The Impact of Nurse Leader Rounding on Staff Nurse Perceptions of the Work Environment

Bobby Bluford
Eric T. Riebsomer

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The Impact of Nurse Leader Rounding on Staff Nurse Perceptions of the Work Environment

by

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and

Eric T. Riebsomer

Project Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Nursing Practice

University of New Mexico College of Nursing

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“The Impact of Nurse Leader Rounding on Staff Nurse Perceptions of the Work Environment”

Bobby Bluford and Eric Riebsomer

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(Member)
Abstract

Effective communication and creating healthy work environments are two significant challenges nursing leaders face daily. When communication is poor and work environments are not healthy, nurses leave organizations, which is costly and disruptive to patients and the organization. The global pandemic caused by the novel coronavirus COVID-19 compounded problems related to poor communication and healthy work environments due to cyclic surges in patient volumes and increased spans of control of nursing leaders. Nursing leaders are challenged to find ways to improve communication with frontline nurses and improve work environments. This project implemented a structured rounding tool for nurse leaders to use to communicate with frontline staff nurses. The project aimed to evaluate nursing staff’s perception of their nurse leaders’ authentic nurse leader qualities and their work environment before and after implementing the structured rounding tool. The project was a quantitative study that used pre- and post-survey data to measure the effect of a nurse leader rounding tool. It provided insight into the challenges faced by nurse managers to support staff nurses and create healthy work environments. Although the intended outcome was not achieved, the processes of the project did identify the need for nurse managers to adapt their leadership during a pandemic to create or maintain meaningful, open communication with their staff nurses and to foster healthy work environments.

**Keywords:** Communication, authentic nurse leadership, healthy work environment, structured rounding, nursing satisfaction, job satisfaction.
Dedication

This scholarly project is dedicated to all those who have been by our sides through this process: our family, friends, classmates, faculty, and co-workers. Your patience and support during this process has been immeasurable. We also dedicate this project to our fellow nurses and nurse leaders. Each of you is amazing in what you do, and you continually strive for what is best for your patients. Especially at the time of this study, the struggles you face may seem never-ending. We as a profession will prevail, and we will continue to be a guiding light to patients, their families, and the communities where we work.
Acknowledgments

We would like to take this opportunity to give special thanks to the people who have shared their guidance, experience, and time to make this project possible.

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To Dr. Penny Beattie, thank you for your support and commitment to allowing us to engage your organization with our scholarly project.
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<th>Description</th>
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<tbody>
<tr>
<td>AACN</td>
<td>American Association of Critical Care Nurses</td>
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<tr>
<td>ANL</td>
<td>authentic nurse leadership</td>
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<tr>
<td>ANLQ</td>
<td>Authentic Nurse Leadership Questionnaire</td>
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<tr>
<td>CE-HWES</td>
<td>Critical Elements of a Healthy Work Environment Survey</td>
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<tr>
<td>CNO</td>
<td>chief nursing officer</td>
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<tr>
<td>HWE</td>
<td>healthy work environment</td>
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<tr>
<td>LPN</td>
<td>Licensed Practical Nurse</td>
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<tr>
<td>NLR</td>
<td>nurse leader rounds</td>
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<tr>
<td>PES-NWI</td>
<td>Practice Environment Scale of the Nursing Work Index</td>
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<tr>
<td>PRN</td>
<td><em>pro re nata</em> (i.e., when necessary or as needed)</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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CHAPTER ONE: INTRODUCTION AND BACKGROUND

During the year 2020, the landscape of healthcare dramatically changed due to the global pandemic fueled by the novel coronavirus COVID-19. Consequently, the standards of nursing practice also changed from encouraging touch and spending time with patients to limiting physical contact with patients and maintaining a safe distance. Additionally, communication between nurses and patients became less effective due to the muffling effects of respirators. The rapid cycles of volume surges of increasingly higher acuity patients compounded the preexisting nursing shortage. The lack of nurses forced nurse leaders to redesign nursing care models and stretch staffing levels to ensure patients received appropriate care to the greatest extent possible.

These changes pushed nurses to work more hours in unfamiliar work environments with new teams of varying skill mixes. The principle of standardized practice to promote safe, quality care lost its influence as promoting patient survival took priority. Nurses found themselves isolated and feeling unsupported. To make matters worse, wage wars to attract nurses erupted across local communities and across the country. Nurses in high-stress jobs with little opportunity for renewal or self-care found leaving their home institutions, if not leaving the profession altogether, for high-paying travel jobs to be an attractive option. These factors perhaps represent the pinnacle of the need for nurse leaders to develop methods to keep their staff engaged and create functional, healthy work environments (HWEs).

Problem Statement

Communicating effectively and creating HWEs are two key challenges nursing leaders face daily. When communication is poor and work environments are not healthy, nurses leave organizations. When this happens, it is costly and disruptive to patients and
disruptive to the nursing team. Studies show HWEs are created through strong nursing leadership. As healthcare organizations attempt to achieve excellent patient safety and quality given current fiscal and regulatory challenges, the need to have an HWE with a highly engaged, satisfied frontline workforce is critical (Hanse et al., 2016). Toxic work environments lead to poor behaviors, including shunning, self-absorption, bullying, incivility, aggressiveness, harassment, and passivity (Giordano-Mulligan & Eckhardt, 2019). These types of environments greatly impact the organization’s ability to provide the best care possible for patients. Nurse leaders who create a positive work culture, environment, and organization generate and sustain an HWE. However, not all nurse leaders demonstrate the behaviors needed to do this. In fact, nurse managers often perceive themselves as having more positive behaviors than those reporting to them perceive of them. Understanding staff nurses’ perceptions of their nurse manager’s leadership behavior is important to organizational success. Provision 6 of the Code of Ethics for Nurses prescribes that nurse leaders individually and collectively are responsible for creating a work environment that supports safe, quality care (American Nurses Association, 2015). Based on their position and experience, nursing leaders are responsible for cultivating a professional work environment. To do so, they must understand the culture of their respective span of control. What are the significant factors that motivate frontline nurses to participate actively in effective communication with their nurse leader? What is needed to create an HWE? This scholarly project identifies how nurse leaders can best engage frontline staff nurses in effective communication, enabling them to provide safe, quality care in an HWE.
PICOT Question

Do frontline nurses and nurse leaders perceive an improvement in communication and a healthier work environment after implementation of a monthly nurse leader rounding tool with staff nurses in an acute care setting?

Objectives and Goals

The goal of this study was to explore whether the implementation of a structured rounding tool helped to cultivate an HWE through clear, consistent, closed-loop communication and produced positive perceptions in both staff and leaders of their relationship with each other.

Scope of the Study

This study was conducted at a local hospital located in downtown Albuquerque, New Mexico. The study was limited to inpatient units, including critical care units, medical-surgical units, progressive care units, the emergency department, and procedural areas (e.g., surgical services and interventional radiology). The survey population consisted of RNs who worked full- or part-time on day, night, or various shifts (as typically seen in surgical services and interventional radiology) and who had worked at the facility for at least 90 days. The study excluded traveling nurses, PRN nurses, nursing instructors who did not work for the participating hospital, and nursing students. The study also included nurse managers at the director level and above who had been in their role for a minimum of 6 months.
CHAPTER TWO: REVIEW OF LITERATURE

To locate literature related to the influence of nurse leader rounding on staff to create a safe, engaging work environment, we conducted a search in the Cumulative Index to Nursing and Allied Health database. The initial search included the terms nurse leaders, work environment, and staff engagement as a Boolean phrase. To ensure we found the most recent literature, we limited the publication year range to 2016 to 2020. This resulted in more than 1600 articles. We revised the search terms to nursing leadership, patient outcomes, and nursing satisfaction. We continued to refine the search by adding the search term turnover. We continued to search the database using the same date limiters but incorporating the keyword phrases leadership rounds, engagement, healthy work environment, and outcomes. This limited the search results sufficiently to create a focused literature review.

Leadership Qualities

Saleh et al. (2018) designed a qualitative research study to explore how the management style of nurse leaders affected the job satisfaction of bedside nurses. They utilized a semi-structured interview incorporating demographic and open-ended interview questions with 35 nurses from different specialties in a medical city in Saudi Arabia. Participants received an invitation to be included through referrals from their colleagues. The study did not represent all the nursing specialties or nursing units in the sample, which potentially limited the applicability of the research.

Saleh et al. (2018) found that nurse leaders positively impacted nurse satisfaction by establishing a structured work environment and ensuring that standards applied to all nurses equally. Participants felt discontent when they perceived that standards were not applied to all nurses in the same manner due to preferential treatment based on nationality. Staff nurses
felt that nurse leaders showed favoritism to staff of similar national origin as their leader. Similarly, staff nurses did not feel they were able to voice concerns directly to the chief nursing officer (CNO). Staff nurses perceived that mid-level nurse leaders impeded communication with the CNO, which diminished the trust they had with their frontline nurse leader. The study findings indicated that trust is an important component in the relationship between nurse leaders and frontline nurses. Because Saleh et al.’s study did not include all nursing units, implementing their findings immediately in the practice environment may not be possible, but these findings do provide the initial blocks to design a practice paradigm.

