

### Chief Editor

Dr. A. Singaraj, M.A., M.Phil., Ph.D.

### Editor

Mrs.M.Josephin Immaculate Ruba

### EDITORIAL ADVISORS

1. Prof. Dr.Said I.Shalaby, MD,Ph.D.  
Professor & Vice President  
Tropical Medicine,  
Hepatology & Gastroenterology, NRC,  
Academy of Scientific Research and Technology,  
Cairo, Egypt.
2. Dr. Mussie T. Tessema,  
Associate Professor,  
Department of Business Administration,  
Winona State University, MN,  
United States of America,
3. Dr. Mengsteab Tesfayohannes,  
Associate Professor,  
Department of Management,  
Sigmund Weis School of Business,  
Susquehanna University,  
Selinsgrove, PENN,  
United States of America,
4. Dr. Ahmed Sebihi  
Associate Professor  
Islamic Culture and Social Sciences (ICSS),  
Department of General Education (DGE),  
Gulf Medical University (GMU),  
UAE.
5. Dr. Anne Maduka,  
Assistant Professor,  
Department of Economics,  
Anambra State University,  
Igbariam Campus,  
Nigeria.
6. Dr. D.K. Awasthi, M.Sc., Ph.D.  
Associate Professor  
Department of Chemistry,  
Sri J.N.P.G. College,  
Charbagh, Lucknow,  
Uttar Pradesh. India
7. Dr. Tirtharaj Bhoi, M.A, Ph.D,  
Assistant Professor,  
School of Social Science,  
University of Jammu,  
Jammu, Jammu & Kashmir, India.
8. Dr. Pradeep Kumar Choudhury,  
Assistant Professor,  
Institute for Studies in Industrial Development,  
An ICSSR Research Institute,  
New Delhi- 110070, India.
9. Dr. Gyanendra Awasthi, M.Sc., Ph.D., NET  
Associate Professor & HOD  
Department of Biochemistry,  
Dolphin (PG) Institute of Biomedical & Natural  
Sciences,  
Dehradun, Uttarakhand, India.
10. Dr. C. Satapathy,  
Director,  
Amity Humanity Foundation,  
Amity Business School, Bhubaneswar,  
Orissa, India.



ISSN (Online): 2455-7838

SJIF Impact Factor (2017): 5.705

EPRA International Journal of

# Research & Development

(IJRD)

Monthly Peer Reviewed & Indexed  
International Online Journal

Volume: 3, Issue:7, July 2018



Published By :  
EPRA Journals

CC License





# STRUCTURED NURSING CARE ROUNDS: EFFECT ON RELIABILITY IN DELIVERING ESSENTIAL CARE

Lillykutty M.J<sup>1</sup>

<sup>1</sup>Ph.D Scholar, INC National Consortium for Ph.D in Nursing, New Delhi

Dr.Rebecca Samson<sup>2</sup>

<sup>2</sup>Dean, College of Nursing, Pondicherry Institute of Medical Sciences

## ABSTRACT

*The present study aimed at evaluating the effect of Structured Nursing Care Rounds (SNCR) on reliability in delivering essential care at a hospital in Ernakulam District, Kerala. SNCR claims that it would establish frequency and regularity with which the universal elements of essential nursing care are delivered to patients. Quasi-experimental nonequivalent group pre and post design was utilized as the framework of the study in a sample of thirty six nursing professionals. At pre-test, no significant difference ( $p > 0.05$ ) was noted between the control and experimental groups with respect to the domains of essential care. However, post-test showed significant difference between control and experimental group. In all the items the mean score of experimental group was significantly higher than that of control group ( $p < 0.05$ ). There was a significant difference in the mean score between pre and post tests of experimental group at 0.05 level with respect to: assessment and recording ( $p < 0.001$ ) nurse-patient interaction ( $p < 0.001$ ) promptness in meeting the patients' needs ( $p < 0.001$ ) fundamentals of care ( $p < 0.001$ ) patient education and discharge ( $p < 0.001$ ) organization of care ( $p = 0.011$ ) and overall quality in delivering essential care ( $p < 0.001$ ). No significant association could be detected between essential care score and score demographic variables of sample ( $p > 0.05$ ). However, essential care and nursing shift had a significant association ( $p = 0.039$ ). The study endorses that a structured approach to nursing care rounds on patients is an effective intervention in delivering essential care consistently.*

