

Peer Feedback to Improve
Daily Nurse Leader Patient Rounding

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Executive Summary

Improving the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) performance within the acute care setting is necessary to ensure high-quality care to patients served, maximized reimbursement, and enhanced market share (Al-Amin et al., 2018; Quigley et al., 2021). One approach for improving overall HCAHPS performance is elevating the patient's perspective of the nurse leader visiting daily (Morton et al., 2014). The nurse managers within a 264-bed acute care facility in southern California consistently perform nurse leader patient rounding, yet the patient perception of the "nurse manager visited daily" shows significant variation. If the trend continues, the hospital will not achieve the target five star rating and is at risk of losing its four star rating, decreasing patient retention, and reducing the market share. Augmenting the approach for patient rounding was necessary.

Peer feedback was the primary strategy utilized to augment nursing practice to mitigate the deficits in patients' perception of the nurse leader visiting daily. Peer feedback is a proven strategy for enhancing practice effectiveness by expanding knowledge, skills, and behaviors (Haag-Heitman & George, 2011; Korkis et al., 2019). Implementing peer feedback required three phases to ensure practitioner uptake: education, paired leader rounding, and reflective learning. With the original plan, the manager rounding responsibility expanded to include nursing managers from the utilization review and the quality service lines. Changes to the executive leadership team resulted in adapting the originally agreed upon leader participants. A reduction in manager participants may have contributed to stalled patient satisfaction outcomes.

With the transition of the Senior Vice President and Chief Nurse Executive, the rounding team reverted to the department-level nursing managers. While this represents a short-term setback, system-level goals have been established to extend patient rounding to the ancillary

support and non-nursing managers. The nature of the mandate improves the proactive touchpoints with the patient to improve the experience from a system-level perspective instead of nursing alone.

The implementation of this project supports the need to generate additional knowledge related to peer feedback as a practice standard among nursing managers and the role of leader rounding to improve overall patient satisfaction. Through developing a refined understanding, an optimized patient care experience is possible. Only through the spirit of inquiry, the rigor of generating new knowledge, and the timely implementation to practice will healthcare professionals realize optimal outcomes for the patients served.

Peer Feedback to Improve Daily Nurse Leader Patient Rounding

Background

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a nationally sanctioned standardized survey to ascertain patients' perspectives of their hospitalization. The Centers for Medicare and Medicaid Services (CMS) and the HCAHPS Project Team oversee the question composition and public reporting processes (U.S. Centers for Medicare & Medicaid Services, 2021). Individuals have access to hospital performance to gauge the quality of care afforded by the facility. Furthermore, organizations utilize the data obtained from post-hospitalization surveys to prioritize initiatives to enhance performance. In addition to HCAHPS performance impacting CMS reimbursement for facilities, improved scores correlate with increased patient retention, increased market share, and reduced patient complaints (Quigley et al., 2021).

The purpose of this quality improvement project is to enhance the patients' satisfaction through augmenting nurse leader rounding. Contained within the summation are an overview and significance of the defined problem, the context for the quality improvement strategy, the faith-based and theoretical framework, literature synthesis, project objectives, implementation strategies, the financial impact of implementation, project outcomes, implications for practice, and recommendations for further enhancement.

Problem Statement and Significance of HCAHPS Performance among Organizations

The following section provides the problem statement and the project's significance in improving the patients' overall satisfaction at a 264-bed acute care facility in southern California. Historical performance data is also presented to substantiate the need leading to this change project.

Problem Statement

The nurse managers within a 264-bed acute care facility in southern California consistently perform nurse leader patient rounding, yet the patient perception of the “nurse manager visited daily” shows significant variation. If the trend continues, the hospital is at risk of losing its four star rating, decreasing patient retention, and reducing its market share.

Significance of the Problem

Over the last two decades, the United States has allotted significant resources and passed legislation to improve health care. With the Affordable Care Act's passing in 2010 and aligned with The Institute of Healthcare Improvement's triple aim, significant attention has been placed on improving the care experience, enhancing quality, and containing costs (Quigley et al., 2021; U.S. Centers for Medicare & Medicaid Services, 2021). As an example of the resources toward improving care experience, of the nearly \$2 billion allotted for value-based incentive payments, 25% of these funds were for HCAHPS performance in 2020 (Indovina et al., 2021). These national efforts have led to incremental improvements in overall performance as measured by trended HCAHPS outcomes (Al-Amin et al., 2018; Chatterjee & Maddox, 2018; Mazurenko et al., 2017).

Several studies have synthesized post-hospitalization patient satisfaction data to isolate correlational factors influencing improved patient outcomes. One study analyzed the performance of 2,059 hospitals between 2009 and 2013 and revealed that 7% maintained top-quartile performance throughout the timeframe. Of significance, staffing levels, the teaching status of the facility, and a more competitive market within the community were correlated with sustained top-quartile results (Al-Amin et al., 2018). Expanding the importance of healthcare organizations prioritizing patient care experience, one systematic review revealed significance in

the relationship of higher patient satisfaction scores with patient retention, the likelihood of patients to recommend the facility, and fewer patient complaints (Quigley et al., 2021). While there is a propensity for prioritizing the care experience of the patients served to improve satisfaction, quality, and cost, significant variability in performance persists.

A publicly reported HCAHPS performance review in November 2021 indicates that 255 acute care facilities in California have patient survey reporting available. Only one is ranked as five stars, representing 0.04% of the state's hospitals. Further rankings include 12.2% of the facilities being four stars, 46.7% being three stars, 32.5% are two stars, and 8.2% are one star (U.S. Centers for Medicare & Medicaid Services, n.d.).

The focus hospital for the quality improvement initiative is located in Orange County, California, and has a four star rating. This region is one of the nation's most competitive healthcare landscapes; understanding market competition is crucial for attracting and retaining patients. Through a review of the public reporting on HCAHPS performance, 30 hospitals are included within a 25-mile radius. On a five star scale, zero hospitals are five star, two are four star, nine are three star, eleven are two star, three are one star, and five are unrated (U.S. Centers for Medicare & Medicaid Services, n.d.). With less than 7% of the hospitals in the region performing at a four star or higher rating, opportunities exist to optimize patient satisfaction.

The following section provides an overview of the environmental context of HCAHPS performance for the focus hospital of the quality improvement project.

Environmental Context

To provide additional context to the importance of the quality improvement project, this section delineates the setting where the project took place and a market analysis. Strengths, weaknesses, opportunities, and threats demonstrate performance trends before implementation.

Environmental Context

Implementation of an enhanced approach for conducting nurse leader patient rounding is proposed for a 264-bed, Magnet-designated acute care facility in southern California. In recognition of the pursuit of exemplary patient satisfaction to improve quality and cost-effectiveness, the facility has prioritized patient care experience as a core imperative for the last decade. Furthermore, the attainment of a five star summary rating was included in the 2019-2022 organization strategic plan. The organization's mission and overall market landscape drives a desire to optimize the patient satisfaction rating. A summary of the strengths, weaknesses, opportunities, and threats before the project implementation is summarized in Table 1.