Donohue-Porter et al. (2019) examined the relationship between nurse leaders and their RN staff at a 600-bed, non-academic medical center. Specifically, the study examined how leadership qualities related to job satisfaction, organizational commitment, and organizational citizenship behaviors. The study included 206 nurses and used the leader–member exchange theoretical framework, existing validated survey tools, and descriptive analysis. In addition, the study included correlations, general linear modeling, and multi-level modeling, which resulted in a $p$ value of less than .001, supporting the strength and validity of the study.

Key findings of Donahue-Porter et al. (2019) included higher reported job satisfaction and organizational commitment when RNs perceived a better relationship with their immediate supervisor. However, organizational citizenship behavior was not significantly correlated with the perception of the relationship, job satisfaction, or organizational commitment. The first finding is consistent with research conducted by Perry et al. (2018) indicating that job satisfaction was one of the indicators for intent to leave a position. Perry et
al.’s study’s surveys were administered shortly after several other organizational surveys, which could have been a limiting factor in the low response rate.

**Work Environment Impact**

Koinis et al. (2015) conducted a study investigating the impact that work environment can have on healthcare workers’ mental–emotional health and examining strategies to cope with negative consequences. The researchers utilized a standardized questionnaire entitled Coping Strategies for Stressful Events with 220 randomly picked professionals working in the hospital. The sample of respondents included physicians, nurses, nursing assistants, other health professionals, and medical and nursing students who had daily contact with patients. The questionnaire evaluated strategies healthcare workers use to overcome stressful situations or events. Of the 220 questionnaires distributed, 200 were returned for a 91.36% response rate. The study found three key elements influenced participants’ perception of their quality of life: the work environment affected their emotional health and coping strategies, their amount of healthcare experience affected how they employed coping strategies, and their age influenced their perception of their quality of life.

Raso et al. (2020) conducted a study to explore the relationship between clinical nurses’ perceptions of the authentic nurse leadership (ANL) of their manager and their perceptions of the work environment on their unit. This cross-sectional descriptive study was conducted at a national conference, included 254 nurses, and utilized the Authentic Nurse Leadership Questionnaire (ANLQ) in conjunction with the Critical Elements of a Healthy Work Environment Survey (CE-HWES) to obtain results.

The three questions Raso et al. (2020) explored were:

1. What is the clinical nurses’ perception of the ANL of their manager?
2. What is the clinical nurses’ perception of their work environment?

3. What is the relationship between clinical nurses’ perception of their managers’ ANL and their perception of the work environment in their unit? (p. 491)

Key findings of this study indicated that age, education, practice setting, years of experience, and Magnet status had no influence on ANL or HWE. ANLQ subscale scores in areas such as skilled communication, effective decision-making, and meaningful decision-making were found to have a positive relationship with an HWE in the eyes of frontline RNs.

**Meaningful Recognition**

Salvant et al. (2020) conducted a study to identify what frontline staff valued as recognition compared to what nurse leaders perceived their staff to value. The study used a quantitative research design and utilized a previously published survey employing a 5-point Likert scale. The original scale rates 31 forms of recognition to create six significant categories of recognition (Salvant et al., 2020). The researchers administered the survey to 46 frontline RNs and support staff and 10 nurse leaders at a high-volume Level 1 urban trauma center. The methodology did not identify criteria used to determine the staff or the location. The study compared the mean value of the meaningful forms of recognition first between the two groups by position, then by age stratification. The forms of recognition used for comparison included monetary reward, opportunities for growth, written acknowledgement, public acknowledgement, private verbal feedback, and schedule adjustments.

No significant variations in perceptions of meaningful recognition were evident between the frontline staff and nursing leaders. However, Salvant et al. (2020) identified differences between what Millennials, Generation Xers, and Baby Boomers valued as important forms of recognition. Millennials valued monetary rewards, while Generation Xers
and Baby Boomers valued written and public recognition. The disproportionate share of leaders included in the study limited its findings. Age stratification balanced the two groups more evenly and supported results that indicated differences exist between generational groups regarding preferred forms of recognition. Based on this study, nurse leaders should be sensitive to the different value constructs for each generation represented in their respective teams.

**Quality Outcomes**

Perry et al. (2018) conducted a three-level study using a mixed-method research design. Their focus was determining which factors influence nurse satisfaction positively and negatively and how nursing satisfaction impacts quality of care. The researchers also explored whether nursing leaders could cultivate a work environment that positively affected nursing satisfaction to reduce adverse events. The first level of the study focused on how the nursing practice environment impacted nurse satisfaction and nurse retention using the Practice Environment Scale of the Nursing Work Index (PES-NWI). The sample consisted of 2,596 RNs and LPNs randomly selected across 110 hospitals and 206 outpatient Army military treatment facilities. Data were made available to the researchers at the respondent level without being rolled into a system-level score.

The second level of Perry et al.’s (2018) study obtained existing data from a paper-based Army Provider Level Satisfaction Survey administered to 141,565 outpatients randomly selected 48 hours after their visits from 110 military treatment facilities to gauge levels of patient satisfaction. Data were made available to the researchers at the facility level. Both PES-NWI and Army Provider Level Satisfaction Survey results were collected during the same 4-month time frame in 2015. The third level of the study collected retrospective
data from 35 healthcare facilities on adverse events, but these data were only available as representative of system data. The researchers grouped results from the first level study (PES-NWI surveys) into categories and embedded them into the second and third level studies to analyze their impact on outpatient satisfaction scores and patient adverse events.

Perry et al.’s (2018) results correlated nurse satisfaction with positive patient satisfaction and fewer adverse events, but they showed less correlation between nurse dissatisfaction and the occurrence of adverse events. Also, the results demonstrated that supportive leadership, positive physician–nurse relationships, and advancement opportunities correlated positively with nursing satisfaction. The context of the data in each of the analyses was heterogeneous and limited the applicability of the results in broader contexts, with the exception of results from the PES-NWI, which provided user-level data. The findings demonstrated that nursing leadership could impact nursing satisfaction, but the study left additional need to explain the impact nursing leadership has on quality care.

Ayaad et al. (2019) evaluated the impact of structured nurse leader rounds (NLRs) on cancer patients’ satisfaction with nursing care. A stratified random sampling technique placed patients in either the experimental group \((n = 90)\) or the control group \((n = 90)\). Power analysis determined a medium effect size, though the actual sample size was greater than what was recommend by power analysis \((190 \text{ versus } 124, \text{ respectively}, \text{ with } 10 \text{ excluded from the actual sample})\). Descriptive statistics, \(t\)-tests, and one-way ANOVA were performed and reported. The use of random sampling and statistical analysis gave this study strength and validity. Key findings of this study indicated differences between the study groups in patients’ satisfaction, that structured leader rounding positively impacted the patients’
experience, and that the use of NLRs improved patient satisfaction and enhanced nursing care.

While Ayaad et al. (2019) focused on patient satisfaction, their study provided insight regarding the use of NLRs to improve RN job satisfaction and/or work environment. Part of the researchers’ purpose in conducting NLRs was to improve communication and engagement, which was demonstrated relative to patients in the study. While the study is not generalizable to the United States, it provides insight to the value of NLRs.

**Summary**

The major themes of the articles in this literature review were work environment (Koinis et al., 2015; Raso et al., 2020), nursing leaders’ impact on nursing satisfaction (Perry et al., 2018; Saleh et al., 2018), and the positive impact nurse leader rounding has on the work environment and nursing satisfaction (Ayaad et al., 2019). These studies provide useful findings in both quantitative and qualitative perspectives, giving insight into what bedside nurses need from their leaders to achieve job satisfaction. Key findings of these studies highlight the importance of supportive leadership (Perry et al., 2018; Saleh et al., 2018), physician–nurse relationships (Perry et al., 2018), and career advancement (Perry et al., 2018). In addition to these main drivers, the importance of a well-defined, equitable practice environment is also a pivotal factor in cultivating nurse satisfaction (Saleh et al., 2018).

Although Salvant et al. (2020) did not directly address leadership qualities or practice environments, the researchers provided insight into nursing satisfaction from the viewpoint that leaders should not attempt a one-strategy-fits-all approach when devising satisfaction or retention initiatives. The nurse leader must be perceptive enough to assess variations in how
their workforce values different motivation factors, and they must use differentiated methods to support satisfaction and engagement on multi-generational nursing teams.

