CE Home Study Course

Scripting and Rounding
Impact of the Corporate Care Model on RN Autonomy and Patient Advocacy
This home study CE is part one of a two-part series. Look for the second installment and the CE quiz to appear in the next issue of National Nurse.

Description

This home study course examines the impact of scripting and rounding on the autonomous practice of registered nurses that interferes with their critical role as patient advocates. Scripting and rounding schemes are being aggressively marketed, incentivized, and implemented in a variety of acute-care and outpatient settings using deceptively reassuring terms on embracing change, transforming care at the bedside, and increasing customer satisfaction designed to create and influence the public’s “perception” of quality.

It describes a new restructuring model for nursing, which is aimed at deskilling and automating RN interactions with patients. Under these new schemes, patient outcomes are secondary to patient satisfaction scores based on consumer service and hospitality as practiced by companies such as Disney and five-star hotels. These schemes are being mandated by hospital policy over the objections of direct-care RNs despite the fact that there is a dearth of evidence linking patient satisfaction to positive clinical healthcare outcomes.

Objectives

Upon completion of this home study RNs will be able to:

- Articulate their major advocacy role in the delivery of safe, therapeutic, and effective patient care where the patients’ individual healthcare needs, interests, and wishes are respected and protected.
- Explain the potential of protocols and patient interaction scripts for replacing individualized human interaction in the delivery of healthcare.
- Describe how rounding, scripts, and rigid protocols can supplant critical thinking and override the independent professional clinical judgment of registered nurses.
- State why safe staffing with specific, numerical RN-to-patient ratios, and the requirement that hospitals staff up from the minimum based on individual patient acuity, is an evidence-based practice that improves patient outcomes, results in cost-savings, and increases both patient and nurse satisfaction that allows direct-care RNs to be in control of the nursing process.

Background

In 1996 the Institute of Medicine (IOM) issued a report that recognized the importance of determining appropriate nurse-to-patient ratios. The IOM’s analysis of staffing and quality of care in hospitals concluded by calling for “a systematic effort” (on a national level) to collect and analyze relevant data for the purposes of informing and developing public policy.

According to research funded by the Agency for Healthcare Research and Quality (AHRQ) hospitals with low nurse staffing levels tend to have higher rates of poor patient outcomes. Numerous other studies have found that patients in short-staffed hospital units are more likely to have higher rates of hospital-acquired illnesses and adverse outcomes, such as pneumonia, upper gastrointestinal bleeding, urinary tract infections, shock, longer hospital stays, and failure to rescue. “Failure to rescue” is defined as the death of a patient with a life-threatening complication for which early identification by nurses and medical and nursing interventions can influence the risk of death.

As of March 2004, the largest of these studies on nurse staffing, (jointly funded by AHRQ, the Health Resources and Services Administration, the Centers for Medicare and Medicaid Services and the National Institute of Nursing Research) found the following:

In hospitals with high RN staffing, medical patients had lower rates of five adverse event outcomes.
- Major surgery patients in hospitals with high RN staffing had lower rates of UTIs and failure to rescue.
- Higher rates of RN staffing were associated with a 3 to 12 percent reduction in adverse outcomes.
- Higher staffing at all levels of nursing was associated with a 2 to 25 percent reduction in adverse outcomes, depending on the outcome.

Three AHRQ-funded studies found a significant correlation between lower nurse staffing levels and higher rates of pneumonia. Another study, funded jointly by AHRQ and the National Sciences Foundation, examined the relationship between nurse staffing and hospital patient acuity (the average severity of illness of the inpatient population). Acuity determines how much care a patient needs: the higher the acuity, the more care is required. This study found:

- A 21 percent increase in hospital patient acuity between 1991 and 1996.
- A total decrease of 14.2 percent in the ratio of licensed nursing staff to acuity-adjusted patient days of care because of the increase in patient acuity.
- The skill mix of nursing staff shifted, and as a result, RNs were forced to take on additional supervisory responsibilities that took them away from the bedside at a time when their patients needed more nursing care.