The internal strengths leading up to this project included a consistent organizational focus on the overall patient satisfaction performance with additional emphasis on the patient's perceptions of the nurse leader visiting daily. After several years of inclusion of the survey question, "Did a nurse leader visit you daily?" the health system developed extensive training and resources to support the practice of nurse leader patient rounding. Unfortunately, consistent performance remained elusive.

Challenges that threatened this project's success and overall HCAHPS performance were largely due to inconsistencies in historical performance, competing priorities, system mandates, and significant executive leadership changes that included the Senior Vice President and Chief Nurse Executive. Tables 2 through 6 contain an overview of the service line level HCAHPS performance prior to project implementation. In the competitive market of southern California, acute care facilities must maintain the patient's experience as a top priority.

Market Analysis

Over a 10-year timeframe, the organization has maintained performance in the top decile for overall hospital rating and several individual composites within the HCAHPS survey compared to other hospitals within the community. Many local facilities have recently reported transitioning to more timely feedback processes to enhance their performance improvement methodologies and have dedicated resources to stimulate positive HCAHPS performance. While the historical performance of the subject hospital represents significant strength, ongoing market competition and a drive for excellence have resulted in the desire to achieve an overall five-star rating. With a desire for improvement, a literature review was conducted to determine viable strategies for enhanced practice.

Literature Review and Evidence Synthesis

Maximizing healthcare practitioner consistency and accuracy is one strategy for combatting the U.S. healthcare system's devastating quality and safety outcomes (Chatterjee & Maddox, 2018; Wong et al., 2013). Exploring the literature addressing patient satisfaction reveals targeted strategies to enhance nurses' competence and confidence. As identified by the American Nurses Association (ANA) in 1988 and reiterated in the latest Nursing Scope and Standards of Practice, nurses are expected to include peer feedback as a professional accountability (2015). Peer feedback is an interpretation of practice against a standard, with direct communication between colleagues of the same rank. Furthermore, the practice-focused feedback should be timely and not anonymous (Task Force on Peer Review, 1988; Brunson et al., 2020; Haag-Heitman & George, 2011; Lal, 2020; Roux, 2020). Since the practice standard was identified, abundant scholarly work has recounted additional evidence for clinical and work

environment improvements associated with peer feedback implementation. The following section will discuss the literature review process and the evidence synthesis.

The following databases were used to review the literature: The Cumulative Index for Nursing and Allied Health (CINAHL), Google Scholar, Medline, and PubMed Central (PMC). Search terms included: peer feedback, peer evaluation, peer review, nurse, and nurse manager. Limitations were added to exclude articles pertaining to students, journal writing, and journal editing.

Search Results

Various searches of the keywords identified above yielded 127 articles. All abstracts were reviewed to determine inclusion and exclusion status. Articles were excluded for the following reasons: seventy-nine peer reviews in the context of scholarly writing submission, eight survey tool evaluations, five organization-level appraisals, and four patient-centric disease management. The remaining 31 articles are the basis for synthesizing literature associated with nursing peer feedback. Twenty-three scholarly works comprise expert opinion with the remaining methods: one qualitative, one descriptive mixed method, two quasi-experimental, two mixed correlational, one single randomized control, and one systematic review. Articles represent work over the last decade, including four published between 2011 and 2012, five published between 2013 and 2015, and 22 published between 2016 and 2021.

As a result of the literature review, the work reveals different frameworks for implementing peer feedback and several trends toward improved quality and work environment indicators. While a majority of the literature is of expert opinion with anecdotal conclusions of causation, perceived benefits to nursing practice and patient outcomes prevail. The following section summarizes the 31 articles, including supporting data and emerging trends.

Supporting Data and Emerging Trends

There are five supporting data and emerging trends found in the 31 articles reviewed: methods of implementation, nursing professional development and accountability, work environment engagement and mentorship, identification of system issues and improved quality outcomes, and partial implementation of practice standards.

Methods of Implementation

Nursing peer feedback embedded within the annual evaluation process frequently lacks all elements of the practice standard as it is not continuous and is commonly guided by the manager with the anonymity of the reviewer (Bowen-Brady et al., 2019; Murphy et al., 2018; Roberts & Nones Cronin, 2017; Ryiz-Semmel et al., 2019; Whitney et al., 2016). As demonstrated by Karas-Irwin and Hoffman, through incorporating a quarterly reviewer process between the manager and a peer, self and peer-assessed managerial competencies improved (2014). An association of enhanced engagement resulted when anonymity was removed from the process, with peers communicating feedback directly (Bowen-Brady et al., 2019; Karas-Irwin & Hoffman, 2014; Murphy et al., 2018; Roux, 2020). Furthermore, specific education for effectively participating in peer feedback with how to receive and provide practice-focused education led to enhanced incorporation of feedback in professional development goal setting (Murphy et al., 2018; Ryiz-Semmel et al., 2019; Shaffer et al., 2011). Peer feedback as a part of the post-incident review further enhanced engagement with safety conversations.

Peer feedback as the result of an unintended adverse event incorporates the practice tenets of peer appraisal against a standard; feedback is provided in a timely manner and promotes safety conversations. Incident-based peer review is commonly achieved by referring a potential nursing practice concern to a committee of nursing colleagues of the same level of practice.

Models that deploy a managerial component for reporting reveal an enhanced sense of accountability without demonstrating improvement in the other engagement indicators (Branowicki et al., 2011). While the process is intended to evaluate the appropriateness of nursing practice decisions, it runs in parallel with the quality review processes to contribute to defining system-level challenges (Drobny et al., 2019; Herrington & Hand, 2018; Kirkland-Kyhn & Teleton, 2018; Spiva et al., 2014; Thomas et al., 2020). Furthermore, a model that includes the involved practitioner during the review process increased comfort with the evaluation and enhanced engagement with organizational safety conversations (Korkis et al., 2019; Major et al., 2013). Peer feedback incorporated through routine competency enhancement reveals additional benefits.

Integrating peer feedback during routine nursing competency optimization involves shared nurse interactions, perceived systemic practice gaps, and new process implementation (Whitney et al., 2016). Adoption of the peer feedback approach offers the best scenario for including all six elements of the nursing feedback standard: involves individuals of the same rank, practice-focused assessment, feedback is timely and routine, emphasizes continuous learning and safety, is not anonymous, and incorporates the developmental stage of the practitioner (Brunson et al., 2020; Cortez et al., 2017; George & Haag-Heitman, 2011; Lamonica et al., 2016; Major et al., 2013; Mangold et al., 2018; Pham et al., 2016; Stewart, 2021). In addition to the connection of improved work environment indicators with the previously cited modes of peer feedback, the deployment of the mechanism leads to enhanced safety and clinical indicators (Cortez et al., 2017; Major et al., 2013; Mangold et al., 2018; Pham et al., 2016; Stewart, 2021; Wong et al., 2013). In addition to the peer feedback implementation tactics, several results were reported across the various approaches.