Perry et al. (2018) attempted to demonstrate that quality outcomes are directly related to nursing satisfaction in a practice environment. Due to the limitation of their data sources, their findings did not tie to nursing satisfaction on a unit level. However, linkage did appear to exist on a system level, which helped shape the specificity of this scholarly project. Each of the reviewed articles provided recommendations on how nurse leaders can develop nurse satisfaction, which appears to be of considerable interest based on the amount of literature available on the topic. The element that surfaced from this review to merit additional research was whether nursing satisfaction ties to quality outcomes, and, if it does, what factors are necessary to facilitate an HWE? Finally, Ayaad et al. (2019) demonstrated how nurse leader rounding with their staff can build HWEs through positive leader–staff interactions, which improve nursing satisfaction. When nursing satisfaction is improved, nursing care and retention are positively impacted (Ayaad et al., 2019; Salvant et al., 2020).
CHAPTER THREE: CONCEPTUAL FRAMEWORKS AND METHODOLOGY

The conceptual frameworks used for this project were Giordano-Mulligan and Eckardt’s (2019) ANL framework and the American Association of Critical-Care Nurses (AACN; 2015) framework for HWEs.

**Authentic Nurse Leader Framework**

The ANL framework has been studied extensively since Avolio and Gardner (2005) began exploring better ways to lead. The notion of ANL as it relates to nurses was further studied by Wong et al. (2010), who focused on positive role modeling, honesty, integrity, and high ethical standards in the development of leader–follower relationships.

According to the ANL framework, three main ideas describe ANL: integrity, transparency, and altruism. These three qualities contain five elements of authentic leadership: moral and ethical perspective, self-awareness, relational integrality, shared decision-making, and caring (Giordano-Mulligan & Eckhardt, 2019). One of the key attributes of authentic leadership is that the leader knows who they are as a person and as a leader, including what they believe and value. Further, an authentic leader knows they will interact with others transparently in all decisions. These qualities make an authentic leader effective and lead to positive outcomes like trust, satisfaction, organizational commitment, performance, and organizational citizenship behavior from team members (Giordano-Mulligan & Eckhardt, 2019).

**Critical Elements of a Healthy Work Environments Framework**

The AACN (2015) publication *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence* highlighted six essential standards required to establish an HWE. These are: skilled communication (nurses must be as
proficient in communication skills as they are in clinical skills); true collaboration (nurses must be unyielding in pursuing and fostering true collaboration); effective decision-making (nurses must be valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations); appropriate staffing (staffing must ensure the effective match between patient needs and nurse competencies); meaningful recognition (nurses must be recognized and must recognize others for the value each brings to the work of the organization); and authentic leadership (nurse leaders must fully embrace the importance of an HWE, live it, and inspire others in its achievement; AACN, 2005; AACN, 2016; Ulrich et al., 2019).

With proper implementation, these standards ensure nurses have the skills, resources, accountability, and authority to make decisions that allow them to provide excellent care for patients and their families. Adopting these six standards involves creating the necessary systems, structures, and organizational cultures to offer the ongoing education necessary for success. For this to happen, an organization must recognize that people often create and support unhealthy work environments due to lack of knowledge, skills, and experience (AACN, 2005; AACN, 2016; Ulrich et al., 2019).

**Project Description**

The project team for this study was comprised of a principal investigator, who had general oversight and accountability for the project, and two student investigators. The project team implemented this quality improvement project in three parts. The first part was a pre-intervention survey (pre-survey), which utilized two established, validated survey tools to obtain a baseline of how frontline nurses perceived their nurse leadership (ANL qualities) and their work environment (an HWE or not).
The second part of the project entailed implementing a structured rounding tool for 12 weeks. The rounding tool was to be used by nurse leaders with their frontline nursing staff. Rounding on staff was done a minimum of once per month (more was encouraged) and consisted of focused conversations with individual nurses that lasted a minimum of 10 to 15 minutes. The intervention also implemented consistent, closed-loop feedback to follow-up with information gathered during rounding. To track their rounding, nurse leaders used an iPad with rounding software to log and track issues. Additionally, a stop light report was used if issues were found. If the solution to an issue was simple, it was recommended the nurse leader fix it immediately, document it, and announce it. If the nurse leader was unsure of the solution to an issue, they were to be candid with the nurse about their uncertainty and place the issue on a stop light report. The nurse leader was encouraged to empower the employee to seek a solution if possible. If no feasible solution could be found, the nurse leader was candid with the employee about the reason a solution was infeasible. Nurse leaders kept track of whom they had spoken to. If rounding was delegated to a manager, the nursing director acknowledged the conversation topics discussed between the delegated manager and the employee, which demonstrated nursing leadership’s involvement and commitment.

The student investigators developed a training module (see Appendix A) on the expectations of purposeful rounding, the questions nurse managers should ask, and the closed-loop communications that were given to the hospital’s nursing leadership. The training module was available through the hospital’s computer-based training system and was available for a 4-week period prior to implementing the rounding tool. Once completed,
nurse leaders acknowledged they had completed the training, and the acknowledgement was tracked in the hospital’s learning management system.

The third part of the project was a post-intervention survey (post-survey). The same survey tools used for the pre-survey were used for the post-survey. Data from this survey were compared to the baseline survey information to explore whether implementing the rounding tool impacted nurses’ perceptions toward nurse leaders and the work environment.

**Setting**

The setting for this project was a 453-bed acute care hospital located in Albuquerque, New Mexico. The hospital is one of the largest in the state and provides the full range of medical and surgical healthcare services. Its inpatient units include medical/surgical, emergency, interventional radiology, operating room, critical care, step-down, and pediatric.

**Study Population**

The population consisted of frontline nurses who were either full-time or part-time; worked day, night, or various shifts (particularly in interventional radiology or surgical settings); and had worked there for at least 3 months. The population included agency nurses who had been employed at the facility for at least 6 months. The population of nurse leaders included those at the manager level or above who had been in their role for a minimum of 3 months. Excluded from the study were PRN nurses, agency nurses who had been there less than 6 months, nursing instructors who did not work for the hospital, and nursing students.

**Data Collection Process and Tools**

After the institutional review boards of both the university and the participating hospital granted approval for this project (see Appendices B and C), study data were collected and managed using REDCap® electronic data capture tools hosted by the
University of New Mexico. REDCap® is a secure, web-based software platform designed to support data capture for research studies. It provides: (a) an intuitive interface for validated data capture; (b) audit trails for tracking data manipulation and export procedures; (c) automated export procedures for seamless data downloads to common statistical packages; and (d) procedures for data integration and interoperability with external sources (Harris et al., 2009; Harris et al., 2019).

The survey instruments used to measure perception of ANL qualities and HWE were the ANLQ and the CE-HWES. The ANLQ was developed by Giordano-Mulligan and Eckardt (2019) and consists of 29 items on a 5-point Likert-type scale ranging from 0 (never) to 4 (all the time), with 5 subscales representing the key attributes of authentic nursing leadership. The subscales are: self-awareness, moral–ethical courage, relational integrality, shared decision-making, and caring. The self-awareness category consisted of six questions that related to nursing leaders’ knowledge, vison, and confidence. The moral–ethical courage consisted of four questions that described nursing leaders’ actions and ethical standards and how they are influenced relative to the decisions they make. Relational integrality consisted of seven questions that related to how trustworthy, positive, and non-judgmental nurse leaders are, as well as how they own up to mistakes. Shared decision-making was based on six questions that indicated how a leader listens, encourages new ideas, and follows through with decisions. The last subscale was caring and consisted of six questions that reflected how compassionate and empathetic the leader is perceived to be. Cronbach's α in Giordano-Mulligan and Eckhardt’s (2019) original study was 0.96 (Raso, 2020).

The CE-HWES is an 18-item survey based on standards set by the AACN for HWEs. Each item includes a 5-point Likert-type response ranging from 1 (strongly disagree) to 5
(strongly agree). Each of the standards consisted of three questions that related to skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership. The scales measure the health of the work environment in participants’ work units and organizations. In AACN’s (2005) original study, the questions and scales were administered to two groups of 250 subjects each. Both samples were tested for reliability, showed internal consistency with identical factor structures, and had Cronbach's $\alpha$ scores of 0.80 or better (Raso, 2020).

The rounding tool used for the intervention was based on Studer Groups rounding for outcomes and consisted of five standardized questions:

1) What is working well today?
2) Is there anyone I should recognize for outstanding work?
3) Are there any processes that need to be adjusted?
4) Do you have the tools to do your job?
5) Is there anything I can help with right now?

Rounding was conducted using iRound, a digital rounding platform developed by Press Ganey® that was already being utilized by the hospital. Two reports were created so the student investigators could review how many rounds were being completed and what responses were given to the standardized questions.