Concerns that have arisen from increased patient acuity and increased workload appear to be directly related to job dissatisfaction expressed by nurses in a variety of research studies.

These reports were developed and written by outside research and academic organizations designated as Evidence-based Practice Centers, and are based on rigorous, comprehensive reviews of relevant, peer-reviewed scientific literature. The AHRQ’s goal in sponsoring these reports was to provide the scientific foundation that public and private organizations can use to improve the quality and delivery of healthcare services.

Although inadequate staffing places a heavy burden on nurses and adverse events are painful for patients, there is a considerable financial burden as well. Another AHRQ study found that all adverse events (pneumonia, pressure ulcer, UTI, wound...
infection, sepsis, patient fall/injury, and med/drug events) were associated with increased costs. For example, the cost of care for patients who developed pneumonia while in the hospital rose by 84 percent. The length of stay increased by 5.1-5.4 days, and the probability of death rose 4.67-5.5 percent (Cho, Ketefian, Barkauskas, et al., 2003).

Hospitals have pursued a number of strategies to limit costs and increase revenue by reducing their RN staff and replacing them with unlicensed assistive personnel. McCue, Mark, and Harless conducted a study published in 2003 that examined the relationship between nurse staffing, quality of care, and hospital financial performance. The researchers found a statistically significant increase in operating costs when hospitals increased their staffing of RNs, but no statistically significant decrease in hospital profit, suggesting that the cost-benefit of reduced complications and length of stay offsets the additional cost incurred by increasing the ratio of the RN staff.

The Institute of Medicine: From Safety to Quality. How did we get here from there?

IN 1999 THE IOM COMMITTEE ON QUALITY OF HEALTHCARE IN AMERICA published its landmark report, “To Err is Human.” The IOM reframed medical error as a chronic threat to public health. One of the report’s main conclusions is that the majority of medical errors do not result from individual recklessness or the actions of a particular group – this is not a “bad apple” problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them. For example, stocking patient-care units in hospitals with certain full-strength drugs, even though they are toxic unless diluted, has resulted in deadly mistakes.

Thus, mistakes can best be prevented by designing the health system at all levels to make it safer – to make it harder for people to do something wrong and easier for them to do it right. Of course, this does not mean that individuals can be careless. People still must be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.

The IOM committee followed its initial report 18 months later in 2001 with a second report titled, “Crossing the Quality Chasm.” The Quality Chasm report broadly implied that patient safety is only part of a larger picture. Indeed, in a theoretical opinion article titled, “A User’s Manual for the IOM’s ‘Quality Chasm’ Report,” Dr. Donald Berwick stated the second report was “even more important because it deals with the entire terrain of concerns about healthcare quality.” He further opined that “to the serious student of healthcare quality and the serious leader of needed change, it signals the possible dawning of a new and persistent sense that the U.S. healthcare system’s performance in many dimensions, not just safety, is unacceptably far from what it should be.” In bold print under the title of the article, Berwick asserts, “Patients’ experiences should be the fundamental source of the definition of quality.”

How reliable is a check list?

IN 2002, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) formed a partnership with the AHRQ to develop, test, and seek endorsement of a nationally standardized survey tool and methodology for such data collection that would allow “valid” and credible practical comparisons to be made among hospitals locally, regionally, and nationally. Over the years many hospitals have collected information on patient satisfaction for their own proprietary use for quality control, marketing, and advertising purposes. Although many hospitals administered their own surveys or were already working with survey vendors to design and administer a patient satisfaction survey as part of their own internal quality improvement efforts, the questions and methodologies were customized and did not allow comparison across hospitals.

AHRQ published a Federal Register notice on July 24, 2002, soliciting the submission of existing instruments measuring patients’ perspectives on care. The notice of request for measures closed on September 23, 2002. The seven submissions received were reviewed rigorously by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) II Grantees (AIR, Rand, and Harvard).

Three criteria were considered in reviewing the submissions: 1) Does the instrument capture the patients’ perspectives on care in acute-care and/or hospital settings?; 2) Does the instrument demonstrate a high degree of reliability and validity?; and 3) Has the instrument been widely used, not just in one or two research studies or local hospital settings?