Nursing Professional Development and Accountability

Implementation of peer feedback correlates with improved professional development, including goal setting and progress toward achievement (Bowen-Brady et al., 2019; Branowicki et al., 2011; Brunson et al., 2020; George & Haag-Heitman, 2011; George & Haag-Heitman, 2015; Goble et al., 2017; Karas-Irwin & Hoffman, 2014; Lal, 2020; Lamonica et al., 2016; Mangold et al., 2018; Murphy et al., 2018; Pham et al., 2016; Pinero et al., 2019; Roy et al., 2020). In a 2018 quasi-experimental study, Murphy et al. deployed a pretest and post-test design to assess the impact of a structured, routine peer feedback model. As a result of this approach, post-survey findings showed significance in an improved perception of professional development. In addition, several studies delineated the manager's role to ensure adequate resources and the frontline nurse to drive practice decisions, enhanced frontline autonomy, and professional accountability results (Branowicki et al., 2011; George & Haag-Heitman, 2015; Goble et al., 2017; Pham et al., 2016). In addition to the shift in the perception of personal accountability, nursing peer feedback also contributes to how practitioners view their contributions to the collective professional practice.

Work Environment Engagement and Mentorship

Twelve articles revealed a correlation between the implementation of peer feedback and an enhanced work environment, including overall engagement and mentorship (Cortez et al., 2017; George & Haag-Heitman, 2011; George & Haag-Heitman, 2015; Karas-Irwin & Hoffman, 2014; Korkis et al., 2019; Mangold et al., 2018; Murphy et al., 2018; Pham et al., 2016; Pinero et al., 2019; Ryiz-Semmel et al., 2019; Shaffer et al., 2011; Spiva et al., 2014). After deploying a competency-based peer feedback strategy, nursing satisfaction surveys revealed enhancements in the perceptions of organizational safety programs (Cortez et al., 2017; Murphy et al., 2018;

Pinero et al., 2019). Additionally, implementing peer feedback contributed to the value placed on mentorship for continuous improvement across the discipline (Karas-Irwin & Hoffman, 2014; Korkis et al., 2019; Spiva et al., 2014). Along with the profession's benefits of nursing peer feedback, the practice contributes to improved unit and organization-level achievements.

Identification of System Issues and Improved Quality Outcomes

Fourteen articles revealed a relationship between the implementation of incident-based reviews and a routine, just-in-time approach with the identification of system issues and improved quality outcomes (Brunson et al., 2020; Cortez et al., 2017; Drobny et al., 2019; George & Haag-Heitman, 2011; George & Haag-Heitman, 2015; Herrington & Hand, 2018; Korkis et al., 2019; Lal, 2020; Major et al., 2013; Mangold et al., 2018; Pham et al., 2016; Spiva et al., 2014; Stewart, 2021; Wong et al., 2013). Nurses who participated in the peer-review process reported an enhanced incidence and impact of identifying necessary system enhancements toward increased safety and quality (Herrington & Hand, 2018; Korkis et al., 2019; Spiva et al., 2014). Furthermore, a correlation was demonstrated between safety improvements, pressure injury prevention, central line-associated bloodstream infections, and catheter-associated urinary tract infections (Cortez et al., 2017; Mangold et al., 2018; Pham et al., 2016; Stewart, 2021). While a significant amount of evidence supports the practice of nursing peer feedback, many organizations remain challenged in adopting a meaningful, robust evidence-based framework.

Partial Implementation of Practice Standard

Though nursing peer feedback is an essential component of the Collaboration, Quality of Practice, and Professional Practice Evaluation standards defined by the ANA (2015), full enculturation across the nursing profession remains elusive. Furthermore, several published

articles and prevailing perceptions of peer feedback reveal faults in the program design as they do not align with the entire practice standard (Whitney et al., 2016). The preservation of the anonymity of the reviewers is included in some models for the annual appraisal and incident-based reviews (Branowicki et al., 2011; Pfeiffer et al., 2012; Roux, 2020; Ryiz-Semmel et al., 2019; Siedlecki, 2016; Whitney et al., 2016). Additionally, there is an apparent lack of consistency in implementing the standard that achieves timely and continuous feedback (George & Haag-Heitman, 2011; George & Haag-Heitman, 2015; Roberts & Nones Cronin, 2017). With these identified inconsistencies, the nursing profession is charged with developing multifactorial approaches to achieving the full scope and potential benefits of nursing peer feedback.

While the above literature analysis recounts evidence published before project implementation, a post-implementation review yielded one additional quasi-experimental study that evaluated the connection of peer review in knowledge uptake for simulation coordinator educators. Utilizing all of the tenets of peer feedback during the simulation education, the pre-posttest evaluation correlated with significant improvement in curriculum competence, self-reported engagement, and overall confidence (Roh, 2021).

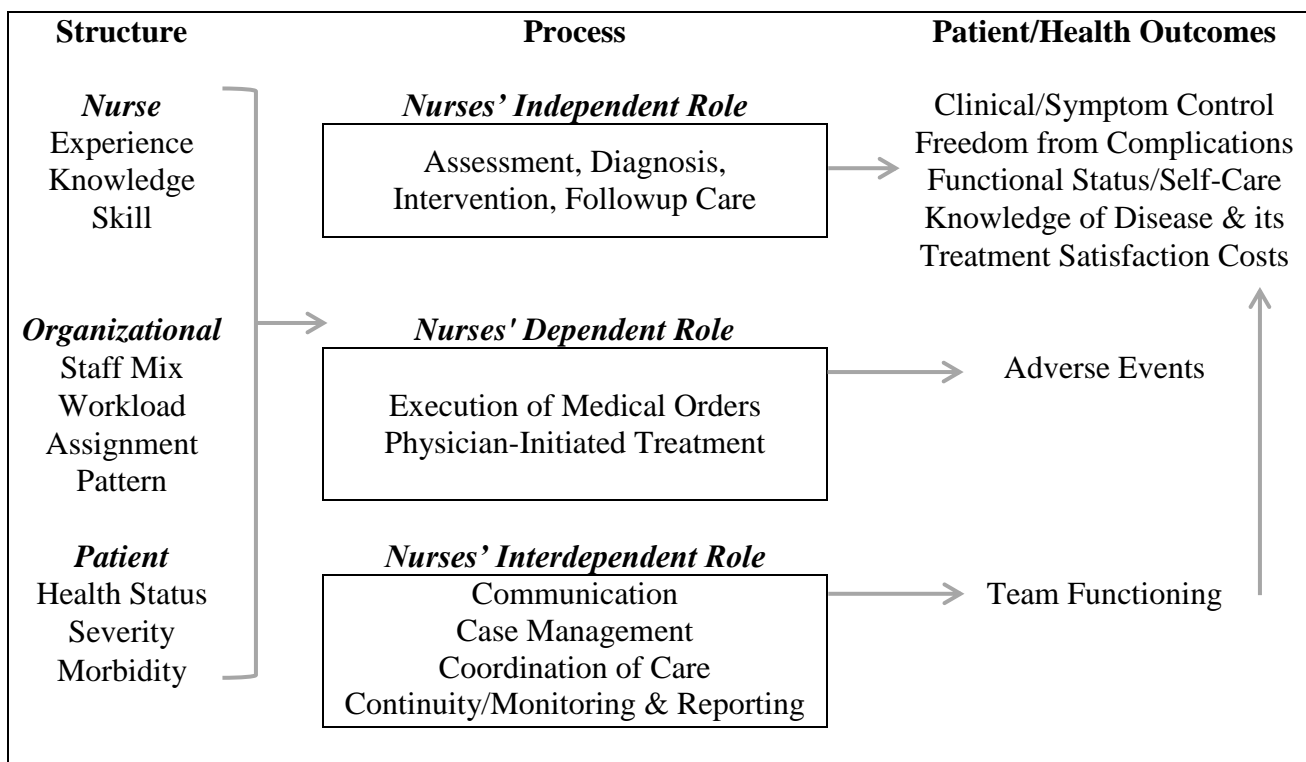
Considering the longstanding nursing professional practice expectation of adopting peer feedback, significant variation in approaches for implementing the standard persists. With the extent of evidence available to support enhanced outcomes, implementing peer feedback within nurse leader patient rounding offers a solution to the stagnant performance. The following section provides an overview of the theoretical framework for developing this project.