The student investigators loaded the survey tools along with the emails for potential nurse participants provided by the hospital into REDCap® and developed a participant consent form outlining the project objectives and goals. After the nurse leaders completed training on the rounding structure and process, participants received a standard email containing the consent and a link to the surveys from REDCap®. Student investigators sent
invitations with reminders for completing the pre-intervention survey between October 27 and November 8, 2021, with an end date of November 20, 2021.

The project investigators held a project kick-off meeting on November 19, 2021 with the nurse leaders prior to implementing the rounding intervention. The purpose of that meeting was to make sure everyone understood the project and to answer any questions. The intervention began on November 20, 2021 and ran through February 7, 2022. The student investigators sent the initial post-survey invitation on February 8, 2022 and a second reminder for completing the post-intervention survey on February 22, 2022. The end date for the post-survey was March 1, 2022. All data were captured in REDCap®, with personal information de-identified for participants’ anonymity.

The student investigators used IBM® SPSS Version 28 software for data analysis of pre-and post-intervention survey data. Statistical data included descriptive statistics, a paired samples t-test, and Cronbach’s α. The paired samples t-test identified statistically significant differences between pre-and post-intervention data. The Cronbach’s α determined the reliability of the survey’s Likert scales.

**Statistical Methods and Data Analysis**

The student investigators used IBM® SPSS Version 28 software for data analysis of pre-and post-intervention survey data, and Microsoft® Excel to analyze the frequencies in percentages of the data from the rounding intervention. Statistical data explored in SPSS included pre- and post-intervention survey demographic data, descriptive statistics, and an independent samples t-test. Demographic data included gender, race, ethnicity, employment status, position, department, shift, age, and years of experience practicing nursing. Data analysis also employed descriptive statistics to evaluate data obtained from the two surveys.
The student investigators obtained data from the 29 items on the ANLQ survey, which consisted of a 5-point Likert-type scale ranging from 0 (never) to 4 (all the time), with five subscales representing the key attributes of authentic nursing leadership. The five subscales were self-awareness, moral-ethical courage, relational integrality, shared decision-making, and caring.

The student investigators also collected data from the 18-item CE-HWES survey, which consisted of a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree), with six subscales representing the standards of an HWE. The standards were skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership. The scoring guidelines were: needs improvement (1.00 to 2.99), good (3.00 to 3.99), and excellent (4.00 to 5.00). The analysis utilized the independent samples t-test to evaluate statistically significant differences between the means of pre- and post-intervention data from the ANLQ and HWES surveys. Parameters analyzed were $t$, $df$, and statistical significance ($p < .05$). Cohen’s $d$ effect sizes were defined as small ($< .2$), medium ($.5$), and large ($>.8$). All statistical tests were two-tailed.

**Quality**

Project implementation and data collection were feasible, practical, and determined to be appropriate for the hospital setting, as indicated by the support letter from the hospital’s CNO and sponsor of the project (see Appendix D). The surveys used were existing and validated. The student investigators obtained written permission by the authors of the survey tools prior to use (see Appendices E and F). The University of New Mexico granted the student investigators access to use the REDCap® database—an institutionally based closed source, with responses directly inputted by RN participants. Only the principal investigator
and student investigators had access to the results, ensuring data security. To further assure validity of the research design, the sample size of participants needed to be large enough to establish whether correlations existed between the pre-intervention and post-intervention survey results. The student investigators performed a power analysis to determine the target number of sample respondents for the site. The student investigators also used G*power® to conduct an a priori analysis for an independent t-test to determine that a sample size of 64 pre- and 64 post-survey responses provided 80% power to detect a medium effect (Cohens $d = 0.5$) difference in means.

**Ethics and Human Subjects Protection**

The primary ethical concerns in this study were breach of confidentiality and emotional, social, or financial risk (Dixon, 2017). Project investigators did not collect any personal identifying information. Nurse participants did not incur any cost for their participation in the project and were not required to answer any questions they were uncomfortable answering. Furthermore, participation in this project was voluntary, and the nurse participants consented prior to accessing each survey (see Appendix G). Nurse participants entered their responses into REDCap® directly; therefore, neither the project investigator nor the student investigators knew how specific individuals responded. The student investigators submitted the project to the university’s institutional review board, as well as the participating hospital’s affiliated institutional review board for approval.

**Budget**

The project’s budget was primarily in-kind, as demonstrated in the letter of support from the CNO of the participating hospital. The Health Sciences Center at the University of New Mexico provided REDCap® access for no fee. Participants were recruited in part by the
hospital’s CNO and in part through a flyer developed in PowerPoint by the student investigators (see Appendix H) and distributed through workplace emails.

**Timeline**

**Figure 1**

*Project Timeline*

- UNM and Presbyterian IRB submittal: Early Nov. 2021
- Disseminate pre-intervention survey via email: End of Nov. 2021
- Implement intervention: Mid Feb. 2022
- Data review and interpretation: April 2022
- Defend final project: April 2022

- IRB approval: Aug. 2021
- Staff training on intervention: Dec.–Feb. 2021-2022
- Disseminate post-intervention survey via email: Feb.–March 2022
- Complete project: April 2022
CHAPTER FOUR: RESULTS AND DISCUSSION

Results

The overall response rate for the pre- and post-intervention surveys were low. The rate of those who responded to the pre-survey was 10.3% \((n = 97)\), and the rate of those who responded to the post-survey was 10.1% \((n = 95)\). The number of rounds completed \((n = 87)\) over the 3-month period of the intervention was also very low, with only 3% of the potential rounds completed. This analysis excluded incomplete surveys, which left a total sample size of \(n = 77\) for the pre-survey, \(n = 64\) for the post-survey, and \(n = 87\) for rounds completed. To achieve a medium effect size (Cohens \(d = 0.5\)), both surveys required a minimum sample size of \(64\) responses, which was similar to the a priori analysis for an independent \(t\)-test. Both surveys achieved the target sample sizes.

The demographic breakdown of the respondents is shown in Table 1. Pre-survey data showed 85.7% of respondents were female \((n = 66)\), and the post-survey data showed similar results, with the majority of respondents being female \((n = 54)\) again, which accounted for 84.4%. Most of the respondents for the pre-survey were Not Hispanic or Latino/a \((n = 52, 67.5\%)\); 77.9% of pre-survey respondents were White \((n = 60)\). Similarly, 79.7% of post-survey respondents were White \((n = 51)\); 4.8% were African American \((n = 1, 1.6\%)\), American Indian or Native Alaskan \((n = 1, 1.6\%)\), or Native Hawaiian or other Pacific Islander \((n = 1, 1.6\%)\); and 15.6% chose Other \((n = 3, 4.7\%)\) or Prefer not to answer \((n = 7, 10.9\%)\).
Table 1

*Demographics*

<table>
<thead>
<tr>
<th></th>
<th>Pre-Survey (n = 77)</th>
<th>Post-Survey (n = 64)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>66</td>
<td>85.7</td>
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<tr>
<td>Gender-fluid</td>
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<td>-</td>
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<tr>
<td>Male</td>
<td>9</td>
<td>11.7</td>
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<td>Non-Binary</td>
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<td>-</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>2</td>
<td>2.6</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>American Indian or native Alaskan</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Islander</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>6</td>
<td>7.8</td>
</tr>
<tr>
<td>White</td>
<td>60</td>
<td>77.9</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>6.5</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>5</td>
<td>6.5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino/a</td>
<td>25</td>
<td>32.5</td>
</tr>
<tr>
<td>Not Hispanic or Latino/a</td>
<td>52</td>
<td>67.5</td>
</tr>
</tbody>
</table>

As shown in Table 2, more than half of respondents (59.8%) in the pre-survey fell into two age categories: 25 to 34 years old (n = 23, 29.9%) and 35 to 44 years old (n = 23, 29.9%). In comparison, 67.2% of post-survey respondents fell into two age categories: 35 to 44 years old (n = 25, 39.1%) and 45 to 54 years old (n = 18, 28.1%). The different age categories represented varying years of experience in nursing. In the pre-survey, 42.9% of respondents had more than 10 years of experience (n = 30), followed by 22.1% who had 5 to 10 years of experience (n = 17). Post-survey data showed similar results: 46.9% of
respondents had more than 10 years of experience ($n = 30$), followed by 18.8% who had 5 to 10 years of experience ($n = 12$).