In January 2003, AHRQ submitted to CMS a draft HCAHPS instrument that consisted of 66 questions. AHRQ drew upon the seven surveys submitted by vendors, a comprehensive literature review, and earlier CAHPS work to develop the HCAHPS instrument. Most reviewed studies of hospital patient satisfaction used institution-specific measures rather than a standard instrument.

The instruments reviewed included the HCA Patient Judgments System Questionnaire/Nashville Consulting Group Survey; the Comprehensive Assessment of Satisfaction with Care Instrument; the SERVQUAL; the Press Ganey Survey, and several privately prepared instruments. In instances when AHRQ drew upon items in existing surveys from vendors, it made material changes, modifying wording and changing the response sets. The instrument that was developed to meet the need for publicly reporting patient perspectives on care information is called Hospital CAHPS, or HCAHPS.

In 2003, CAHPS II investigators and the Agency for Healthcare Research and Quality (AHRQ) performed an empirical analysis of the HCAHPS pilot data of hospital patients’ perspectives of care to evaluate the degree to which these experiences corresponded with the Institute of Medicine’s (IOM’s) nine domains of care: respect for patient’s values; preferences and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support; involvement of family and friends; transition and continuity; and access to care.

While some of the survey items correlated strongly with this hypothesized domain or composite in pilot studies, it became clear that the general hypothesized structure was inconsistent with the observed data. Based on analyses of the data and stakeholder suggestions, a revised HCAHPS survey was produced that consists of questions assessing seven internally developed domains of care: (1) nurse communication; (2) nursing services; (3) doctor communication; (4) physical environment; (5) pain control; (6) communication about medicines; and, (7) discharge information.

The revised survey also includes global rating items for nursing
care, doctor care, and hospital care. A single item is also included that assesses whether or not the patient would recommend the hospital to family and friends. The seven composites had a median internal consistency reliability of 0.69 and a median hospital-level reliability of 0.74 in the pilot study. In addition, these reporting composites were significantly associated with global ratings of the hospital and willingness of patients to recommend the hospital to family and friends.

In May 2005, the final 27-item HCAHPS survey was endorsed by the National Quality Forum (NQF), a national organization that purportedly represents the interests of consumer groups, professional associations, purchasers, federal agencies, and research and quality organizations. In December 2005 the federal Office of Budget and Management gave final approval for the national implementation of HCAHPS for public reporting purposes.

**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**

The HCAHPS is a standardized, publicly reported nationwide survey of patients' perceptions of their hospital experience that was intended to produce data that allows “objective and meaningful” comparisons of hospitals on topics that are important to consumers. The three broad goals of the HCAHPS survey are:

- **to produce data** about patients’ perspectives of care.
- **to encourage new incentives for hospitals** to improve quality of care through public reporting of the results.
- **to enhance accountability in healthcare** by increasing transparency, (through public reporting of consumer satisfaction perceptions), of the quality of hospital care provided in return for public investment.

Hospitals implement HCAHPS under the auspices of the Hospital Quality Alliance (HQA), a private/public partnership that reportedly includes major hospital and medical associations, measurement and accrediting bodies, government, consumer, and other stakeholders with an interest in improving hospital quality. The survey, its methodology, and the results it produces are in the public domain.

The enactment of the Deficit Reduction Act of 2005 created an additional incentive for acute-care hospitals to participate in HCAHPS. Since July 2007, hospitals subject to the Inpatient Prospective Payment System (IPPS) annual payment update provisions (“subsection (d) hospitals”) must collect and submit HCAHPS data in order to receive their full IPPS annual payment update. IPPS hospitals that fail to publicly report the required quality measures, which include the HCAHPS survey, may receive an annual payment update that is reduced by 2.0 percentage points. Non-IPPS hospitals, such as Critical Access Hospitals, may voluntarily participate in HCAHPS.

The recently enacted Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) includes HCAHPS among the measures to be used to calculate value-based incentive payments in the Hospital Value-Based Purchasing program, beginning with discharges in October 2012.