**KEY WORDS:** structured nursing care rounds, reliability, essential care, nursing professionals

## INTRODUCTION

**Background of the study:** A structured care approach of nurses can improve patients' experience of care. A well-thought out nursing visits to patients at set intervals build their trust in safe and reliable nursing care. Anticipatory clinical rounds improve treatment outcomes among patients and also alleviate undue pressure on nurses. Hourly and second hourly nursing rounds are one among many nursing care innovations, which are being pursued by some of the US & European hospitals.<sup>1</sup>

**Need and significance:** Progressive declines in providing fundamental care have been a concern among nurses. These universal aspects of nursing care are to be discharged to patients consistently. Essential to the quality of health care is patient's safety, satisfaction and nurse-patient relationships. At the same time, progressively more chaotic and industrial type of hospitals may show the way to the

loss of therapeutic presence, and this tone down the credibility of nursing professionals as bearers of compassionate caring<sup>2</sup>. Therefore the need of the time is to identify and test interventions that can provide positive experiences to patients during their hospital stay.

**Review of literature:** The iconic image of Florence Nightingale, the lady with the lamp, who cared for soldiers in the Crimean War, always set nursing professionals on drive and energy. However, the old image of nurses as ones who look out for direction from physicians has long since been substituted by newer image of nurses like professionals and providers of competent caring. Amazingly, newer images catch the attention of young girls and boys to the nursing profession<sup>3</sup>. Some of the high-profile reports have brought to the awareness regarding poor standards of delivering basic nursing care to patients.

These include inadequate attention to the feeding, position, personal hygiene and skin integrity<sup>4</sup>.

The modern healthcare scenario surrounded by multiple demands does not make easy additional time with patients. At the same time, growing body of evidences recommend more nursing time per patient for better outcomes. However, health professionals on wards say there is never enough time to do everything, and that they are full of activities and paper work as well<sup>5-7</sup>. Generally, nurses are inclined to toil more or less around problems rather than recognizing new ways of putting in order their work<sup>8</sup>. On the other hand, interventions have been developed specially to create a calmer and less chaotic environment for health professionals and patients as well, and to find additional time to care.<sup>9</sup>

Researchers support that structured approach to the delivery of care improves holistic and fundamental aspects of nursing care that is individual to the needs of their patients. A nurse intentionally taking rounds on patients was also endorsed by prime minister David Cameron as giving nurses time to care<sup>10</sup>. In general, a structured hourly clinical round by nurses is an effective method to improve patient satisfaction and clinical outcomes. A Program evaluation explains outcomes related to the implementation of hourly rounds are an increase in overall patient satisfaction scores, decrease in patient falls and hospital-acquired pressure ulcers<sup>11</sup>.

**Purpose of the study:** The purpose of this study was to test an evidence-based nursing intervention called, 'Structured Nursing Care Rounds' by staff nurses in the context of an Indian hospital and to evaluate its benefits on reliability of delivering essential care to the patients. 'Structured Nursing Care Rounds' was a bottom-up approach that empowers nursing personnel to implement new ways to improve patient care practices. The goals of these structured bedside visits to patients were to increase the amount of time nurses spend in direct patient care, to improve the quality, reliability and safety of patient care, to develop a patient-centered care and to reduce adverse eventualities. This intervention was also to increase the frequency of physical presence and resulting in patients' positive perception of care and overall satisfaction.

## RESERCH METHODOLOGY

**Research Question:** Will structured nursing care rounds by staff nurses make any difference in the reliability of delivering essential care to patients?

**Statement of the research study:** Effect of Structured Nursing Care Rounds (SNCR) on reliability in delivering essential care to patients as perceived by nursing professionals at a hospital in Ernakulam District, Kerala.

### Objectives

- A. To assess reliability of delivering essential care before the SNCR
- B. To assess reliability of delivering essential care after the SNCR

- C. To determine the effect of SNCR on the reliability of delivering essential care
- D. To find the association between dependent variable and sample variables

**Research hypotheses:** The following hypotheses were tested at 0.05 level of significance.

H<sub>1</sub>: Mean post-test essential care score will be significantly higher than pre-test score among nursing professionals of SNCR wards.

H<sub>2</sub>: Mean post-test essential care score among nursing professionals of SNCR wards will be significantly higher than post-test score among nursing professionals of non-SNCR wards.