**Table 2**

*Age and Years of Experience*

<table>
<thead>
<tr>
<th>Age</th>
<th>Pre-Survey ($n = 77$)</th>
<th>Post-Survey ($n = 64$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>%</td>
</tr>
<tr>
<td>18-24 years old</td>
<td>4</td>
<td>5.2</td>
</tr>
<tr>
<td>25-34 years old</td>
<td>23</td>
<td>29.9</td>
</tr>
<tr>
<td>35-44 years old</td>
<td>23</td>
<td>29.9</td>
</tr>
<tr>
<td>45-54 years old</td>
<td>19</td>
<td>24.7</td>
</tr>
<tr>
<td>55-64 years old</td>
<td>6</td>
<td>7.8</td>
</tr>
<tr>
<td>65-74 years old</td>
<td>2</td>
<td>2.6</td>
</tr>
<tr>
<td>Years of Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>8</td>
<td>10.4</td>
</tr>
<tr>
<td>2-3 years</td>
<td>8</td>
<td>10.4</td>
</tr>
<tr>
<td>3-5 years</td>
<td>11</td>
<td>14.3</td>
</tr>
<tr>
<td>5-10 years</td>
<td>17</td>
<td>22.1</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>33</td>
<td>42.9</td>
</tr>
</tbody>
</table>

Table 3 shows the employment status of the respondents, which included type of employment, shift, patient population, and department. Most respondents for both the pre- and post-surveys were full-time employees ($n = 63$ and $n = 54$, respectively), which accounted for 81.8% and 84.4% respectively. In the pre-survey, 85.7% of respondents were frontline RNs ($n = 66$), while 14.3% were nurse managers ($n = 11$); in the post-survey, 78.1% were frontline RNs ($n = 50$), and 20.3% were nurse managers ($n = 13$). These RNs and nurse managers worked various shifts. The largest group, 61%, worked day shift ($n = 47$). Post-survey data showed similar results, with 64.1% working day shift ($n = 41$). Most nurses in both the pre- and post-surveys worked with the adult population ($n = 69$ and $n = 52$).
respectively, or 89.6% and 81.3%). Five different departments were represented in the study.

Most pre- and post-survey respondents indicated they worked in the progressive care department (n = 38 and n = 24, respectively, or 49.4% and 37.5%).

**Table 3**

*Employment Status*

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Pre-Survey (n = 77)</th>
<th>Post-Survey (n = 64)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>63</td>
<td>81.8</td>
</tr>
<tr>
<td>Part-time</td>
<td>14</td>
<td>18.2</td>
</tr>
<tr>
<td>Position</td>
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<td></td>
</tr>
<tr>
<td>Agency RN</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>PHS RN</td>
<td>66</td>
<td>85.7</td>
</tr>
<tr>
<td>Nurse manager</td>
<td>11</td>
<td>14.3</td>
</tr>
<tr>
<td>Department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care</td>
<td>22</td>
<td>28.6</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>2</td>
<td>2.6</td>
</tr>
<tr>
<td>Medical-Surgical</td>
<td>13</td>
<td>16.9</td>
</tr>
<tr>
<td>Progressive Care</td>
<td>38</td>
<td>49.4</td>
</tr>
<tr>
<td>Procedural Areas</td>
<td>2</td>
<td>2.6</td>
</tr>
<tr>
<td>Shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day</td>
<td>47</td>
<td>61</td>
</tr>
<tr>
<td>Night</td>
<td>25</td>
<td>32.5</td>
</tr>
<tr>
<td>Variable</td>
<td>5</td>
<td>6.5</td>
</tr>
<tr>
<td>Population Type</td>
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<td></td>
</tr>
<tr>
<td>Adult</td>
<td>69</td>
<td>89.6</td>
</tr>
<tr>
<td>Pediatric</td>
<td>7</td>
<td>9.1</td>
</tr>
<tr>
<td>Adult and Pediatric</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Table 4 summarizes the survey group statistics. The key attributes of authentic nursing leadership showed consistent means in the pre-survey results (n = 77). The post-survey results (n = 64) were consistent, though lower than the pre-survey results. Results for
the ANLQ from the independent samples t-test showed that between the pre-and post-survey, there were statistically significant differences in the data, having a small, but close to medium effect size, thus contradicting the assumption that no significant statistical difference would be found. For the five subscales, data were reported as equal variances not assumed.

Table 4

Survey Statistics

<table>
<thead>
<tr>
<th>ANLQ characteristics a,b</th>
<th>Pre/Post</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
<th>Cohen's d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-awareness</td>
<td>Pre</td>
<td>77</td>
<td>3.50</td>
<td>0.67</td>
<td>2.41</td>
<td>108.96</td>
<td>0.018</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.15</td>
<td>0.99</td>
<td>2.74</td>
<td>100.53</td>
<td>0.007</td>
<td>0.5</td>
</tr>
<tr>
<td>Moral-ethical Courage</td>
<td>Pre</td>
<td>77</td>
<td>3.50</td>
<td>0.64</td>
<td>2.99</td>
<td>98.85</td>
<td>0.004</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.09</td>
<td>1.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relational integrity</td>
<td>Pre</td>
<td>77</td>
<td>3.51</td>
<td>0.64</td>
<td>2.49</td>
<td>105.81</td>
<td>0.015</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.06</td>
<td>1.06</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared decision-making</td>
<td>Pre</td>
<td>77</td>
<td>3.38</td>
<td>0.73</td>
<td>2.55</td>
<td>111.39</td>
<td>0.012</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.41</td>
<td>0.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring</td>
<td>Pre</td>
<td>77</td>
<td>3.51</td>
<td>0.64</td>
<td>1.32</td>
<td>139</td>
<td>0.19</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.07</td>
<td>1.10</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Healthy work environment c,d</td>
<td>Pre/Post</td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>t</td>
<td>df</td>
<td>p</td>
<td>Cohen's d</td>
</tr>
<tr>
<td>Skilled communications</td>
<td>Pre</td>
<td>77</td>
<td>3.67</td>
<td>0.86</td>
<td>1.2</td>
<td>139</td>
<td>0.23</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.46</td>
<td>0.92</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>True collaboration</td>
<td>Pre</td>
<td>77</td>
<td>3.37</td>
<td>0.89</td>
<td>0.809</td>
<td>139</td>
<td>0.42</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.18</td>
<td>0.99</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective decision-making</td>
<td>Pre</td>
<td>77</td>
<td>3.65</td>
<td>0.79</td>
<td>-0.705</td>
<td>139</td>
<td>0.48</td>
<td>-0.1</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.54</td>
<td>0.87</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate staffing</td>
<td>Pre</td>
<td>77</td>
<td>3.07</td>
<td>1.10</td>
<td>1.81</td>
<td>139</td>
<td>0.07</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.20</td>
<td>1.10</td>
<td></td>
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<td></td>
</tr>
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<td>Meaningful recognition</td>
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<td>0.94</td>
<td>1.39</td>
<td>139</td>
<td>0.18</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>64</td>
<td>3.50</td>
<td>0.94</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a The higher the mean (4 is the highest), the better the respondent perceived their leader.

b For the independent samples t-test, equal variances not assumed.

c Scoring: “Needs improvement” (1.00 to 2.99), “Good” (3.00 to 3.99), and “Excellent” (4.00 to 5.00)

d For the independent samples t-test, equal variances assumed.
The key attributes from the CE-HWES survey showed consistent means in the pre-survey results \((n = 77)\). The post-survey results \((n = 64)\) were consistent as well, though slightly lower than the pre-survey results in all subscales except adequate staffing, where there was a slight increase in the mean. Results for the CE-HWES from the independent samples \(t\)-test showed that between the pre- and post-survey, there were no statistically significant differences in the data, with a small effect size. For the six subscales, data were reported as equal variances assumed.

Table 5 shows the demographics of the rounding intervention participants.

**Table 5**

*Demographics—Rounding Intervention*

<table>
<thead>
<tr>
<th></th>
<th>Rounds ((n = 87))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td><strong>Affiliation</strong></td>
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</tr>
<tr>
<td>PHS</td>
<td>80</td>
</tr>
<tr>
<td>Agency</td>
<td>7</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>69</td>
</tr>
<tr>
<td>Part-time</td>
<td>15</td>
</tr>
<tr>
<td>PRN</td>
<td>2</td>
</tr>
<tr>
<td><strong>Shift</strong></td>
<td></td>
</tr>
<tr>
<td>Day</td>
<td>65</td>
</tr>
<tr>
<td>Night</td>
<td>21</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
</tr>
<tr>
<td><strong>Nurses' tenure</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>14</td>
</tr>
<tr>
<td>1–2 years</td>
<td>9</td>
</tr>
<tr>
<td>3–5 years</td>
<td>20</td>
</tr>
<tr>
<td>&gt; 5–10 years</td>
<td>42</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
</tr>
</tbody>
</table>
Of the 87 rounds completed, 92% were completed by the facility’s nurses \( (n = 80) \) compared to agency nurses. Most of them were full-time \( (n = 69) \), which accounted for 79% of survey respondents. Seventeen percent were part-time \( (n = 15) \), and only 2% were PRN \( (n = 2) \). Of the nurses who responded, 75% worked on the day shift \( (n = 65) \), and 48% had been a nurse for 5 to 10 years \( (n = 42) \). Twenty-three percent had been nurses for 3 to 5 years \( (n = 20) \), 16% for less than 1 year \( (n = 14) \), 10% for 1 to 2 years \( (n = 9) \), and 3% chose no response \( (n = 3) \).