The HCAHPS survey asks discharged patients about their recent hospital stay. The survey contains 18 core questions about the so-called “critical” aspects of their hospital experiences, communications with doctors and nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital environment/patient rooms, pain management, communication about medicines, discharge information, overall rating of the hospital, and would they recommend the hospital to family and friends.

The HCAHPS survey is not restricted to Medicare beneficiaries, and is administered to a random sample of adult patients across medical conditions between 48 hours and six weeks after discharge. Hospitals may use an approved survey vendor, or collect their own HCAHPS data (if approved by CMS to do so). To accommodate hospitals’ preferences, HCAHPS can be implemented by a choice of survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition (IVR).

**If you’re happy and you know it, clap your hands?**

Although the stated aim of the HCAHPS is to produce valid and reliable objective data for hospital comparison, many credible researchers are of the opinion that the number of confounding variables poses a substantial threat to the validity of the data. Experienced medical and nursing researchers know that patients’ perceptions and the subjective interpretation of their experiences can be limited and of little value as a consistent and reliable indicator of quality, due to several uncontrollable variables such as differing levels of cognitive ability, impairment due to illness, injury, clinical condition, and the side effects of therapeutic interventions and medications that may render their responses useless as empirical evidence and for making meaningful comparisons.

And what about the patients who died? It’s a small leap to consider the fact that since those “customers” won’t be coming back, their satisfaction, or lack thereof, with the care they received, is of little concern to the proprietors of hospitality industry schemes. It stands to reason, because what they’re looking for is repeat “business” and customer loyalty based on “satisfaction.” The exception of course, would be the “perception” of the family and friends. Professionals understand that loss and grief is a process that can involve many stages, from shock and numbness, shame and doubt, to anger and frustration.

If families are not “happy” or “satisfied” with the outcome of their loved one’s hospitalization, chances are they might be inclined to go looking for someone to blame; chances are they might even consider filing a lawsuit against the hospital; chances are that a good consumer advocate attorney might lift the lid on the smiles and satisfaction marketing schemes and uncover the fact that the hospital’s RN-to-patient ratios were unsafe, and that subtle signs and symptoms of deterioration were missed due to deliberate short-staffing.

The point being that as nurses, we’re educated, licensed, and experienced to assess whether or not the care we’re able to provide is safe, therapeutic, and effective, and whether or not there are barriers to our ability to apply the nursing process for the exclusive benefit of our patients. Patients and their families are generally not qualified or sophisticated enough to make that determination with regard to true “quality” of care indicators, i.e., whether or not there were sufficient numbers of competent RNs employed and on duty to meet their needs and reduce their risks of suffering preventable complications of their illness, injury, or treatment.

**Ignoring the evidence: Collaboration with industry for profit and control**

Over the past several years, many hospitals have cut costs by reducing their licensed nursing staff in response to declining man-
aged care reimbursement contracts. Other hospitals have cut spending for support personnel, thereby increasing the workload of RNs. One reason for changing nursing processes and systems is to strongly embed management control to ensure the development of behaviors and skills that reflect the institutional business strategy.

Key elements of the restructuring of the hospital environment from a nursing process model to a corporate care model are driven by the economic incentives of institutional providers and the commercial mandates of the healthcare industry. Along with shared governance schemes and new technologies, many hospitals are now introducing scripted “rounding” schemes. These schemes require RN loyalty to the business enterprise. This is hostile to the fiduciary responsibility of the RN to provide care in the exclusive interests of their patients.

For example, the Studer Group, a proprietary proponent of these schemes, published a newsletter/press release article titled “Rounding for Outcomes: How to Increase Employee Retention and Drive Higher Patient Satisfaction.” It’s written by a nurse who is identified as a “Studer Group Coach.” The author states, “While many organizations struggle with issues related to pain management, response to call lights, attention to personal needs, and increasing their sensitivity to patient’s inconvenience, rounding is a powerful way to shape the experience for patients and increase patient perception of care.”

From an evidence-based standpoint, this author has a vested and biased interest in promoting the program. The references for the article used to support her claims are Studer Group press releases, promotional materials, and Press-Ganey opinion surveys from 2000 and 2003.