H<sub>3</sub>: There will be significant association between dependent variable and sample variables

## Operational definitions

### What is SNCR?

SNCR is a nurse-initiated structured process where nurses on wards in hospitals carry out regular checks with individual patients from time to time. Further, the model of rounds involves a nurse-patient interaction on an hourly basis during the day and two hourly at night. SNCR of '9Ps' bring the different elements of nursing care into a harmonious and efficient relationship. This approach meets the patients' needs by providing timely, quality and safe patient care. This drive of bedside nursing facilitates finding of deteriorating patients, early signs of pressure ulcer, peripheral intravenous infiltration and phlebitis; it can also reduce the risk and rate of falls, the disturbing sounds of call bells, and minimize patients and caregivers flocking in front of the nurses' station. Above all, an improvement in patient experience of care is the definite indicator with regard to the benefit of this nursing intervention. Along with scheduled or required tasks, nurses carryout one or more of the following nine caring behaviors:

1. Person centred care and for which introduce self and know the patient by name
2. Plan and brief about hourly bedside visit to put the patient at ease
3. Pain level
4. Positioning to prevent pressure ulcer
5. Peripheral intravenous catheter/cannula to prevent phlebitis and infiltration
6. Proximity of personal items to prevent falls
7. Perform faithfully essential care and other scheduled tasks as well
8. Pay attention to patient education including discharge plan
9. Presence and dedication will be provided to every patient, saying at the close of each visit, "Is there anything else I can help you with? I, or someone from my team, will come back in an hour".

SNCR make possible forefront teams to systematize ward work and to make certain all patients are given

attention on a regular basis. Thus it brings stability to care, accessibility and assurance to patients. SNCR offers nursing professionals definite caring behaviors. SNCR, to put in plain words, starts on with opening words in which staff nurses explain why they are present to each patient on an hourly basis. This introduction builds on trust and confidence in patients. The staffs round on patients for the realization of 9Ps along with scheduled tasks, attention to their comfort and glances the environment for any hazard for patient's wellbeing. The rounds also incorporate, asking usually, "Is there anything else I can do for you – I have time". This provides confidence in patients towards the frequent bedside visits by nurses and their dedication in providing consistent care.

**Essential care:** Essential care includes six domains of patient care with 31 items: (i) assessment and recording (ii) nurse- patient interaction (iii) promptness in meeting patients' needs (iv) fundamentals of care (v) patient education and discharge instructions and (vi) organization of care.

**Nursing professionals:** In this evaluation study, nursing professionals are head nurses and shift in-charges of eight adult medical surgical wards, making a total of thirty six sample.

**Research approach:** Quantitative

**Research design:** Quasi-experimental nonequivalent groups pre and post design<sup>13</sup>

**Sample:** Nursing professionals (head Nurses and shift in-charges)

**Setting:** Eight adult medical surgical wards at a tertiary care hospital in Ernakulam

**Sample size:** Control group (18) and Experimental group (18), making a total of 36.

**Sampling technique:** Complete/total sampling

**Intervention:** Structured Nursing Care Rounds by staff nurses

**Description of the data collection instrument:**

**Essential Care Scale (ECS):** ECS is self report instrument, meant to measure the specific elements of essential nursing care in wards. ECS quantifies frequency and regularity with which the universal elements of patient care has been carried out in wards before and during the intervention, from the point of

view of shift in-charges and head nurses. This tool consists of two parts: Section A, on demographics, to assess age, gender, marital status, professional education, and years of nursing experience, experience in the present institution and experience in the present position. Section B to assess six domains of patient care essentials with 31 items: (1) assessment and recording (8 items), (2) nurse - patient interaction (4 items), (3) promptness in meeting patients' needs (5 items), (4) fundamentals of care (9 items), (5) patient education and discharge instructions (3 items) and (6) organization of care (2 items). The perceptions of head nurses and shift in charges would be represented on a scale of 1 to 5; 1= never, 2=rarely, 3=sometimes, 4=often and 5=almost-always to each on a 31 items self-rated instrument. Score of 31 to 52 represent poor quality in the essentials of nursing care, 53 to 103 moderate and a score of 104 to 155 would indicate high level of quality in the essentials of nursing care in experimental conditions. In order to evaluate the reliability of the ECS through test-retest, 10 nurses would complete it twice within a 3-day interval. The test/retest result (Cronbach's  $\alpha=0.801$ ) evidenced a high reliability of the questionnaire.