Theoretical Framework

Determining the patient's experience with a nurse leader visiting daily provides insight into the critical leadership function of maximizing quality care standards and mitigating patient

concerns (Kline & McNett, 2019; Morton et al., 2014). A theoretical framework offers a structure for viewing opportunities and constructing interventions. This section provides an overview of the theoretical framework guiding the proposed project toward elevating patients' perspectives of their hospitalization and the specific focus of the nurse leader visiting daily. The Nursing Role Effectiveness Model (NREM) is the theoretical foundation for developing, implementing, and evaluating the nursing practice improvement project.

Figure 1: Nursing Role Effectiveness Model (Irvine et al., 1998)



Nursing Role Effectiveness Model

The NREM was adapted from the Donabedian Structure-Process-Outcome framework. With a drive toward maximizing nurse-sensitive clinical indicator performance, the NREM authors reimagined Donabedian's work through the lens of nursing practice. The elements of structure, process, and outcomes were redefined by leveraging the tenets of the nursing

profession (Amaral et al., 2014; Doran et al., 2002; Irvine et al., 1998; Lukewich et al., 2019). Furthermore, both frameworks illustrate the necessary, interconnected factors that drive effective results (Irvine et al., 1998).

The structure category of the triad includes patient characteristics, nursing attributes, and organizational constructs (Doran et al., 2002; Irvine et al., 1998; Lukewich et al., 2019). In the age of delivering patient-centered care, any healthcare strategy would be deficient not to recognize the circumstances of the individual being served. Furthermore, the NREM emphasizes the practitioners' qualities, including experiences, knowledge, and skills. Implementing an enhanced nurse leader patient rounding practice with peer feedback explicitly targets the evolution of the manager's knowledge and skills. As the final aspect of the characteristics within the structure domain of the NREM, organizational factors such as staffing resources complete the first component (Irvine et al., 1998; Lukewich et al., 2019). Within the project, the organization must endorse and aid in re-prioritizing of responsibilities to permit full manager engagement in the practice expectation. The interconnected nature of these variables influences the deployment of processes and the achievement of outcomes.

As a second component of the NREM, processes are classified by the nurses' independent, dependent, and interdependent roles. Executing the nursing process is an example of the independent nursing function, while implementing a physician order is a dependent role (Irvine et al., 1998; Lukewich et al., 2019). Care coordination through an interdependent mode has increased in importance as the literature supports improved quality outcomes (Reeves et al., 2017). With the implementation of peer feedback as a component of the routine daily nurse leader patient rounding practice, an interdependent practice emerges as the primary mode of operation. Including this approach ensures stakeholders' engagement for progressing system-

level issues. Factors from both the structure and process components of the NREM impact the attainment of patient outcomes.

As the final component of the NREM, patient outcomes are not only defined by the attainment of quality indicators but also include avoiding adverse events and maximizing team functioning (Irvine et al., 1998; Lukewich et al., 2019). Workplace measures such as staff satisfaction and injury avoidance indicate the connection between structure and process. Furthermore, the summation is directly correlated with the attainment of patient-centric outcomes. Examples of health outcomes include eliminating complications, enhancing functional ability, and service satisfaction (Irvine et al., 1998; Lukewich et al., 2019). Application of the NREM lends insight to evolving nursing practice related to enhanced patient satisfaction performance. Reporting patient satisfaction scores will remain a key component throughout this project to ensure that the nursing leaders are aware of their effectiveness and that the team can collectively identify further opportunities for augmenting this practice imperative. In addition to using the NREM theoretical framework to guide this project, a faith perspective is crucial for supporting leaders participating in patient rounding.

Faith Integration

As a core imperative of nursing practice, nurses choose this profession as a means of service to others. Through service to others, achieving superior outcomes is the universal aim of the professional group. In a leadership role responsible for driving the organization's patient satisfaction outcomes, the leader of this quality improvement initiative attests to both generalized statements. As a result of the desire to serve and the attainment of exemplary outcomes, achieving these goals at a standard lower than anticipated creates discouraging sentiments. A

source of personal inspiration is necessary to motivate a persistent approach toward service and continuous improvement.

A Christian worldview provides personal inspiration and commitment that I am in this role, prioritizing the service to others as my life's work. Through reflection and prayer, I receive renewed energy to pursue a positive impact on my peers and the patients we serve. As stated in Galatians 6:9, "Let us not become weary in doing good, for at the proper time we will reap a harvest if we do not give up" (The Holy Bible, 1973/2011). As the leader responsible for the overall performance of patient satisfaction and for implementing best practices to support continuous improvement, I recognize discouragement in the lack of sustained performance. This recognition is a personal acknowledgment and an observation of the managers responsible for this practice. The nursing leaders in this organization have persistently revisited the daily nurse leader patient rounding methods. Despite these efforts, we have not experienced success with the investment of time and energy. Considering the lack of anticipated results, it is understandable for all to become skeptical of their ability to attain the desired outcome.

While considering the benefits of providing effective daily nurse leader patient rounding, paired with the managers' inconsistent patient satisfaction outcomes, Galatians 6:9 inspires the project development team to lend a solution to stimulate the necessary persistence. Given care's complex, dynamic nature, organizations must establish structures and systems to promote the practitioners' success. A modified approach is warranted to optimize the project leader and nurses' effectiveness by recognizing that the consistent practice of nurse leader rounding has not yielded the anticipated service outcomes. With the guidance of the theoretical framework and biblical affirmation, the goals of this project are described in the subsequent section.