Other so-called “studies” and articles reviewed on rounding reveal a similar lack of rigorous scholarly study and empirical scientific evidence to support what appear to be preconceived and purported claims of satisfaction and quality outcomes. There are serious concerns about the validity and reliability of rounding/scripting studies due to oversimplification of the conceptual design and inaccurate correlation of questionable “nursing sensitive” indicators to quality patient outcomes, including the use of voluntary, proprietary, and confidential data.

There is a critical lack of systematic and ongoing monitoring and evaluation of the effects of organizational redesign and staffing reconfiguration on patient outcomes. There has been drastic clinical restructuring of nursing processes, and the acuity of patients has been rising steadily for years. Patient care is more complex, causing an increase in nurses’ workloads, especially with the imposition of additional burdens of data collection that is unrelated to initial and ongoing patient assessments, documentation of the actual care provided to the patient, and the evaluation of patient’s response to the treatment, patient education, and nursing advocacy activities.

Research designs can lead to meaningless “findings” if care is not taken in the selection of variables and in avoiding the temptation to assume that because a variable is associated with a particular outcome, that it is therefore a cause of that outcome. The results of several rounding and patient satisfaction “studies” are highly suspect as measures of quality.

It’s important to note that the National Quality Forum (NQF) lists 15 voluntary consensus standards for nursing-sensitive care (standards based on patient outcomes, nursing interventions and system level measures) and consensus-based performance measures for nursing care. A reduction in the patient’s use of call lights is NOT one of them! Undaunted, a number of misguided champions of change have embraced scripting and rounding initiatives and other transforming-care-at-the-bedside initiatives.

In the race to “publish or perish,” several clever and even amusing titles have washed up along the periphery of our nursing literature shoreline like so much debris that’s cast off from the sea of serious and credible research. These papers all but ignore the results of more rigorous scientific studies on the relationship between the significance of increased nurse-to-patient ratios with staffing that is flexed up from the minimums based on patient acuity, and their well-documented impact on improved patient safety, nurse and patient satisfaction, and therapeutic outcomes that address the NQF standards in a more comprehensive and meaningful way.

Most of the published results of rounding and scripting schemes are as substantive as sea foam due to their lack of identification of critical problems such as deliberate short-staffing and its relation to preventable complications and patient deaths, and the implementation of effective solutions, such as increasing the number of direct-care RNs at the patient’s bedside. Below is a selected listing of article titles:

- Ring for the Nurse! Improving Call Light Management
- Hourly Rounding for Positive Patient and Staff Outcomes: Fairy Tale or Success Story?
- Rounding for Outcomes Using Scripts
- Call Light Study: A Summary Abstract from the Studer Group
- You Called? Hourly Rounding Cuts Call Lights
- Rounding for Outcomes: A Practical Tool to Increase Patient and Staff Satisfaction
- Effects of Nursing ROUNDS on Patient Call Light Use, Satisfaction, and Safety
- How to Increase Employee Retention and Drive Higher Patient Satisfaction
- Hourly Rounding: How One Nurse Reduced Call Lights to Almost Zero
- Patient Rounding: A Prescription for Satisfaction

Critical thinking and analysis: Food for thought

Some of the authors of these articles on rounding are refreshingly upfront about the weaknesses and limitations of their findings. Common threads and concerns begin to emerge, and the prudent nurse should be apprised of them in order to more critically and properly evaluate the lofty claims made by proponents and authors with undisclosed biases that are often unsubstantiated. According to one such article by Kocis and Miksch (2007), “A search for written evidence revealed a paucity of literature regarding the direct use of rounding as a strategy.”

Yet another commentary, by Melnyk (2007), with regard to a study titled, “Nursing Rounds and Patient Safety” (Meade, Bursell, and Ketelsen, 2006) is instructive. Melnyk describes a rating system for evaluating the hierarchy of research evidence (Melnyk and Fineout-Overholt, 2005). She encourages clinicians to evaluate the strength of the evidence presented in a study before initiating a change in practice.