**Data collection procedure:** The nursing professionals surveyed were head nurses and shift in-charges of the selected medical-surgical wards. Complete/total sampling was used to invite head nurses and shift in-charges. The nursing professionals of the intervention wards were considered as a test group and of the control wards as a comparison group. Both groups were pre-tested, and post-tested at the closing phase of intervention period. The only difference was that one of the groups was trained and they were also supportive of structured nursing care rounds by their staff nurses.

**DATA ANALYSIS**

**1. DEMOGRAPHIC VARIABLES**

**Table 1: Distribution of age, gender, marital status and professional education**

Demographic Variables		Control (N=18)	Experiment (N=18)	Total (N=36)	Fisher's Value	p - value
Age	20 - 25 Years	0 (0.0%)	6 (33.3%)	6 (16.7%)	F=9.825	0.013
	26 - 30 Years	9 (50.0%)	9 (50.0%)	18 (50.0%)		
	31 - 35 Years	8 (44.4%)	2 (11.1%)	10 (27.8%)		
	36 - 40 Years	0 (0.0%)	0 (0.0%)	0 (0.0%)		
	Above 40 Years	1 (5.6%)	1 (5.6%)	2 (5.6%)		
Gender	Male	0 (0.0%)	0 (0.0%)	0 (0.0%)	--	--
	Female	18 (100.0%)	18 (100.0%)	36 (100.0%)		
Marital status	Single	1 (5.6%)	8 (44.4%)	9 (25.0%)	F=7.259	0.018
	Married	17 (94.4%)	10 (55.6%)	27 (75.0%)		
Professional Education	GNM Nursing	14 (77.8%)	12 (66.7%)	26 (72.2%)	F=1.844	0.601
	BSc Nursing	4 (22.2%)	4 (22.2%)	8 (22.2%)		
	PB BSc Nursing	0 (0.0%)	2 (11.1%)	2 (5.6%)		

Table 1 shows that Mean age 29.85 of control group is significantly higher than that of experimental group 26.32 (p<0.05). Only female nurses are in the two groups and in equal numbers. ‘Singles’ are significantly higher in experimental group compared to that of control group (p<0.05). Among ‘married’ no significant difference in numbers could be

detected (p>0.05) between control and experimental group. Professional education: No significant difference in numbers can be detected between control and experimental groups with respect to the professional education (p>0.05).

**Table 2: Distribution of years of experience, experience in present institution, and area of practice**

Demographic Variables		Control (N=18)	Experiment (N=18)	Total (N=36)	Fisher's Value	P - value
Years of Experience	0 - 6 Months	0 (0.0%)	0 (0.0%)	0 (0.0%)	5.147	0.413
	7-12 Months	0 (0.0%)	1 (5.6%)	1 (2.8%)		
	1 - 3 Years	2 (11.1%)	5 (27.8%)	7 (19.4%)		
	3 - 5 Years	5 (27.8%)	6 (33.3%)	11 (30.6%)		
	5 - 8 Years	7 (38.9%)	3 (16.7%)	10 (27.8%)		
	8 - 10 Years	3 (16.7%)	1 (5.6%)	4 (11.1%)		
	Above 10 Years	1 (5.6%)	2 (11.1%)	3 (8.3%)		
Experience in Present Institution	Up to 6 Months	0 (0.0%)	2 (11.1%)	2 (5.6%)	12.572	0.010
	7-12 Months	0 (0.0%)	1 (5.6%)	1 (2.8%)		
	1 - 3 Years	4 (22.2%)	6 (33.3%)	10 (27.8%)		
	3 - 5 Years	12 (66.7%)	3 (16.7%)	15 (41.7%)		
	5 - 8 Years	1 (5.6%)	4 (22.2%)	5 (13.9%)		
	8 - 10 Years	0 (0.0%)	2 (11.1%)	2 (5.6%)		
Area of Practice	Medical & Surgical	18 (100.0%)	17 (94.4%)	35 (97.2%)	1.029	0.990
	Others	0 (0.0%)	1 (5.6%)	1 (2.8%)		

Table 2 shows that no significant difference can be noted between the two groups with respect to years of experience (p>0.05), experience in the present institution (p>0.05) and area of practice (P>0.05).