Project Objectives and Outcomes

To enhance the patient's perception of the overall hospital rating and nurse leader visiting daily, implementing peer feedback within practice offered a solution toward evolving patient-centered care. This section provides an overview of the targeted objectives and outcomes by implementing peer feedback within the nurse leader rounding structure. The short-term and long-term objectives of the project included:

Short-Term Goals:

1. By December 1, 2022, 80% of nurse leaders will complete nurse leader patient rounding and peer feedback education.
2. By December 31, 2022, 80% of nurse leaders will participate in at least two peer rounding events and peer feedback for each.
3. By December 30, 2022, 80% of nurse leaders will lead one case presentation utilizing the standardized reporting template.
4. By January 31, 2023, nurse leaders will complete daily patient rounding with an overall penetration of 90% over a 1-month timeframe.

Long-Term Goals:

1. By April 30, 2023, the monthly nurse leader rounding score will improve from the pre-implementation baseline measure.
2. In the 1st quarter of 2023 (January 2023- March 2023), HCAHPS performance for the patient's perspective of leader rounding will increase from a baseline 2021 performance year-end (October 2020- September 2021) result of 60.1% to 62%.
3. The organizational overall HCAHPS performance will increase from a 2021 baseline of 4 stars to a 2023 performance of 5 stars.

A phased approach for implementation was deployed, and measures of success were defined in terms of both process and outcome indicators. Ensuring education and competency attainment across the management team was set at 80%. In determining the effectiveness of this quality improvement project, HCAHPS performance compared to baseline outcomes has been analyzed to determine statistically significant signs of improvement. The subsequent section describes the strategies for implementing this evidence-based nursing practice initiative.

Quality Improvement Methods

Implementing peer feedback was the primary strategy for augmenting the nursing practice to mitigate the deficits seen with the patient's perception of the nurse leader visiting daily. This section provides details of the implementation strategies that took place, key stakeholder involvement, and the project timeline. The implementation of peer feedback required several phases to ensure practitioner uptake. Phase 1 included establishing the current practice standard related to daily patient rounding. The next step provided an opportunity for practice with a peer to evolve one's competence. The final phase included a reflection on practice, an opportunity for shared learning, and promoting the leader's confidence in the practice expectation. Additional details of each phase are provided in the subsequent sections.

Phase 1

In line with the NREM and the development of the nurse's experience, knowledge, and skills, the project's first phase included education on the fundamental practice of nurse leader rounding. The project required expanding the manager rounding responsibility to include unit-based managers and managers from shared services. The expanded group included the nursing managers from utilization review, perioperative services, and the quality service line. During phase 1, all managers received didactic education to develop knowledge related to the patient

rounding practice. Upon completing the module, participants engaged in rounding simulation to develop effective rounding practices, service recovery, and staff recognition skills. Validation of the organization's standard competency tool for leader rounding was used as the rubric for demonstrating knowledge acquisition. Upon completion, participants then advanced to peer feedback training.

Phase 2

As aligned with the NREM and further enhancing the leader's skills, the second phase of the project implementation focused on developing nurse manager competency in receiving and providing peer feedback. Evidence for effective peer feedback included evaluating practice against an approved standard, followed by direct communication, including strengths and opportunities as appropriate (Task Force on Peer Review, 1988; Brunson et al., 2020; Haag-Heitman & George, 2011; Lal, 2020). A validation tool was used to ensure consistent execution of the peer feedback process. Utilizing this tool, each participant was validated on their skill of providing peer feedback. While knowledge related to peer feedback is straightforward, practice change represents a challenging cultural shift. In addition to the didactic and simulation-based learning activities, practice change was the primary focus during Phase 3 of the project implementation.

Phase 3

After the conclusion of the education events, Phase 3 consisted of weekly check-ins to debrief the patient rounding and peer feedback experiences. The post-analysis reinforced the interdependent aspect of rounding as outlined in the NREM. The project lead and/or the Care Experience manager facilitated each session. Each manager conducted at least two rounds per week with a peer with the intent of receiving feedback. The weekly check-ins were used to

promote the effectiveness of the joint rounding episodes. Galatians 6:9 guided the necessity for recognizing that managers may be experiencing skepticism with another revised attempt at maximizing the impact of leader rounding. The opportunity to debrief struggles and successes created a community of support and shared persistence to achieve their unifying goal of improving patient satisfaction results.

Each session started with a review of the data related to the number of rounds completed by each manager and preliminary post-discharge satisfaction scores. Using a standard reporting tool, managers presented one case to their colleagues. The case presentation included a brief synopsis of the patient, pertinent case complexities, a summation of the manager's self-assessment of their rounding, and two to three items learned from peer feedback. The final element of the summary included two to three takeaway messages as a result of the patient interaction. This feedback informed the primary manager and their peers about how to incorporate change into future rounds. The details included system challenge identification, staff recognition, and other valuable information to enhance the overall service provided to our patients. After the participants completed Phase 3, the program was considered fully implemented, and the post-implementation patient satisfaction results were monitored to evaluate effectiveness. Project implementation would not have been possible without essential stakeholder engagement.

Stakeholder Engagement

Implementing a quality improvement project requires the engagement of key organizational stakeholders. The team must be diverse and representative of individuals who can influence the success or inhibition of the project aim (Stucky et al., 2022). In addition to the leaders who participated in this quality improvement project, other key stakeholders included the

Senior Vice President (SVP), service line leaders, and content experts. From an executive sponsor perspective, the SVP promoted engagement with leader-patient rounding amongst all leaders and endorsed two hours of protected time daily for this practice. Throughout this project, content experts were utilized in all phases of development, implementation, and data monitoring. As a final highlight to implementation, expanding the rounding responsibility to include ancillary services was novel and required service line leader endorsement for participation. Through the executive and service line leader commitment to the project, participation was mandated for all involved nursing leaders as a performance expectation. The following section outlines the timeline of project events.

Timeline for Activities

Upon receiving confirmation from the organization and academic Institutional Review Board of the exempt nature of the project, implementation began in September 2022. Phase 1 of leader rounding education dates occurred on September 20, October 31, November 18, and November 29, 2022. Phase 2 peer feedback education occurred on November 7 and December 1, 2022. As the final implementation phase, case presentations took place weekly from November 11 through December 30, 2022. After completing all interventions, the post-implementation data evaluation occurred by monitoring patient satisfaction response scores.

Data Collection

The organizational performance of the post-discharge patient satisfaction survey determined the overall effectiveness of the project. While HCAHPS performance is the ultimate dataset of interest, evaluation of an interim measure provides the basis for determining impact. Due to CMS processes, the organization does not receive the results of these performance evaluations until 10 to 12 weeks from the patient's discharge (U.S. Centers for Medicare &

Medicaid Services, 2021). The delay in receiving these measures limits the ability to trend post-implementation performance within the project's scope and will continue to be monitored for long-term impact. The organization utilizes a “Real-time” (RT) surveying process as a leading indicator of overall HCAHPS performance. The subsequent section provides an overview of the data collection and analysis deployed throughout this project to measure implementation effectiveness.