A Level I study presents “evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs), or evidence-based clinical practice guidelines based on systematic reviews of RCTs.” Randomized controlled trials are the strongest
design for testing cause and effect relationships. Quantitative study is ideal for testing hypothesis and for hard sciences trying to answer specific questions.

On the other hand, the lowest level on the study design totem pole of hierarchical and qualitative research is a Level VII study, which cites "evidence from the opinion" of the authors or reports of "expert" committees. Qualitative study is a much more subjective form of research in which researchers often allow themselves to introduce their own bias to help form a "more complete" picture. Qualitative research may yield stories or descriptions of feelings and emotions, and the interpretations of research subjects are given weight; there is no attempt to limit their bias.

Scripting, rounding, and patient satisfaction researchers have an apparent preference and attachment to the "less-than-rigorous" form of qualitative study, so their own bias often plays heavily into the results. While qualitative studies have their place, the researchers must have the integrity to disclose their biases, and be forthcoming about the weaknesses and limitations of their study when reporting their findings and making recommendations. A cursory review of the literature demonstrates that many of the recommendations to implement scripting and rounding schemes are not supported by the so-called "evidence" presented by the author(s).

For example, the findings in the 2006 study by Meade, et. al, were listed as follows: "Of the 46 units in 22 hospitals that participated in the (Rounds/Patient Safety) study, data from 19 units in 8 hospitals were excluded from the analysis because of poor reliability and validity of data collection." Melnyk's commentary, (with implications for action in clinical practice and future research), regarding the study by Meade and associates, includes the following statements:

"When assessing whether findings from an intervention study are valid (i.e., as close to the truth as possible), it is important to answer some key questions, including whether: (1) random assignment to study groups was used, (2) the study groups were equal at baseline on key demographic and clinical variables, and (3) all of the subjects were accounted for at the end of the study. This research used a quasi-experimental design that did not randomly assign hospital units to one of the three intervention groups, which resulted in non-equivalent groups at the beginning of the experiment (e.g., patient satisfaction and falls were not equal among the three groups at the beginning of the study). In addition, there was a high attrition rate in this research, (i.e. data from several units were excluded from the analysis), which also threatens the internal validity of this study."

Melnyk generously rates this study as a Level III in terms of strength of design. The question remains as to whether or not it measures what it intends to measure in terms of a relationship between safety and satisfaction.

**HCAHPS is purposely misread and misapplied by the industry**

**The HCAHPS Survey** is a standardized tool that asks discharged patients about their recent hospital stay for purposes of measuring customer satisfaction. However, it is but one of the indicators currently used by CMS that purportedly allows the public to compare hospital quality. The prestigious Institute of Medicine reports have recommended a healthcare culture "that is transparent, open, safe, and honest about its defects and its performance." And, the IOM warns against “toxic financing schemes” and has recommended that CMS establish service area experiments of payment reform as a way to encourage improvement.

Although a greater focus on patient safety has been a trend since the Institute of Medicine’s landmark report in 1999 estimating that 44,000 to 98,000 people die yearly as a result of medical errors, several recent studies have turned the spotlight on nursing as a safety net. When nurses’ workloads are too heavy, safety can too easily become compromised. Can we expect nurses caring for too many patients or working too many hours, and burdened with tasks and data collection schemes, to continue to catch 86 percent of the medication errors made by physicians and pharmacists that they usually intercept before such errors reach the patient?

It has become apparent to many of the critical thinkers among direct-care RNs that some of the presumably well-intended "change agents" out there, in their rush to win their employer’s coveted “early adopter” and “champion of change” badges, are guilty of not using well-constructed pre- and post-implementation studies of therapeutic outcomes to determine whether or not a change in practice and care model delivery is even justified in the first place.

According to Dr. Berwick, “the overall strengths of the IOM’S ‘Quality Chasm’ report lies foremost in its systems view. Rooted in the experiences of patients as the fundamental source of the definition of quality, the report shows clearly that we should judge the quality of professional work, delivery systems, organizations, and policies, first and only by the cascade of effects back to the individual patient and to the relief of suffering, the reduction of disability, and the maintenance of health.”

