Hourly Rounding:
Using the 5P's

1. **Background**

   Public reporting about patient satisfaction scores to help improve quality of care is a national standard. Patient satisfaction is directly related to nurse responsiveness and patient safety (Tea, Ellison, & Feghali, 2008). Nurses are frequently interrupted with non urgent patient requests that can reduce time for medical care by interfering with nurse workflow (Duffin, 2010). These interruptions can lead to decreased nurse responsiveness and job dissatisfaction (Tzeng & Yin, 2009). Hourly rounding literature suggests that purposeful hourly rounding can improve quality of care, patient and nurse satisfaction (Deitrick, Baker, Paxton, Flores, & Swavely, 2012). The goal of this project was to achieve high levels of nurse compliance with hourly rounding documentation on Weinberg 5A/HEMB4 units at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins Hospital using information obtained from a comprehensive literature review. Twenty-seven articles were reviewed. Twenty-five met criteria of project. Six key factors were identified from the articles reviewed (Table 1).

2. **Methods**

   A rounding checklist was developed based on samples from the literature. Attached to the checklist were sample statements for nurses (Table 2). RN’s were educated about the benefits and implementation of hourly rounding at staff meetings. Rounds were conducted hourly during wake hours and every two hours during sleep hours. Checklists were placed outside of patient rooms on a weekly basis. Upon admission, patients were informed about the rounding project in a “welcome letter” that explained the 5 P’s: Pain, is managed, Position is comfortable, Potty needs are met. Possessions are in reach and Pumps (IV) are not beeping. Compliance of the checklist documentation was reviewed weekly. Compliance was calculated by total number of completed rounds columns documented over total number of hourly rounds columns in a 24 hour period. The staff with low checklist compliance rates were given reminders by email and verbal counseling was given to those that were noncompliant by the Clinical Nurse Specialist.

3. **Results**

   Overall compliance was good to very good with rates between 81% - 97% of all shifts on both Units 5A and HEMAB. The largest decrease in compliance occurred in weeks 9 and 10 when the Clinical Nurse Specialist who oversaw the project was on vacation. This indicates the need for leadership roles to ensure success in compliance documentation. Daily compliance would decrease with new staff, understanding, and when highly critical patients on the unit needed greater levels of support. However, fluctuation between units could not be determined. Nurses work on both units, maintaining consistency in personnel.

4. **Conclusions**

   Hourly rounding is a patient centered, quality improvement initiative that uses key interventions to improve patient satisfaction, fall rates and decrease call bell use.

   High levels of compliance has been proven achievable by hourly rounding checklists.

   Nursing and patient education was used to achieve this level of compliance. Nursing acceptance of their new roles and advocacy appears central to achieving high levels of compliance as evidence by a drop in compliance when the Clinical Nurse Specialist was on vacation.

   A major barrier to hourly rounding included compliance of staff signing paper checklists outside of patients room and manual compliance measurement.

5. **Future Directions**

   Track staff compliance using a locator badge device to assess attendance and length of time in room. Aim for 90th percentile or greater compliance

   Increase patient education on hourly rounding

   Compare patient satisfaction, fall rates and call bell rates pre and post intervention.

   Implement hourly rounding on other units once compliance is consistently high on 5A and HEMAB.

6. **References**

   A comprehensive list of references is provided in the final package. The key included references are:


**Funding Source:**
The Helene Fuld Leadership Program for the Advancement of Patient Care Quality and Safety