The four topics reported on for the rounding intervention were: “Do you have what you need?”, “What is working well?”, “What else can I help you with?”, and “Is there anyone I should recognize for outstanding teamwork?” The question “What should they be recognized for?” was left out of the data to maintain privacy for people mentioned in the response. Sixty-four percent of respondents felt they had what they needed \( (n = 56) \). When asked “What is working well?”, 93% felt teamwork was good on their unit \( (n = 81) \), 85% felt they provided quality care \( (n = 74) \), 72% felt they had a positive relationship with providers \( (n = 63) \), 48% said they were recognized for doing a job well \( (n = 42) \), 46% felt their unit was staffed well \( (n = 40) \), 36% felt they were compensated well \( (n = 31) \), 32% indicated they had the supplies/tools to do their job \( (n = 28) \), and 6% utilized the other category \( (n = 5) \). For the question “What else can I help with?”, the largest category of response was supplies/tools \( (n = 28) \), accounting for 32% of respondents. Staffing \( (n = 5) \) was the next largest category at 29%, closely followed by compensation \( (n = 15) \), which accounted for 17% of responses. The other category \( (n = 15) \) accounted for another 17% of responses; however, in some cases a comment was made, while in many, no comment was made. The remaining categories, quality issue \( (n = 2, 2\%) \), teamwork issue \( (n = 1, 1\%) \), recognition \( (n = 5, 6\%) \), and provider
relationship \((n = 5, 6\%)\) were not seen frequently. For the last question, “Is there anyone I should recognize for outstanding teamwork?”, 60% of respondents indicated yes \((n = 52)\). Table 6 summarizes the frequencies of topics uncovered during the rounds that were completed.

**Table 6**

*Frequencies of Topics Found During Rounding*

<table>
<thead>
<tr>
<th>Question</th>
<th>Rounds ((n = 87))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have what you need?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>56 (64)%</td>
</tr>
<tr>
<td>No</td>
<td>20 (23)%</td>
</tr>
<tr>
<td>No response</td>
<td>2 (2)%</td>
</tr>
<tr>
<td>What is working well?</td>
<td></td>
</tr>
<tr>
<td>I have the supplies/tools to do my job.</td>
<td>28 (32)%</td>
</tr>
<tr>
<td>Staffing for our unit is good.</td>
<td>40 (46)%</td>
</tr>
<tr>
<td>We provide quality care.</td>
<td>74 (85)%</td>
</tr>
<tr>
<td>Teamwork on our unit is good.</td>
<td>81 (93)%</td>
</tr>
<tr>
<td>I am recognized for doing a job well.</td>
<td>42 (48)%</td>
</tr>
<tr>
<td>I am compensated well.</td>
<td>31 (36)%</td>
</tr>
<tr>
<td>Positive relationship with providers</td>
<td>63 (72)%</td>
</tr>
<tr>
<td>Other</td>
<td>5 (6)%</td>
</tr>
<tr>
<td>What else can I help with?</td>
<td></td>
</tr>
<tr>
<td>Supplies/tools</td>
<td>28 (32)%</td>
</tr>
<tr>
<td>Staffing</td>
<td>25 (29)%</td>
</tr>
<tr>
<td>Quality issue</td>
<td>2 (2)%</td>
</tr>
<tr>
<td>Teamwork issue</td>
<td>2 (1)%</td>
</tr>
<tr>
<td>Recognition</td>
<td>5 (5)%</td>
</tr>
<tr>
<td>Compensation</td>
<td>15 (17)%</td>
</tr>
<tr>
<td>Provider relationship</td>
<td>5 (5)%</td>
</tr>
<tr>
<td>Other</td>
<td>15 (17)%</td>
</tr>
<tr>
<td>Is there anyone I should recognize for outstanding teamwork?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>52 (60)%</td>
</tr>
<tr>
<td>No</td>
<td>34 (39)%</td>
</tr>
<tr>
<td>No response</td>
<td>1 (1)%</td>
</tr>
</tbody>
</table>
Summary of Findings

Data obtained from the 29 items on the ANLQ survey consisted of responses on a 5-point Likert-type scale that included 0 (never), 1 (rarely), 2 (some of the time), 3 (most of the time), and 4 (all the time). The results are indicative of the specific questions related to the five subscales. The independent samples t-test for the pre- and post-intervention survey results for ANLQ indicated there were no differences in staff nurses’ perceptions of their nurse managers in four of the five subscales: self-awareness, moral–ethical courage, relational integrality, and caring. Data showed nurse managers exhibited these behaviors “most of the time”. The data for the fifth subscale, shared decision-making, indicated a change in staff nurses’ perception of their nurse managers from “most of the time” in the pre-intervention survey to “some of the time” in the post-intervention survey. This decrease in mean was just below 3 (\(N = 64, M = 2.98, SD = 1.09\)). However, for all five ANLQ subscales, the post-intervention survey means decreased from the pre-intervention survey and were statistically significant, with a small, but close-to-medium effect size.

Data collected from the 18 items on the CE-HWES survey consisted of responses on a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree), with six subscales representing the standards of an HWE. The CE-HWES data showed there were no differences between pre- and post-intervention surveys in how the staff nurses perceived their work environment. Based on the means of the six standards (skilled communications, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership), the nurses felt their work environment was good. The independent samples t-test for pre- and post-intervention survey results showed no statistically significant
differences in the means with all subscales having a $p$-value greater than .05 and a small effect size, indicating the impact of any change was small.

Data from the structured rounding tool were first reviewed during the second week of the intervention when very few rounds had been completed. Because of the initial lack of structured rounds completed, the student investigators worked with the project sponsor to encourage nurse managers to focus on completing the structured rounds. This helped increase the number of rounds; however, by the time the increase was seen, it was late in the intervention period. The scope of the project’s intervention also included a stop light report; unfortunately, one was not utilized during the intervention period. Due to time constraints and a slow start to gathering data from rounding, the student investigators decided there was not enough time left in the project to initiate a stop light report.

**Discussion**

The intent of this project was to identify whether frontline nurses and nurse leaders perceived an improvement in communication and a healthier work environment after implementing a monthly nurse rounding tool. To measure this, the student investigators conducted a statistical analysis between the pre-and post-intervention surveys. Statistically, given the low number of structured rounds completed during the project, the differences in results between the two surveys were not unexpected. The project was not able to demonstrate improved communication nor improved perception of a healthier work environment. However, data also showed in both the pre- and post-surveys that nursing staff perceived their nursing leaders and their work environment positively. This was reflected in the fact that they perceived their nurse leaders as exhibiting ANL qualities “most of the time”
and their work environment as “good,” and that perception did not change over the course of the project.

Along with the results, the student investigators also identified positive insights. One was the commitment of the nurse managers, nurse directors, and the CNO to improve perceptions of effective communication and an HWE. Evidence of their commitment began with the first pre-project meetings with nurse leaders and the CNO and included the amount of time they offered to the project and their dedication to establishing the project’s objectives and measures. Another positive insight was the flexibility of the nurse leaders during a very difficult time. Shortly after initiation of the project, a variant of COVID-19 created a surge of patients, which compounded the difficulty of providing care to patients by exacerbating staffing challenges that already existed and the difficulty of implementing new crisis standards of care. Nurse leaders had to prioritize patient care and helped by providing direct patient care themselves rather than utilizing the rounding tool. As the surge of patients declined, nurse leaders were able to resume use of the rounding tool, as evidenced by the increased number of rounds completed in a short period of time. While this project was unable to demonstrate what the student investigators originally posited, it demonstrated the challenges nurse leaders face today in seeking best practices to improve their professional relationships with frontline nurses during a pandemic.

**Implications for Practice**

While the results of this project did not identify changes based on the specific intervention of a structured rounding tool and stop light report, they did support one main implication. Nurse managers are encouraged to identify processes to engage with their nurses that are sufficiently agile to withstand interruptions to normal operations, such as a
pandemic. The landscape of nursing practice has changed because of the COVID-19 pandemic. Unless nurse managers can develop mechanisms to hardwire purposeful rounds with their staff, there will be continued difficulties in engaging and retaining staff nurses.