In addition to being an approved HCAHPS vendor, the National Research Corporation (NRC) offers clients RT surveying support. NRC worked with this 264-bed acute care facility to stratify a process for meeting the CMS HCAHPS mandate and reserving the remaining patient visits for surveying through the RT platform. Patients can only participate in one of these surveys, and randomization occurs to ensure a representative sample (U.S. Centers for Medicare & Medicaid Services, 2021; Winchell & DeMers, 2022). The RT outcome performance is the primary basis for measuring the effectiveness of the quality improvement project.

Randomly selected patients are invited to participate in a post-hospitalization survey through the RT platform one to two days after discharge. The initial contact is made via text message. Without a response within 24 hours, the patient is sent an email inviting participation in the survey. A final attempt is made by placing an interactive voice response call to the patient. The links stay active for 14 days after the initial attempt at contact. Appendix A lists the survey questions consisting of 19 scaled queries and one open-ended inquiry. Once the patient completes the information, NRC tabulates the weighted responses and avails aggregate data to the organization within 24 to 48 hours from the patient's response (Winchell & DeMers, 2022).

The monthly performance for two questions was tracked for effectiveness: 1) “Using any number from 0 to 10, where 0 is the worst hospital possible, and 10 is the best hospital possible,

what number would you use to rate this hospital?” and 2) “Did a nurse leader visit you daily during your stay?” The first question is marked affirmative for a score of nine or ten and null for anything less. The patient can respond on a 4-point Likert scale regarding the second question, including no, yes somewhat, yes mostly, or yes definitely. Utilizing the top-box methodology, the “yes definitely” response is tabulated as affirmative, and the remaining answers are null. Both questions yield a percent positive performance and a percentile ranking (Winchell & DeMers, 2022).

The project facilitator and data analyst obtain aggregate reports using the NRC Health System Dashboard. Organization and unit-level data were abstracted at monthly and quarterly intervals. Additionally, data was viewed utilizing the top-box methodology reported in percentage and percentile performance. While the survey does not equate to the organization’s HCAHPS performance, NRC promotes a high correlation between the RT and HCAHPS data sets (Winchell & DeMers, 2022).

Analysis of outputs occurred throughout the project implementation. It included: 1) education completion on the patient rounding standardized practice, 2) education completion related to receiving and providing peer feedback, 3) participation in case presentation activities, and 4) performance data monitoring. Attaining greater than 80% compliance with leader participation in all implementation phases and improving patient satisfaction scores equate to successful practice change. The next section provides an overview of the resources required for the execution of the quality improvement project.

Finances and Resources

Implementing peer feedback with the nurse leader's patient rounding practice requires minimal organizational budgetary allocation. Table 7 illustrates the budget summary necessary

for this project and includes the resources and potential revenue generated. Significant endorsement and dedication of time were essential to ensure the successful implementation of the defined activities. Regarding resource allocation, administrative time was necessary for developing and facilitating the project activities. Nurse managers attended two education sessions, each approximately two hours in duration. Twenty-five nurse managers were included in the participant group. Additionally, managers participated in at least four weekly meetings lasting 60 minutes each. For the development of the program and implementation of education, the total investment is estimated to cost approximately \$16,600. More significant than the confined episodes defined above, endorsement of the expanded nurse leader rounding expectation impacted some managers' responsibilities.

While unit-level nurse managers were accustomed to the accountability of daily patient rounding, including nursing managers from other services represents a novel approach within the organization. Executive and service line leader endorsement of the expanded accountability was necessary for successful deployment. In addition to the time identified above, the additional manager involvement from three different service lines equates to approximately 1040 hours per year. Prioritizing time from an already busy management team required re-evaluating and reassigning or abandoning other responsibilities. Over the first year of enhanced daily leader patient rounding, program costs are estimated to be \$477,640. While the accumulative spend on the project remains nominal when considering the total hospital budget, prioritization of time must not be an under-estimated commodity.

This investment's potential return includes reducing patient complaints, increasing reimbursement through the value-based purchasing structure, and increasing patient membership. While complaint mitigation is anticipated to be immediate, improved reimbursement and market

share are projected to occur during project implementation's second and third years. The organization's executive leadership provided the estimates used to derive the potential gains as the literature is sparse to monetize the direct financial impact from elevating the overall HCAHPS summary star performance. Mitigating the cost of project implementation, the total projected net revenue after three years of project implementation is estimated to be just over 3.6 million dollars. The anticipated project impact is financially beneficial and aligns with the organization's mission of providing high-quality, affordable healthcare services to the communities served.

Final Results and Outcome Analysis

Upon completion of the implementation phases of the project, four months of post-implementation data were monitored and analyzed to reveal the preliminary intervention effectiveness. Within this section is a discussion of the results, attainment of goals, unanticipated consequences, and influence of the theoretical framework and faith integration on the project outcomes.

The ultimate measure of effectiveness is the impact of the patient's perspective as measured by the standardized post-hospitalization satisfaction survey. Due to the regulatory surveying processes, sufficient time has not passed to utilize the HCAHPS results. The RT survey data has been analyzed to determine improvement from the baseline performance. Table 8 displays the overall hospital rating from the perspective of the patient for four different samples: Hospital Level ($N = 1,314$), Critical Care Service ($n = 207$), Medical/Surgical/Telemetry ($n = 783$), and Maternal Child Health ($n = 314$). Ratings were given on a 0-10 scale, with 0-8 being the low group and 9-10 being the high group. These two groups were compared for the pretest period (September through December) to the post-test group (January through April). Inspection

of the table found none of the four chi-square tests to be significant at the $p < .05$ level (see Table 8).

Table 9 displays the nurse leader ratings from the perspective of the patient for four different samples: Hospital Level ($N = 1,236$), Critical Care Service ($n = 190$), Medical/Surgical/Telemetry ($n = 743$), and Maternal Child Health ($n = 293$). Ratings were given on a four-point Likert scale, with *yes, definitely* being the high group and all three lower ratings being the low group. These two groups were compared for the pretest period (September through December) to the post-test group (January through April). Inspection of the table found none of the four chi-square tests to be significant at the $p < .05$ level (see Table 9). While the measure of interest does not reveal significant improvement, several benefits for the project implementation have been realized.

Short-Term goal attainment was realized for the unit-level nursing managers with some limitations experienced by the nursing leaders from alternate services. All participants in the identified cohort completed nurse leader patient rounding education and peer feedback competency and participated in at least two peer feedback rounding events. This education and practice initiative resulted in 92% completion of patient rounding for January 2023. Monthly rounding drifted during the subsequent months, with completion of 79% to 83% for February through April.

Additionally, the service line leaders for the utilization review and quality service lines determined that their routine participation in leader rounding was not sustainable and opted out of the practice. Due to this changed agreement, only the unit-level nursing managers completed the case presentation objective by sharing what each learned with their peers. While out-of-scope for this project assessment, HCAHPS will be utilized to gauge the overall impact and attainment

of the defined long-term goals. A review of the SWOT analysis reveals factors of success and challenges toward realizing improvement in patient satisfaction scores.