**Table 3: Distribution of nursing shifts, current job position and experience in current position**

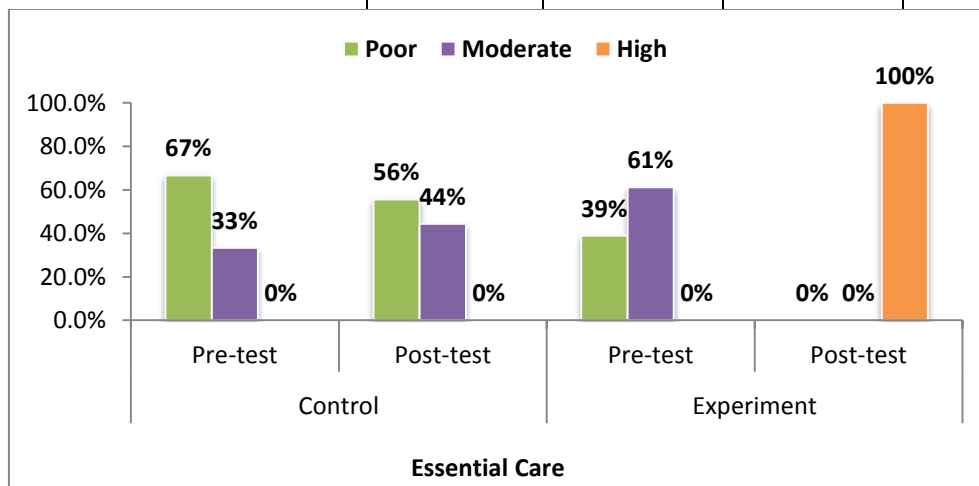
Demographic Variables		Control (N=18)	Experiment (N=18)	Total (N=36)	Fisher's Value	P-value
Nursing shifts	Day	0 (0.0%)	6 (33.3%)	6 (16.7%)	7.200	0.019
	Evening	0 (0.0%)	0 (0.0%)	0 (0.0%)		
	Night	0 (0.0%)	0 (0.0%)	0 (0.0%)		
	All Shifts	18 (100.0%)	12 (66.7%)	30 (83.3%)		
Current Job position	Head Nurse	6 (33.3%)	6 (33.3%)	12 (33.3%)	0.000	1.000
	Shift In-charge	12 (66.7%)	12 (66.7%)	24 (66.7%)		
Experience in current position	Up to 6 Months	0 (0.0%)	2 (11.1%)	2 (5.6%)	4.110	0.461
	7-12 Months	0 (0.0%)	1 (5.6%)	1 (2.8%)		
	1 - 2 Years	7 (38.9%)	8 (44.4%)	15 (41.7%)		
	2 - 5 Years	10 (55.6%)	7 (38.9%)	17 (47.2%)		
	5 - 10 Years	1 (5.6%)	0 (0.0%)	1 (2.8%)		
	Above 10 Years	0 (0.0%)	0 (0.0%)	0 (0.0%)		

According to table 3, there is significant difference (p<0.05) with regard to shift working. Numbers in day shift in experimental group is significantly higher than in the control group (p<0.05). No significant difference in the numbers of nurses in the two groups

in head nurses and shift-in-charge (p>0.05) with regard to current job position and experience in current position (p>0.05).

**Table 4: Distribution of reliability in delivering essential care**

Essential Care	Control (N=18)		Experiment (N=18)	
	Pre-test	Post-test	Pre-test	Post-test
Poor	13 (72.2%)	12 (66.7%)	13 (72.2%)	0 (0.0%)
Moderate	5 (27.8%)	6 (33.3%)	5 (27.8%)	0 (0.0%)
High	0 (0.0%)	0 (0.0%)	0 (0.0%)	18 (100.0%)



**Figure 1: Distribution of reliability in delivering essential care**

Among the control 13 (72.2%) at pre-test and 12 (66.7%) at post test report reliability in delivering essential care is 'poor', whereas 5 (27.8%) at pre-test and 6 (33.3%) at post test report that quality is 'moderate'. Among the experimental 13 (72.2%)

report poor and 5 (27.8%) as moderate at pre test and at post test the entire sample (100%) report 'high quality' in essential care.

