than 200,000 individuals) in Detroit are functionally illiterate. This aspect of the study is aimed at determining the impact reading levels have on Veterans’ understanding of prescription labels.

The VA labeling project study is expected to be the catalyst for standardizing the VA prescription label design to fit the needs of the veteran nationwide, as well as influence label design at other medical systems.

The study is expected to be completed by the end of this summer. To find out more information regarding the VA medication label study please contact Keith Trettin at keith.trettin@va.gov

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Update: Patient Safety Curriculum Program for Faculty and Residents

By Joe Murphy, M.S., A.P.R., NCPS public affairs officer

The Patient Safety Curriculum program was first piloted in 2003, with a focus on faculty development workshops. High-fidelity simulation was added in 2010. The curriculum program provides content and methods that introduce patient safety concepts into medical training; in particular, the usefulness of human factors engineering in solving patient safety problems.

“We have several ongoing tasks,” said Douglas Paull, M.D., a VA surgeon and director of NCPS’ Patient Safety Curriculum program. “For instance, we carry out research into patient safety medical education, constantly developing and redeveloping the content for the program.”

Paull said another major task is to conduct workshops at VA sites around the nation: “Rolling our sleeves up and getting engaged with faculty and residents on the front lines to deliberately practice patient safety behaviors and to work together to make care safer.”

Measurement of the program’s effect is also extremely important. Participants are often eager to discuss their experiences directly following the training sessions.

“We get immediate feedback on the success of the teaching day,” said Linda Williams, R.N., assistant director of the program. “In every workshop we learn things that result in improvements to future workshops. So we’ve been able to become more effective in our teaching methods.”

Williams help found the curriculum program and reflected on its progress. “The big need we initially identified was faculty development,” she said. “We really focused on talking to residents’ teachers, their faculty and program directors.” Williams said an important element of this was to emphasize that residents be involved in patient safety problem solving.

Throughout the years, the training has promoted interactive teaching methods. “We want the educational methods to be appropriate for adult learners, not just a series of lectures with PowerPoint,” Williams noted.

“Interactivity is key, along with using teaching styles that are consistent with principles of human factors engineering.”

To make this a reality, small group and individual exercises are included with each didactic learning session. “The newest improvement is the addition of high-fidelity simulation,” Williams said, “used to teach teamwork and communication skills. And it’s something remarkable to see.”

Day one of the current model is devoted to teaching faculty. Breakout sessions are conducted the following day, specifically for residents. Their teachers are invited to both observe and participate.

She said the content has been treated as “open source,” allowing faculty to adapt the material into a format considered most applicable to the residents they teach.

“The residents’ faculty conduct the simulation debriefings,” said Paull, noting an important aspect of the training. “Faculty have also managed simulation props and implemented scenarios. So we are providing resources to the faculty to teach patient safety and they are in turn instructing their own residents during the workshop in a format that they can change, edit and improve.”

He noted an example of scenario-building that included a systems approach to problem solving: “If faculty were conducting education on how to put in a central line, they might do a checklist-guided time-out briefing before the central line.”

Studies continue to show that a majority of adverse medical events involve communication failure. A time-out briefing before a procedure can improve communication and teamwork.

“We hope the skills residents learn from such scenarios transfer into their future endeavors,” he said.

The workshops cannot always be scheduled to take place over two days. “We adapt our educational techniques, ensuring that basic patient safety principles are presented,” continued Paull. He noted that a recent workshop was one day in duration for logistics

reasons. “We had faculty and residents attend together. The simulation scenarios were broadcast on three screens for all present to observe. The faculty and residents then debriefed the cases together.”

One of the reasons for the success of workshop simulation training is that participants can make mistakes: They are not being graded on their performance.

“The beautiful thing about the simulation workshops is that participants are in a safe environment,” said Paull. “Everything stays within those four walls and people are quite comfortable discussing the issues they faced.”

Among the goals for the future include development of patient safety orientation course and a patient safety text book, based on the wide range of work that has been done at NCPS.