The most significant influence on the success and challenges of the project was organization-level buy-in from the executive-level leaders. At the beginning of the project, the total commitment was secured with an endorsement of participation from an expanded leader group. Because of the change in the Senior Vice President and Chief Nurse Executive, organizational priorities shifted, and the rounding team reverted to the department-level nursing managers. While this represents a short-term setback, system-level goals have been established to extend patient rounding to the ancillary support and non-nursing managers. The nature of the mandate improves the proactive touchpoints with the patient to improve the experience from a system-level perspective instead of nursing alone. Leveraging a theoretical framework and biblical perspective continues to serve this quality improvement project.

Despite the impeded improvement in post-implementation satisfaction scores, my faith provides reassurance that the persistent drive for enhancement will lend positive results. Merging the NREM with the belief in serving others inspires continuous improvement. Within the NREM, an emphasis on structure and process for attaining quality patient outcomes guides further exploration of organizational resources. Expanding future patient rounding to include non-nursing leaders is an alternate way of creating an interdependent team approach to enhancing the patient's experience. The next section describes how the project contributes to nursing practice, education, and research.

Implications for Practice

With the findings of this quality improvement project, nursing leaders and educators can apply the findings of this project to further refine nursing professional practice and patient

satisfaction with their experience in the acute care setting. To illustrate subsequent application, this section includes a description of the findings concerning nursing practice and quality outcomes, a proposed enhancement for professional education, and a recommendation for future research related to the application of peer feedback amongst nursing managers.

Despite the successful implementation of enhanced education and the promotion of a peer-based learning environment, perceptions of the patient were not impacted with performance sustained at the current level. Critical factors for further enhancing this practice include engaging a patient advisor group to provide insight into future practice modifications and including leaders outside the unit-level managers. While this strategy was initially secured, the total commitment was not achieved. With future models, engaging executive leaders in this practice will communicate the importance of this strategy across the entire organization. While peer feedback remains a crucial strategy in evolving nursing practice, additional research will further inform optimized performance for nursing managers concerning the patients' perception of hospitalization.

As a result of this quality improvement strategy, three areas to evolve knowledge have emerged: approaches to peer feedback for nursing managers, executive-level engagement in patient satisfaction improvement strategies, and understanding the strength in the correlation between the RT and HCAHPS patient surveying approaches. Of the literature synthesized only four of the 31 articles reviewed included the nurse manager's perspective for peer feedback. Further evidence is needed to assess and define practical approaches for deploying peer feedback amongst this nursing population. In addition to adding to the nursing practice knowledge related to managerial competencies, the role of executive endorsement and survey correlational factors must be addressed.

The success of this quality improvement project largely hinged on the executive leader's enforcement of this practice imperative and the use of the RT survey as a leading indicator for overall performance. Both of these factors changed during the implementation phase. Future success may be enhanced through securing written service-level agreements with a time stamp for participation and re-negotiation. Furthermore, while the expert consultant from the vendor who administers both HCAHPS and RT reported a correlation in the findings of the two surveys, this has not been substantiated during the first year of RT survey implementation. Independent analysis is required to gauge the correlation of outcomes from both surveys before future implications of intervention effectiveness can be demonstrated.

Recommendations

Attaining exemplary patient satisfaction as measured through standardized post-hospitalization surveying remains an organizational and industry-wide imperative for achieving high-quality care, maximized reimbursement, and enhanced market share (Al-Amin et al., 2018; Quigley et al., 2021). While individual attention to aspects of the survey, such as refining the approach to the nurse leader daily rounding, did not reveal impact, a system-wide strategy may lend additional traction toward achievement of this quality improvement aim. From the findings of this intervention, acute care facilities ought to deploy systems to support expanded leader patient rounding to discover driving and impeding factors for overall satisfaction. Additionally, extending this intervention beyond the scope of nursing and including other leaders across the interdisciplinary care team will aid in rapidly understanding system strengths, opportunities, mitigating strategies, individual contributor recognition, and timely service recovery. True exemplary patient satisfaction is possible by shortening the time to receive patient feedback to in-time and taking action from an individual and system approach.

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Table 1

Strengths, Weaknesses, Opportunities, and Threats

	Positive	Negative
Internal	<p>Strengths</p> <ul style="list-style-type: none"> • Best practice (standard) defined • >90% of current leaders have completed training in the previous 18 months (includes managers and charge RNs) • Established dedicated rounding time • Nursing leaders exhibit a high level of agreement in the benefits of conducting rounds (the why) • Long-term trended data available at the unit and hospital level specific to nurse leader patient daily rounding • Senior leader support 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Inconsistent hospital-wide priority for dedicated rounding time (meetings frequently scheduled 10- 1200) • Significant variability in performance at the unit and hospital level from month to month • Several leader rounding initiatives have occurred with immediate success, but sustainability has not been achieved. This may result in skepticism • Variation in practice exists from leader to leader • Poor tracking system results in limited data abstraction • Senior Vice President and Chief Nurse Executive personnel changes
External	<p>Opportunities</p> <ul style="list-style-type: none"> • Survey vendor offers support for this practice • Historically strong overall patient satisfaction when compared to the national benchmark. Overall rating of 4 stars • Strong brand identity • Access to an expert consultant to promote care experience strategies • Higher than average patient response rate • Diverse leadership team and diverse community served • Strong culture of service • Mission for community impact 	<p>Threats</p> <ul style="list-style-type: none"> • KP System-wide initiatives tend to override local priority setting • KP system changed the post-discharge survey process & question related to daily nurse leader rounding • Staff fatigue due to priority overload • Regulatory needs (upcoming announced and unannounced surveys) • Nurse leader burnout and turnover • Area hospitals (competitors) have significant care experience programs in place. • Competitors leveraging real-time surveys for rapid improvement.

Table 2*Hospital-level Patient Satisfaction Data by Performance Year*

	Overall	Leader Rounding
	Topbox (Percentile)	Topbox (Percentile)
2017	82.8 (86 th)	60.2 (91 st)
2018	82.8 (86 th)	59.5 (89 th)
2019	81.9 (84 th)	58.8 (84 th)
2020	82 (84 th)	59.3 (88 th)
2021	81.3 (85 th)	59.8 (90 th)

*Data presented as performance year October 1 through September 30.***Table 3***Critical Care Service Line Patient Satisfaction Data by Performance Year*

	Overall	Leader Rounding
	Topbox (Percentile)	Topbox (Percentile)
2017	82.2 (86 th)	53.4 (36 th)
2018	83.4 (88 th)	59.7 (90 th)
2019	80.1 (81 st)	55.7 (61 st)
2020	81.7 (84 th)	56.4 (63 rd)
2021	80.7 (83 rd)	57.4 (77 th)

Data presented as performance year October 1 through September 30.