**Table 5: Difference in delivering essential care between control and experimental groups in pre-test**

Domains	Groups	Mean	SD	Difference	t - value	df	p - value
Assessment and Recording	Control	16.44	2.148	0.000	0.000 <sup>NS</sup>	34	1.000
	Experiment	16.44	2.406				
Nurse-patient Interaction	Control	9.000	1.940	0.111	0.172 <sup>NS</sup>	34	0.864
	Experiment	8.889	1.937				
Promptness in Meeting Patient's Needs	Control	12.00	2.612	0.000	0.000 <sup>NS</sup>	34	1.000
	Experiment	12.00	2.425				
Fundamentals of Care	Control	19.11	3.288	0.278	0.246 <sup>NS</sup>	34	0.807
	Experiment	19.39	3.483				
Patient Education and Discharge	Control	7.000	0.840	0.111	0.369 <sup>NS</sup>	34	0.715
	Experiment	6.889	0.963				
Organization of Care	Control	5.556	0.784	0.278	0.952 <sup>NS</sup>	34	0.348
	Experiment	5.278	0.958				
Overall Essential Care	Control	69.11	8.352	0.222	0.077 <sup>NS</sup>	34	0.939
	Experiment	68.89	8.911				

NS → The difference is not significant

Table 5 explains that no significant difference (p>0.05) could be noted between the control and experimental groups with respect to: assessment and recording (p 1.000), nurse-patient interaction (p 0.864), promptness in meeting the patients' needs (p

1.000), fundamentals of care (p 0.807), patient education and discharge (p 0.715), organization of care (p 0.348) and overall quality in delivering essential care (p 0.939).

**Table 6: Difference in delivering essential care between control and experimental groups in post-test**

Domains	Groups	Mean	SD	Difference	t - value	df	p - value
Assessment and Recording	Control	15.89	2.374	21.778	22.076**	34	<0.001
	Experiment	37.67	3.447				
Nurse-patient Interaction	Control	9.167	1.757	9.944	13.177**	34	<0.001
	Experiment	19.11	2.676				
Promptness in Meeting Patient's Needs	Control	12.11	2.374	11.222	18.244**	34	<0.001
	Experiment	23.33	1.085				
Fundamentals of Care	Control	19.39	3.432	23.056	26.103**	34	<0.001
	Experiment	42.44	1.504				
Patient Education and Discharge	Control	7.056	0.802	7.611	34.440**	34	<0.001
	Experiment	14.67	0.485				
Organization of Care	Control	5.667	0.767	1.000	2.426*	34	0.021
	Experiment	6.667	1.572				
Overall Essential Care	Control	69.28	7.676	74.611	27.230**	34	<0.001
	Experiment	143.9	8.731				

\*\* The difference is significant at 0.01 level; \* The difference is significant at 0.05 level

From the above table 6 significant difference could be detected between control and experimental group for the following characteristics (p<0.05). In all the

items the mean score of experimental group is significantly higher than that of control group (p<0.05): assessment and recording (p<0.001), nurse-

patient interaction (p<0.001), promptness in meeting the patients' needs (p <0.001), fundamentals of care (p<0.001), patient education and discharge

(p<0.001), organization of care (p=0.021) and overall essential care (p<0.001).

**Table 7: Difference in delivering essential care between pre-test and post-test in control group**

Domains	Groups	Mean	SD	Difference	t - value	df	p - value
Assessment and Recording	Control	16.44	2.148	-3.378	1.966 <sup>NS</sup>	17	0.066
	Experiment	15.89	2.374				
Nurse-patient Interaction	Control	9.000	1.940	1.852	0.678 <sup>NS</sup>	17	0.507
	Experiment	9.167	1.757				
Promptness in Meeting Patient's Needs	Control	12.00	2.612	0.926	0.334 <sup>NS</sup>	17	0.742
	Experiment	12.11	2.374				
Fundamentals of Care	Control	19.11	3.288	1.453	0.753 <sup>NS</sup>	17	0.462
	Experiment	19.39	3.432				
Patient Education and Discharge	Control	7.000	0.840	0.794	0.566 <sup>NS</sup>	17	0.579
	Experiment	7.056	0.802				
Organization of Care	Control	5.556	0.784	2.000	1.000 <sup>NS</sup>	17	0.331
	Experiment	5.667	0.767				
Overall Essentials of Nursing Care	Control	69.11	8.352	0.241	0.251 <sup>NS</sup>	17	0.805
	Experiment	69.28	7.676				

NS → The difference is not significant

From the above table 7 no significant difference could be found between essential care between pre and post tests for: assessment and recording (p=0.066) nurse-patient interaction (p=0.507)

promptness in meeting the patients' needs (p=0.742) fundamentals of care (p=0.462) patient education and discharge (p=0.579) organization of care (p 0.331) and overall in essential care (p=0.805).