“We are also teaming-up with SimLEARN™ on another exciting project,” said Paull. “We are going to work on virtual reality software so that we can program some of the workshop scenarios into a format that will provide an online experience. I think it will be a major change in the way we conduct some of our training in the future.”

Williams is confident the program will continue to flourish and be successful: “Historically, NCPS has approached problem solving through human factors engineering; finding systems-based engineering solutions to patient safety issues.”

“So we are not relying on the expertise gradient that exists in medicine,” she said. “In a way what we want to do is have residents in training become as good at diagnosing and treating systems ills as they are at treating patho-physiology in individual patients.”

Patient Satisfaction and Patient Safety: Outcomes of Purposeful Rounding (Continued from page 1)

conducting it every two hours. The hypothesis was that interjecting rounding as part of nursing care would decrease call light use and patient falls, thus increasing patient satisfaction. Compared to the control units during the first two weeks of the study period, those that implemented routine purposeful rounding found:

- Patients used 5,078 less call lights in one-hour routine purposeful rounding units
- Patients used 1,944 less call lights in two-hour routine purposeful rounding units

The overall quality of care for one-hour and two-hour rounding units increased. The analysis also showed that in the one-hour rounding units, fall rates were significantly lower compared to the control and two-hour rounding units.

Charge nurse rounding (another term for routine purposeful rounding) was implemented in a 27-bed medical surgical unit.⁸ After the charge nurses had conducted a two-hour routine purposeful rounding schedule for three months, falls and call light use dropped and patient satisfaction scores increased. Barriers to charge nurses performing rounds included patient admissions and discharges, staffing and equipment issues.

The concept of a “unit hostess” was implemented in a study⁹ of a busy 58-bed medical unit on the day and evening shift for eight weeks. A unit hostess, in this case, was an unlicensed staff member who conducted routine purposeful rounding on patients four times during an eight-hour shift; in particular, monitoring the unit hallway, answering call lights within five minutes, and attending to patients’ requests that did not require the intervention of a licensed nurse. (If a request required a licensed nurse, the hostess informed the primary nurse.) The study showed that patient call lights were answered more promptly and that patients verbalized satisfaction with care. The results inspired the hospital to hire 21 hostesses for 10 full-time vacant registered nurse positions. Following this, increased patient satisfaction scores were observed.

A clinical review¹⁰ of eleven research articles focused on routine purposeful rounding was also conducted:

- Decreased call light use was observed in five out of six of the studies that reviewed call light use rates
- Seven out of nine studies that

evaluated falls demonstrated a decrease in falls; of the nine studies, eight studies noted increased patient satisfaction

- One study noted decreased use of attendants and restraints

Barriers to hourly rounding included acuity of patients and staffing levels. “Scripting,” a way of communicating with patients using preselected phrases, was viewed as too rehearsed. The research emphasized the importance of critical thinking and prioritization of nursing care.

Conclusion

Routine purposeful rounding by nursing staff can be a tool used to ensure that hospitalized patients are kept safer and more satisfied, and should be considered a part of larger interventions that promote patient safety and comfort.

Patients’ hospital experiences rely heavily in nursing presence and availability; routine purposeful rounding ensures that patients are certain that their nurse or nursing assistant will regularly check on them to assist with their needs. Because this decreases anxiety and increases trust in nurses, facility patient satisfaction scores are likely to go up.

Reducing the barriers to routine purposeful rounding requires management support. For example, if scripting is too rehearsed and unnatural for staff, management should consider allowing staff to use their best judgment when communicating with patients.

Nursing staff values, perception of work environment, and workload are indicators for how well implementing such quality improvements will succeed – and also require management support.

Promoting staff engagement in new initiatives, such as routine purposeful rounding, can help allow an organization thrive in the era of greater transparency. Unfortunately, routine purposeful rounding cannot always be implemented due to such things as a lack of resources or a large number of high-acuity patients.

It’s critical that front-line nurses and nurse managers have the same bottom line, quality and timely patient care. Nurse managers should be urged to commit to a transparent management style and ensure their goals are aligned with front-line staff. Otherwise, organizational changes are unlikely to succeed, whether they a purposeful rounding or other quality improvements.

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