As the principal caregivers in any healthcare system, nurses are critical to the quality of care patients receive, a fact that is well-documented in multiple well-designed studies. The research on patient morbidity and mortality in relation to RN-to-patient staffing has been published in respected peer-reviewed scientific journals over the course of many years. The evidence is clear and convincing that safe staffing saves lives, but the bottom-line, profit-seeking mentality leads most healthcare employers to ignore the preponderance of evidence. Nurses are fed up while their employers waste time and money on unproven tactics and rounding schemes that nibble around the edge of the problem, while patients’ lives hang in the balance and the careers of direct-care nurses are threatened.

National Quality Foundation (NQF) patient-centered outcome measures include: death among surgical patients with treatable serious complications (failure to rescue); central line catheter-associated blood stream infections and rate of septicemia; ventilator-associated pneumonia for ICU and high-risk nursery patients; urinary catheter-associated urinary tract infections; hospital-acquired pressure ulcers; and falls associated with serious injury. NQF system-centered outcome measures include skill mix and percentage of RNs, LVNs, and number of nurse staffing hours, staffing and resource adequacy, voluntary turnover of staff, and collegiality of nurse-physician relations.

Basic rounding and satisfaction study designs usually tout the success of their programs by casually addressing only one outcome goal, a reduction in the number of reported falls, but results so far are spotty and inconclusive. Because of a failure in the researchers’ ability to address or control for significant confounding variables, the results are not applicable or generalizable. It’s scientifically
invalid to assume that these two measures alone, reduction in falls and increased patient satisfaction scores, could or should serve as a proxy for measuring patient safety and quality-of-care indicators. Any study that boils down quality care to two or three variables that are measurable is highly suspect.

The nursing care process is a highly complex and interdependent process involving many participants and variables. Any meaningful measure of quality should take this into account.

A more holistic and scientific study of patient care which takes into account whether or not the care provided is safe, therapeutic, effective, and beneficial to the patient in terms of measurable physiologic and functional outcomes is clearly a more academic approach to research for determining reliable, valid, useful, replicable, and generalizable findings.

**What is scripting and rounding and where does it come from?**

One of the expensive consultants hired by hospital administrators is called the Studer Group. Its founder and CEO, Quinton “Quint” Studer is described by business news interviewers and in company profiles as a former teacher with a master’s degree in special education. Studer started his career in healthcare as a community relations liaison at a substance abuse hospital in Janesville, Illinois. From there he worked his way up the corporate ladder in a variety of hospital administrative positions to eventually become president of Baptist Hospital, Inc., in Pensacola, Florida.

Studer evidently took his leadership cue from contacts at Southwest Airlines, who told him to “focus on the employees, not the...
patients,” after he was given a project to improve patient satisfaction while employed at Holy Cross Hospital. He made a determination that “nurses needed certain requirements to do their jobs properly,” according to one article. For his first performance improvement and customer satisfaction project, Studer turned to the consultants at Press Ganey. According to the Press Ganey website, “Press Ganey questionnaires are the healthcare industry’s method of choice for collecting patient, employee, and physician perspectives.”

The Studer Group currently markets and sells manuals, scripts, books, and interactive video training courses on the subject of influencing customer satisfaction. The Studer Group’s latest book, The Nurse Leader Handbook: The Art and Science of Nurse Leadership (2010) reads like a Carnegie text on “how to win friends and influence people.” Most, if not all, direct-care nurses would be hard pressed to glean any “art and science” of nursing from its pages. The ego hook for nurse managers comes in the introduction with a flattering sales pitch for his program presented in the book’s forward: “As a nurse leader, you know the ultimate goal is to make sure that every patient has a great experience.” (Emphasis added)

Direct-care nurses know that acute-care hospitals are not vacation destinations where patients go for an “E-ticket” ride to Fantasyland and a thrill-seeking experience! Patients needing medical care in hospitals are at risk of significant complications or death. Patients require sufficient numbers of registered nurses with substantial scientific knowledge, experience, and sophisticated technical skills to meet their needs and to prevent complications of their illness or injury. Patients require RNs to provide, monitor, assess, document, and the patient’s response to treatment.