**Table 8: Difference in essential care between pre-test and post-test in experimental group**

Domains	Groups	Mean	SD	Difference	t - value	df	p - value
Assessment and Recording	Control	16.44	2.406	21.23	21.465 <sup>**</sup>	17	<0.001
	Experiment	37.67	3.447				
Nurse-patient Interaction	Control	8.889	1.937	10.221	13.143 <sup>**</sup>	17	<0.001
	Experiment	19.11	2.676				
Promptness in Meeting Patient's Needs	Control	12.00	2.425	11.33	18.098 <sup>**</sup>	17	<0.001
	Experiment	23.33	1.085				
Fundamentals of Care	Control	19.39	3.483	23.05	23.404 <sup>**</sup>	17	<0.001
	Experiment	42.44	1.504				
Patient Education and Discharge	Control	6.889	0.963	7.781	35.000 <sup>**</sup>	17	<0.001
	Experiment	14.67	0.485				
Organization of Care	Control	5.278	0.958	1.389	2.858 <sup>*</sup>	17	0.011
	Experiment	6.667	1.572				
Overall Essentials of Nursing Care	Control	68.89	8.911	75.01	22.818 <sup>**</sup>	17	<0.001
	Experiment	143.9	8.731				

\*\* The difference is significant at 0.01 level; \* The difference is significant at 0.05 level

The above table 8 shows a significant difference in the mean score between pre and post tests with respect to: assessment and recording (p<0.001) nurse-patient interaction (p<0.001) promptness in meeting the patients' needs (p<0.001) fundamentals

of care (p<0.001) patient education and discharge (p<0.001) organization of care (p=0.011) and overall essential care (p<0.001).



**Table 9: Association between essentials care and demographic variables**

Variables		Essentials of Nursing Care		Total	Fisher's Value	p - value
		Poor	Moderate			
Age	20 - 25 Years	5 (83.3%)	1 (16.7%)	6	4.610	0.179
	26 - 30 Years	13 (72.2%)	5 (27.8%)	18		
	31 - 35 Years	8 (80.0%)	2 (20.0%)	10		
	> 40 Years	0 (0.0%)	2 (100.0%)	2		
Marital Status	Single	7 (77.8%)	2 (22.2%)	9	0.185	0.990
	Married	19 (70.4%)	8 (29.6%)	27		
Professional Education	GNM Nursing	16 (61.5%)	10 (38.5%)	26	4.826	0.090
	BSc Nursing	8 (100.0%)	0 (0.0%)	8		
	PBBSc Nursing	2 (100.0%)	0 (0.0%)	2		
Total Years of Experience	7-12 Months	1 (100.0%)	0 (0.0%)	1	3.353	0.745
	1 - 3 Years	6 (85.7%)	1 (14.3%)	7		
	3 - 5 Years	8 (72.7%)	3 (27.3%)	11		
	5 - 8 Years	7 (70.0%)	3 (30.0%)	10		
	8 - 10 Years	3 (75.0%)	1 (25.0%)	4		
	Above 10 Years	1 (33.3%)	2 (66.7%)	3		
Experience in present institution	Up to 6 Months	2 (100.0%)	0 (0.0%)	2	8.021	0.159
	7-12 Months	1 (100.0%)	0 (0.0%)	1		
	1 - 3 Years	7 (70.0%)	3 (30.0%)	10		
	3 - 5 Years	13 (86.7%)	2 (13.3%)	15		
	5 - 8 Years	2 (40.0%)	3 (60.0%)	5		
	8 - 10 Years	1 (50.0%)	1 (50.0%)	2		
	Above 10 Years	0 (0.0%)	1 (100.0%)	1		
Nursing shifts	Day	2 (33.3%)	4 (66.7%)	6	5.428	0.039
	All Shifts	24 (80.0%)	6 (20.0%)	30		
Current job position	Head Nurse	7 (58.3%)	5 (41.7%)	12	1.731	0.247
	Shift In-charge	19 (79.2%)	5 (20.8%)	24		
Experience in current position	Up to 6 Months	2 (100.0%)	0 (0.0%)	2	3.232	0.612
	7-12 Months	1 (100.0%)	0 (0.0%)	1		
	1 - 2 Years	11 (73.3%)	4 (26.7%)	15		
	2 - 5 Years	12 (70.6%)	5 (29.4%)	17		
	5 - 10 Years	0 (0.0%)	1 (100.0%)	1		

The table 9 shows that no significant association could be detected between essential care and demographic variables such as age, marital status, professional education, years of experience, experience in the present institution, current job position and experience in the current position

( $p > 0.05$ ). Essential care and shift working has a significant association ( $p = 0.039$ ).