Table 4*Surgical Service Line Patient Satisfaction Data by Performance Year*

	Overall	Leader Rounding
	Topbox (Percentile)	Topbox (Percentile)
2017	85.5 (85 th)	59.7 (82 nd)
2018	87.1 (89 th)	61.2 (89 th)
2019	86.3 (87 th)	57.9 (80 th)
2020	86.7 (88 th)	60.6 (88 th)
2021	84.1 (82 nd)	59.8 (85 th)

*Data presented as performance year October 1 through September 30.***Table 5***Medical Service Line Patient Satisfaction Data by Performance Year*

	Overall	Leader Rounding
	Topbox (Percentile)	Topbox (Percentile)
2017	81.1 (91 st)	55.4 (88 th)
2018	80.7 (90 th)	54.8 (82 nd)
2019	79.7 (87 th)	55.4 (88 th)
2020	82 (92 nd)	54.9 (82 nd)
2021	83.7 (94 th)	58.7 (95 th)

Data presented as performance year October 1 through September 30.

Table 6*Maternal Child Health Patient Satisfaction Data by Performance Year*

	Overall	Leader Rounding
	Topbox (Percentile)	Topbox (Percentile)
2017	80.6 (72 nd)	70.2 (79 th)
2018	77 (53 rd)	64.6 (52 nd)
2019	77.6 (58 th)	66.2 (59 th)
2020	75.2 (46 th)	65.4 (55 th)
2021	70.9 (24 th)	62.4 (12 th)

Data presented as performance year October 1 through September 30.

Table 7

Budget Summary

Description/Category	Explanation	Cost Breakdown	Total Cost
Labor	Curriculum development will take Care Experience Manager ~24 hours	\$70/hr X 24 hours	\$1,680
	Session facilitation, Care Experience Manager	\$70/hr X 8 hours	\$560
	Session facilitation, Project Manager	\$50/hr X 8 hours	\$400
	Education event, manager participation	\$70/hr X 4 hours X 25 managers	\$7,000
	Weekly meeting for progress validation	\$70/hr X 4 hours X 25 managers	\$7,000
	Annual investment for the completion of patient leader rounding expectation include 1 hour per workday per manager	\$70/hr X 260 hrs/ year X 25 managers	\$455,000
		Cost Subtotal	\$471,640

Description/Category	Explanation	Reimbursement Breakdown	Total Cost
Reimbursement	CMS Value-Based Purchasing Estimated ↑ reimbursement years 2 &3	\$500,000 per year	\$1,000,000
	Increased membership: Membership increase of 5,000 ~ \$2,000,000 Anticipated increase in years 2 & 3	\$2,000,000 per year x 2 years	\$4,000,000
		Subtotal	\$5,000,000
Labor	Patient complaint processing: 5% reduction in complaints. Average cost per processing \$1000/ comment. ~2 complaints per month for year 1 ~1 complaint per month for year 2 & 3	(\$1000 x 24 comments) + (\$1000 x 12 comments) + (\$1000 x 12 comments)	\$48,000
		Subtotal	\$48,000
		Grand Total	\$5,048,000

Expenses			Returns		
Year 1	Subtotal	\$472,740	Reimbursement	Subtotal	\$5,000,000
Year 2	Subtotal	\$455,500	Labor	Subtotal	\$48,000
Year 3	Subtotal	\$455,500		Total	\$5,048,000
	Total	\$1,383,740			

Net Profit	\$3,664,260
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Table 8*Hospital Rating*

Unit	Time	Overall Hospital Rating			
		0 to 8		9 to 10	
		<i>n</i>	%	<i>n</i>	%
Hospital Level (<i>N</i> = 1,314) ^a					
	1. Pretest	191	28.7	475	71.3
	2. Posttest	159	24.5	489	75.5
Critical Care Service (<i>n</i> = 207) ^b					
	1. Pretest	29	24.8	88	75.2
	2. Posttest	25	27.8	65	72.2
Medical/Surgical/Telemetry (<i>n</i> = 783) ^c					
	1. Pretest	98	25.8	282	74.2
	2. Posttest	85	21.1	318	78.9
Maternal Child Health (<i>n</i> = 314) ^d					
	1. Pretest	62	38.5	99	61.5
	2. Posttest	48	31.4	105	68.6

^a $\chi^2(1, N = 1,314) = 2.88, p = .09$, Cramer's *V* = .05.

^b $\chi^2(1, n = 207) = 0.24, p = .63$, Cramer's *V* = .03.

^c $\chi^2(1, n = 783) = 2.41, p = .12$, Cramer's *V* = .06.

^d $\chi^2(1, n = 314) = 1.76, p = .19$, Cramer's *V* = .08.

Table 9*Nurse Leader Rounding Rating*

		Nurse Leader Rounding			
		Lower Rating		Yes,	
Definitely					
Unit	Time	<i>n</i>	%	<i>n</i>	%
Hospital Level (<i>N</i> = 1,236) ^a					
	1. Pretest	222	35.4	405	64.6
	2. Posttest	225	36.9	384	63.1
Critical Care Service (<i>n</i> = 190) ^b					
	1. Pretest	40	36.7	69	63.3
	2. Posttest	31	38.3	50	61.7
Medical/Surgical/Telemetry (<i>n</i> = 743) ^c					
	1. Pretest	128	35.8	230	64.2
	2. Posttest	144	37.4	241	62.6
Maternal Child Health (<i>n</i> = 293) ^d					
	1. Pretest	51	33.6	101	66.4
	2. Posttest	49	34.8	92	65.2

^a $\chi^2(1, N = 1,236) = 0.32, p = .57, \text{Cramer's } V = .02.$

^b $\chi^2(1, n = 190) = 0.05, p = .82, \text{Cramer's } V = .02.$

^c $\chi^2(1, n = 743) = 0.22, p = .64, \text{Cramer's } V = .02.$

^d $\chi^2(1, n = 293) = 0.05, p = .83, \text{Cramer's } V = .01.$

Appendix A*National Research Corporation Health: Real-time Survey Questions*

Question	Scale
*Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital?	Rate 0-10
How likely would you be to recommend this hospital to your family and friends?	
Did nurses treat you with courtesy and respect?	No, Yes somewhat, Yes mostly, Yes definitely
Did nurses listen carefully to you?	
Did nurses explain things in a way you could understand?	
Did you have confidence and trust in the nurses treating you?	
Did the staff do everything they could to help you with your discomfort?	
Did you have enough input or say in your care?	
Were you comfortable talking with nurses about your worries or concerns?	
*Did a nurse leader visit you daily during your stay?	
Did the doctors treat you with courtesy and respect?	
Did the doctors listen carefully to you?	
Did the doctors explain things in a way you could understand?	
Were the different doctors and nurses consistent with each other in providing information about your care?	
After you pressed the call button, did you get help as soon as you wanted it?	
Was a family member or friend allowed to be involved in your stay as much as you wanted?	
Before giving you any new medicine, did care providers describe possible side effects in a way you could understand?	
Was the environment clean and comfortable?	
Did you get information in writing about what symptoms or health problems to look out for after you left?	
What else would you like to say about your experience?	Open Question

*Question serves as the basis of review for the quality improvement project.