**Limitations and Strengths of the Study**

The limitations and strengths of this project impacted its outcomes. Limitations included difficulty in implementing the structured rounding tool, lack of use of a stop light report, and the use of the independent samples \( t \)-test rather than the pared samples \( t \)-test. Although nurse managers received training on the structured rounding tool, its implementation was delayed. The scheduled start date for the structured rounding tool was November 15, 2021, and the scheduled end date was February 6, 2022. During the 12-week project, the new Omicron variant of COVID-19 emerged. Due to an increased number of patients and continuing nursing shortages, nurse managers’ attention was focused on ensuring safe patient care, requiring many nurse managers to work at bedsides to offset increased nurse-to-patient ratios. The time commitment of patient care limited the amount of time for nurse managers to utilize the structured rounding tool with their nurses. Due to limited use of the structured rounding tool, formal stop light reports to track resolutions on issues identified during the structured rounds were not implemented. The intent of the stop light reports was to demonstrate nurse managers’ commitment to improve the work environment to staff nurses.

Based on the expectation that structured rounds would be made at minimum once per month for 3 months by 22 nurse managers with 993 eligible nurses, the student investigators anticipated a total of 2,979 structured rounds would be completed. At the end of the project, the actual number of structured rounds completed was 87. The limited use of the structured
rounding tool and lack of stop light reports impacted the results from the post-implementation survey, as evidenced by the negligible difference between pre-implementation survey and post-implementation survey results.

In addition, the project had limitations related to a change in the statistical model used to interpret the results from the pre-intervention and post-intervention surveys. The project team originally planned to use a paired samples $t$-test but had to change to an independent samples $t$-test to accommodate the method used by student investigators to deploy the surveys in REDCap®. Instead of deploying two of the same surveys for the pre-implementation and post-implementation surveys, the student investigators used a single survey. After the pre-implementation survey closed and the results downloaded, the student investigators deleted the records out of REDCap®. This error was a result of their lack of knowledge of the full functionality of REDCap®. Since the original records were deleted out of REDCap®, no means existed to establish a relationship between the survey groups of the pre-implementation and post-implementation surveys. The independent sample $t$-test is not as statistically powerful as the paired sample $t$-test, but it is statistically valid.

This project had three major strengths: the validated surveys, the number of responses to the surveys, and the support of the scholarly project sponsor. Both the ANLQ and CE-HWES survey tools are structured to provide insight into staff nurse perceptions of their leaders and the work environment. Enough responses to the surveys were collected to produce a statistically small effect size to interpret the data results. The scholarly project sponsor who is the CNO of the organization provided support to the project by encouraging staff nurses to complete the surveys and encouraged nurse managers to utilize the structured rounding tool.
Suggestions for Further Research

This study was designed to explore levels of change relative to nursing leadership qualities and work environment on a conceptual level (i.e., communication, transparency, emotional intelligence, teamwork) after the implementation of a system-wide intervention in a large acute-care setting over a short period of time during a pandemic. Further studies could expand on this study design in a non-pandemic setting in which nursing staff, nursing leaders, and the larger community are not exhausted. Implementing a rounding tool system-wide takes time, education, and buy-in. Future studies could build on the digital platform but implement the rounding intervention over a longer period (6, 12, or 18 months). This would allow more time to gather data and establish a routine with nursing leaders and their staff as well as time for the stop-light report to work as it should in closing the loop in communication. Based on the value the CNO placed on this project, they decided to continue the use of the structured rounding tool and to implement the stop light report. A future study could be designed to look more closely at the subscales and how they correlate to different nursing departments or nurses with differing lengths of nursing experience. This would require larger subsample sizes but could provide insight into issues with leadership and work environments related to specific areas.

Concluding Remarks

This project has provided insight into the challenges faced by nurse managers to support staff nurses and create HWEs. Although the intended outcome was not achieved, the processes of the project did identify the need for nurse managers to adapt their leadership during a pandemic to create or maintain meaningful, open communication with their staff nurses and to foster HWEs. The positive outcomes of this project have led the participating
organization to continue to implement the rounding tool used during the project. Their nurse leaders remain engaged in this process to further develop strong relationships with their staff and continue to foster an HWE. With full support from the CNO and nurse leaders, the system-wide change initiated by this project has and will continue to impact the hospital in a positive way.
References


https://doi.org/10.1111/jnu.12503

https://doi.org/10.1016/j.leaqua.2005.03.001


nursing administrative relationships. *Nurse Leader, 17*(6), 546–551.

https://doi.org/10.1016/j.mnl.2019.02.006


https://doi.org/10.1097/NAQ.0000000000000344


Appendix A: Nurse Leader Training

Staff Nurse Perceptions of the Work Environment

Education for Nurse Managers

Scholarly Project Chair: Dr. Christine Delucas
Scholarly Project Committee Member: Dr. Judy Liesveld
Scholarly Project Sponsor: Dr. Penny Beattie
Appendix B: University of New Mexico Institutional Review Board Approval

Human Research Protections Program

September 17, 2021
Christine Delucas
ADEluca@salud.unm.edu

Dear Christine Delucas:

On 9/17/2021, the HRRC reviewed the following submission:

Type of Review: Initial Study
Title of Study: The Impact of Nurse Leader Rounding on Staff Nurse Perceptions of the Work Environment
Investigator: Christine Delucas
Study ID: 21-308
Submission ID: 21-308
IND, IDE, or HDE: None

Submission Summary: Initial Study

Documents Approved: AACN HWE Assessment
Authentic Nurse Leader Questionnaire
Letter of Support
Participant Consent
Permission to use ANL questionnaire
Permission to use HWE assessment
Recruitment flyer
Riebsomer Bluford IRB Protocol
Signed IAA UNM_Pres

Review Category: EXEMPTION: Categories (2)(i) Tests, surveys, interviews, or observation (non-identifiable)

Determinations/Waivers: Employees.
Provisions for Consent are adequate.
HIPAA Authorization Addendum Not Applicable.

Submission Approval Date: 9/17/2021
Approval End Date: None
Effective Date: 9/17/2021

The HRRC approved the study from 9/17/2021 to inclusive. If modifications were required to secure approval, the effective date will be later than the approval date. The “Effective Date” 9/17/2021 is the date the HRRC approved your modifications and, in all cases, represents the date study activities may begin.

Human Research Protections Program


Institution/organization Providing IRB Review (Institution/Organization A):
Name: University of New Mexico Health Sciences Center Human Research Review Committee (UNMHSC HRRC)
Federalwide Assurance (FWA) #: 00035255

Institution/Project for the Designated IRB (Institution B):
Name: Presbyterian Healthcare System
Federalwide Assurance #: 00006178

The officials signing below agree that the Presbyterian Healthcare System IRB (name of institution B) may rely on the designated IRB for review and continuing oversight of the human subjects research described below (select one below):
☐ This agreement applies to all human subjects research reviewed by Institution A’s FWA.
☐ This agreement is limited to the following specific protocol(s):

Name of Research Project: The Impact of Nurse Leader Rounding on Staff Nurse Perceptions of the Work Environment

Name of Principal Investigator: Penny Beattie, Eric Riebsomer, Bobby Bluford

Funder or Funding Agency: n/a

The review performed by the designated IRB will meet the human subjects protection requirements of Institution B’s OHRP-approved FWA. The IRB at Institution/Organization A will follow written procedures for reporting its findings and actions to authorize audits at Institution B. Relevant copies of the meeting minutes will be made available to Institution B upon request. Institution B remains responsible for ensuring compliance with the IRB’s determination and with the terms of the OHRP-approved FWA. This document must be kept on file by both parties and provided to OHRP upon request.
Signature of Signatory Official (Institution/Organization A):

Date: __________

Printed Name: Richard Larson, MD, PhD
Institutional Title: Executive Vice Chancellor, Vice Chancellor for Research

Signature of Signatory Official (Institution/Organization B):

Norbert Topf, M.D.

Date: 08/19/2021
Printed Full Name: Norbert Topf, MD, PhD
Institutional Title: Chief Medical Quality Officer and IO
Appendix D: Letter of Support from Chief Nursing Officer

PRESBYTERIAN
Hospital

August 18, 2021

To: University of New Mexico IRB
From: Penny Beutler, CNO Presbyterian Hospital
Re: Quality Improvement Proposal/Protocol: Richsomer/Bluford

This is a letter of support for the following UNMSON DNP students: Eric Richsomer and Sobhy Bluford with their quality improvement protocol/proposal:

Title: "The impact of Nurse Leader Rounding on Staff Nurse Perceptions of the Work Environment".

Their clinical site will be at Presbyterian Hospital, 1100 Central Ave SE, Albuquerque, NM and as Chief Nursing Officer, I will be the Senior Leader sponsor and provide my full support to the project. Working with me is Genevieve Gonzales, Nursing Director.

Please feel free to reach out to me for any clarifying questions.