In terms of “evidence-based science”, the Studer Group book and method appears to fall short. In the introduction he writes, “We know what is in here works. Studer Group doesn’t publish anything on theory, based on hypothesis, or based on thought (as in “We think this is true”). The book is basically the result of being out in the field, watching these tools being implemented, and observing and documenting the outcomes.” Instead of scientific research to test a hypothesis, and controlling for variables using unbiased research observers for data collection, analysis, and interpretation, the book apparently presents self-filling and biased opinion surveys and perceptions as “research” rather than empirical evidence.

This research omits a critical IOM recommendation: taking into account organizational variables. Current research on scripting, rounding, and patient satisfaction schemes employs the most simplistic design; holding everything else constant, change one variable and then see what happens. This may be appropriate in a lab setting where everything else can be held constant. The problem is “holding everything else constant” in the real world of applying the nursing process and providing the art and science of nursing care to patients who are uniquely different. It is impossible because the patient’s characteristics, work and practice environments, organizational financial priorities, and emphasis on technology are constantly changing.

The most desired outcome for the Studer Group is not helping the patient achieve his or her optimal level of health and wellness. The goal is apparently about reducing the number of times patients use their call lights. The major problem with patient call lights is that they constitute a significant (according to Studer’s proponents) source of interruptions in workflow, which leads to a high rate of medical errors.

Indeed, frequent interruptions of nurses are, according to the Institute of Medicine (2003) study, a contributing factor in errors, but patient call lights are not identified or documented as the most significant source of errors attributable to interruptions. Low nurse-to-patient ratios and worker fatigue due to forced overtime and lack of rest and nourishment breaks are, however, highly correlated with an increased risk of patient complications according to several published research studies.

The apparent goal of the Studer scheme is to single out nurses, routinize their communications with patients, and provide unscrupulous employers a means for selectively evaluating (through surveillance) employees’ compliance and competence in implementing the employer’s behavior standards with regards to rounding and customer satisfaction schemes. Such surveillance is an example of the use of technology in restructuring initiatives that override the independent professional judgment of RNs and restrict their RN duty and right to advocate. Rounding and scripting is skill degrading and it is purposely designed to maintain a healthcare industry driven by private interest and to assert paternalistic dominance and control of RN autonomy and ability to individualize the nursing care plan based on the individual healthcare needs of the patient.

Managers are instructed to observe and monitor individual nurses, follow up with patients to validate performance expectations, and, as necessary, have “Critical Conversations” with “HighMiddleLow Performers” (sic) and reward their success or punish their failure in using the “Key Words at Key Times (AIDET *sm*) scripts and “Service Recovery” tasks. Such tasks might include writing an “I’m sorry” note, and/or giving gift certificates for a free meal, free parking, or a massage if the patient or family member is upset and complains that there’s been a perceived delay in staff responsiveness.

Management surveillance, discipline and punishment of direct-care nursing staff for failure to fully comply with the additional burden of the hospital’s imposition of these customer service initiatives and schemes may be construed as a form of harassment which is incongruent with promoting a culture of respect for the nursing process and the intellectual knowledge work of nursing.

CNA/NNOC/NNU nurses who’ve been mandated by their employers to attend the Studer Group’s A.I.D.E.T training have reported that they feel disrespected, insulted, and annoyed at the suggestion that their interactions with patients and families should be scripted. They report the “rounding for outcomes” initiative interferes with their ability to plan, prioritize, and individualize their patients’ care, in accordance with the nursing process. Many nurses are reporting they are being subjected to intimidating, offensive scrutiny and disciplined for not following “the script” or completing the additional survey paperwork in a “timely” manner.

According to the Institute for Safe Medication Practices (ISMP), intimidating and disruptive behavior on the part of management can interfere with nursing care and undermine the culture of safety, leading to increased medication errors. According to The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), the presence of “intimidating and disruptive behaviors” in an organization erodes professional behavior and creates an unhealthy and/or hostile work environment that can lead to a reduction in patient safety. End of Part 1.