**FINDINGS**

At pre-test, no significant difference ( $p > 0.05$ ) was noted between the control and experimental groups with respect to domains of essential care. However, post-test showed significant

difference between control and experimental group. In all the items the mean score of experimental group was significantly higher than that of control group ( $p < 0.05$ ). There was a significant difference in the mean score between pre and post tests of experimental group at 0.05 level with respect to: assessment and recording ( $p < 0.001$ ) nurse-patient interaction ( $p < 0.001$ ) promptness in meeting the patients' needs ( $p < 0.001$ ) fundamentals of care ( $p < 0.001$ ) patient education and discharge ( $p < 0.001$ ) organization of care ( $p = 0.011$ ) and overall quality in delivering essential care ( $p < 0.001$ ). No significant association could be detected between essential care and score demographic variables such as age, marital status, professional education, years of experience, experience in the present institution, current job position and experience in the current position ( $p > 0.05$ ). However, essential care and nursing shift has a significant association ( $p = 0.039$ ).

## DISCUSSION

The statistical evidence from the present study suggests that SNCR has invariably helped the nursing personnel in providing a more effective, systematic and reliable delivery of essential care to patients. This new nursing intervention introduced to the nursing professionals and patients of the adult medical-surgical wards upon admission and until discharge, has considerably improved the patient experience through the ongoing and systematic nursing presence. The research on the influence of SNCR on reliability in delivering essential care in the medical-surgical wards of the tertiary care hospital in central Kerala has adds empirical and statistical assertion along the lines already observed and reported by other researchers that regular and systematic checks on patients raise the levels of patient satisfaction, nursing care practice and positive attitude including nursing job satisfaction.

## CONCLUSION

This study adds to the insights of the research world, by illustrating that the implementation of evidence-based practices at unit levels by empowering the frontline nursing personnel can boost quality care and patient satisfaction in our hospitals. Results of this study offers an encouraging signal to the empowerment of front-end nursing personnel to escort a successful alteration in nursing care practice in their patient care units.

## REFERENCES

1. Meade CM et al (2006) Effects of nursing rounds on patients' call light use, satisfaction, and safety. *American Journal of Nursing*; 106: 9.
2. Fitzsimons B et al (2011) Intentional rounding: its role in supporting essential care. *Nursing Times*; 107: 27, early online publication
3. Rhodes, M., Morris, A., Lazenby, R. (February 25, 2011) "Nursing at its Best: Competent and Caring" OJIN: The Online Journal of Issues in Nursing Vol. 16 No. 2.
4. Department of Health (2010) *Independent Inquiry into Care Provided by Mid Staffordshire NHS*

- Foundation Trust January 2005– March 2009. Volume 1. London: DH.5.
5. Cheung R et al (2008) Nursing care and patient outcomes: international evidence. *Enfermeria Clinica*; 18: 1, 35–40.
6. Aiken LH et al (2002) Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*; 288: 16, 1987–1993.
7. Kovner C et al (2002) Nurse staffing and postsurgical adverse events: an analysis of administrated data from a sample of US hospitals. *Health Services Research*; 37: 611–629.
8. Tucker A, Spear S (2006) Operational failures and interruptions in hospital nursing. *Health Services Research*; 41: 3, 643–662.
9. NHS Institute for Innovation and Improvement (2011) *The Productive Series. Parliamentary and Health Services Ombudsman (2011) Care and Compassion? Report of the Health Services Ombudsman on Ten Investigations into NHS Care of Older People.* London.
10. Braide M The effect of intentional rounding on essential care. *Nurs Times*. 2013 May 22-28;109(20):16-8.
11. Brosey, Lisa, Karen S. (2015). Effectiveness of structured hourly nurse rounding on patient satisfaction and clinical outcomes. *Journal of Nursing Care Quality: April/June 2015- Volume 30 – Issue 2 – p 153 -159.*
12. Polit F Denise. *Nursing research. Principles and methods.* 6<sup>th</sup> edn. Washington: Lippincott publication;1999