Sincerely,

Penny L. Beutler, DNP, RN, MBA, CPHQ, BC, NE
Chief Nursing Officer
Presbyterian Hospital
505-724-7149
Appendix E: Permission to Use Authentic Nurse Leader Questionnaire

From: Mulligan, Marie E
Sent: Thursday, April 29, 2021 10:43 AM
To: Eric T Riebsomer
Subject: Re: ANLQ

Thank you

Get Outlook for iOS

From: Eric T Riebsomer <ETRiebsomer@salud.unm.edu>
Sent: Thursday, April 29, 2021 12:28:39 PM
To: Mulligan, Marie E <MMulligan@northwell.edu>
Subject: [EXTERNAL] RE: ANLQ

External Email. Do not click links or open attachments unless you trust the sender and content. Report suspicious emails using Report Phishing button or forward email to phish@northwell.edu

Hi Dr. Mulligan!

Please don’t apologize! I completely understand! We greatly appreciate this, and we definitely will not publish any of the questions.

I look forward to reading your new publication too!

Have a great day, and good luck with DOH.

Eric T. Riebsomer

From: Mulligan, Marie E
Sent: Thursday, April 29, 2021 9:01 AM
To: Eric T Riebsomer
Subject: RE: ANLQ

Hi Eric

I am so sorry that I did not get the questionnaire to you sooner. It has been a very busy week. We are expecting a DOH unannounced survey for a new Cardiac Cath program and I am the exec lead on the program. As you can imagine with COVID the DOH has requested so many additional documents that are additional asks outside of the normal new program regs.
Attached please find the ANLO. I just asked that when you do publish that you do not replicate the questionnaire in the publication for others to use without permission. My intent is for nurse leaders to expand upon my research, but I would like to know that it is worthy research and not used without my knowledge.

Also for your literature review a new publication is coming out in May, “Perceptions of Authentic Nurse Leadership and work environment and the pandemic impact for nurses” JONA 51 (5) 257-263. The ANLO was the instrument and the ANL framework was utilized.

Good luck with your study. Keep me updated on your progress and results.

Marie Mulligan, PhD, RN, NEA-BC, CNOR  
CNO Vice President for Nursing  
Nursing Administration  
Mather Hospital  
75 North Country Road  
Port Jefferson, NY 11777  
Tel: (631) 476-2351  
Cell: (631) 260-0989  
Email: mmulligan5@northwell.edu

Northwell Health  
Visit us at Northwell.edu

---

From: Eric T Riebsomer <ETriebsomer@salud.unm.edu>  
Sent: Thursday, April 22, 2021 12:00 PM  
To: Mulligan, Marie E <MMulligan5@northwell.edu>  
Cc: Bobby G Bluford <BGBluford@salud.unm.edu>; Angeline C Delucas <adelucas@salud.unm.edu>  
Subject: [EXTERNAL] ANLO

external email. Do not click links or open attachments unless you trust the sender and content. Report suspicious emails using Report Phishing button or forward email to phish@northwell.edu

Good morning Dr. Mulligan,

I hope you are doing well out in New York! I wanted to let you know that we have secured a hospital site to perform our study in (wohoo!) and we are ready to put together the implementation piece of our project. That being the case, we would like to get your questionnaire now.

The hospital we will be using is very excited to have us do this project and it seems timing couldn’t be better because they are in the process of implementing a round program similar to what are going to study. They are looking forward to seeing the data we come up with and how it will hopefully support the rounding initiative by showing a positive increase in perceived communication and a healthier work environment. Also, by using this hospital, we will have access to 25-50 nursing directors (depending on
how we define that) and a couple thousand staff nurses that will more than likely fit our inclusion criteria! That is exciting for us, we will potentially have a very nice sample size for our study and will hopefully have very good statistical strength.

Again, we want to thank you for allowing us to use your questionnaire and we are excited to add to the work you have been doing!

Eric T. Riebsomer

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Appendix F: Permission to Use Healthy Work Environment Assessment

January 27, 2021

Bobby Bluford
7400 San Pedro Dr. NE, #1037
Albuquerque, NM 87109
Bobbybluford12@live.com

Dear Mr. Bluford:

Thank you for your reuse request. We hereby grant permission for your reuse of the AACN copyrighted content below, free of charge, subject to the following conditions:

1. Content will be used in a scholarly project focusing on implementation of nurse leader rounding and its correlation with a healthy work environment (baseline assessment, mid-intervention assessment, final assessment) in partial fulfillment of the requirements for the DNP degree pursued at the University of New Mexico.

2. Suitable acknowledgment to the original source must be made, preferably as follows: American Association of Critical-Care Nurses. Healthy Work Environment Assessment Tool. Aliso Viejo, CA. American Association of Critical-Care Nurses. ©AACN. All rights reserved. Used with permission.

3. Permission is granted for the following use case: HWEAT, individual/academic institution, electronic, United States, original language, up to 999 viewers, no changes, current edition and up to 3 years (until January 27, 2024).

Any modifications to the HWEAT would need to be approved by AACN beforehand.

Thank you for your interest in the American Association of Critical-Care Nurses.

Sincerely,

[Signature]

Michael Muscat
AACN Publishing Manager

Accepted:

SIGNATURE                  TITLE                  DATE

27071 Aliso Creek Road • Aliso Viejo CA 92656 • 800.622.3866 • www.aacn.org
Appendix G: Informed Consent

The University of New Mexico Health Sciences Center
Consent and Authorization to Participate in a Research Study

Dear Prospective Participant,

Researchers at the University of New Mexico are inviting you to take part in our computer-based survey about whether the implementation of a structured rounding tool will help cultivate a healthy work environment through clear, consistent, closed loop communication that will produce positive perceptions of both staff and leaders of their relationship with each other.

WHAT ARE THE KEY REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?

Communicating effectively and creating healthy work environments (HWEs) are two key challenges nursing leaders face daily. When communication is poor and work environments are not healthy, nurses leave organizations. When this happens, it is costly and disruptive to patients’, and disruptive to the team. Studies show healthy work environments are created through strong nursing leadership. By participating in this survey, the data you provide will further add to the literature regarding healthy work environments and will provide us insight to whether utilizing a structured communication tool can improve work environments and communication between nurse leaders and staff. As front-line nurses, you are the best source of information on this topic.

Although you may not get personal benefit from taking part in this research study, your responses may help us understand more about how implementing a rounding tool impacts your working environment and perceptions of your nurse leader.

The survey will be administered twice and will take about 20 minutes each time to complete. The survey will first be given prior to implementation of our proposed intervention. This will give us a baseline on how the nursing staff perceive their nursing leader and will provide a baseline on how the nursing staff perceive their working environment. The second survey will be given after the intervention has been implemented for 3 months. This would give us data on if any changes resulted from implementation of the intervention.

Your response to the survey is anonymous which means no names will appear or be used on research documents or be used in presentations or publications. The research team will not know that any information you provided came from you, nor even whether you participated in the study.

Your information collected for this study will NOT be used or shared for future research studies, even though we remove the identifiable information like your name, clinical record number, or date of birth. All data will be kept for no longer than one year in a locked file in Christine Delucas office and then destroyed.

We hope to receive completed questionnaires from about 200 people, so your answers are important to us. Of course, you have a choice about whether or not to complete the survey.
Please be aware, while we make every effort to safeguard your data once received on our servers via REDCap, given the nature of online surveys, as with anything involving the Internet, we can never guarantee the confidentiality of the data while being transmitted to us. If you have questions about the study, please feel free to ask; our contact information is given below. If you have questions regarding your legal rights as a research subject, you may call the UNM Human Research Protections Office at (505) 272-1129.

Thank you in advance for your assistance with this important project. To ensure your responses/opinions will be included, please respond to the survey sent to your email through REDCap, your completed pre-intervention survey will be due by August 15th, 2021, and your post intervention survey will be due by January 15th, 2022. By completing this survey, you will be agreeing to participate in the above-described research study.

Sincerely,

Christine Delucas, DNP, MPH, RN, NEA-BC
Associate Professor
DNP Program Director
College of Nursing, University of New Mexico
adelucas@salud.unm.edu

Eric Riebsomer
College of Nursing, University of New Mexico Health Sciences
PHONE: 505-412-9370
E-MAIL: ETRiebsomer@salud.unm.edu

Bobby Bluford
College of Nursing, University of New Mexico
PHONE: 505-508-8052
E-MAIL: BGBluford@salud.unm.edu
You are invited to participate in this Scholarly Project project with the goals:

✓ To empower frontline nurses to have a voice
✓ To enhance relationships between nurses and their leaders
✓ To help foster a healthy work environment

What’s expected if you choose to participate:

✓ Complete a brief online confidential survey about your current perceptions of your work environment
✓ Watch a brief computer based educational module about how the project will work
✓ Attend one on one meetings with your nursing manager to share your ideas
✓ Complete a final online confidential survey about your perceptions after the project finishes

Scholarly Project sponsor: Dr. Penny Beattie
Primary Investigator: Dr. Christine Delucas
Student Investigators: Eric Riebsomer and Bobby Bluford

THE UNIVERSITY OF NEW MEXICO
HRRC STUDY# 21-308