The efficacy of intentional rounding has been widely debated and questioned so one trust carried out a review to ascertain staff and patient views on its effectiveness.

Staff and patient views on intentional rounding

In this article...

- The perceived benefits of rounding
- The evidence base on the effectiveness of intentional rounding
- Formulating a better model of patient-centred care

Keywords: Intentional rounding/Hourly rounding/Patient-centred care/Acute care

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### 5 key points

1. **Intentional rounding is a debated practice – the evidence base that it improves patient experience or outcomes is low to moderate.**

2. **Staff have expressed concerns that rounding does not individualise care.**

3. **Patients have highlighted that conversation between staff and patients is more important than regular rounds.**

4. **The process of intentional rounding has become task orientated.**

5. **There is a case for co-producing new models of inpatient care that concentrate on the nurse–patient relationship.**

Intentional rounding (also known as “hourly rounding” or “comfort rounding”) has been widely debated in nursing for nearly a decade. First reported in the US in 2006, it is described as a process involving regular nursing checks to ensure each patient’s fundamental care needs are met (Struder Group, 2007; Meade et al, 2006). The emphasis in the US literature is on presence or visibility of nurses in single-patient rooms, to reduce call-bell usage and increase patient satisfaction.

Translating hourly rounding to the UK was promoted in 2012, after a number of high-profile cases of poor-quality care in the NHS (Francis, 2013; Care Quality Commission, 2011). The British prime minister called for “hourly ward rounds to check on patients by their bedside” (Triggle, 2012) and this was backed by the chief nursing officer for England (Department of Health, 2012).

Despite advocating the US initiative, neither the CNO nor the prime minister outlined how rounding should be done in the UK, where the environment and staffing ratios differ from the US. There was also no discussion about the strength of evidence supporting hourly rounding, a drive Snelling (2013) describes as “a politicised search for simple solutions to complex problems”. As a result, hospitals in the UK lacked guidance on how to achieve regular rounding, or how to measure results of investment in rounding.

### Literature review

The majority of evidence supporting hourly rounding originates from the US, focusing on before-and-after measures including falls, pressure-damage incidence and call-bell usage (Halm, 2009; Struder Group, 2007; Meade et al, 2006). Emphasis is on visibility and presence of nurses to provide reassurance in a single-room environment – a contrast to the mainly shared “bay” environment in UK hospitals.

Few UK studies exist and, where they do, samples are small, with researchers failing to use comparative or controlled research methods (Dix et al, 2012; Bartley, 2011; Lucas et al, 2010). Langley (2015) has summarised differing approaches to rounding in the UK, highlighting variation in the measurement of outcomes; reductions in falls, pressure damage or call-bell use as a result of rounding is questionable.

Both patients and staff believe rounding does not necessarily improve care.
Langley (2015) also recommends further research is undertaken using alternatives to quantitative outcome measures. One review has concluded that questions should be raised regarding the quality of the evidence, as well as:

- Who does it, how often, and for which patients?
- What are the implications for skill mix and nurse staffing?
- What are the costs associated with different models? (Kings College London, 2012).

The authors concluded: “further evaluation of the evidence is required to determine effectiveness and cost implications”.

Two reviews have explored the implementation of hourly rounding and its effectiveness (Forde-Johnston, 2014; Mitchell et al, 2014). Both highlight the variability of study protocols and a lack of randomised studies. Mitchell et al (2014) found that all studies were pre-post and open to researcher bias; Forde-Johnston (2014) concluded that all UK studies are evaluative audit. Lack of rigour weakens results, which are consequently presented as anecdotal evaluative recommendations. The generalisability of studies is limited when additional resources are allocated during the study period, which may not be sustainable after the study has ended.

No study has actually observed rounding in practice and it is not possible to attribute any findings to rounding if it is not confirmed that the intervention is actually being carried out. In Bergs et al’s study (2011), some staff declined to have paperwork audited.


Following their first implementation of hourly rounding – a written clock, tick-box approach – Hutchings found a lack of staff engagement and minimal impact on patient experience or care. A new approach using a wall-mounted clock was tried, in which the clock hands were moved to show the time when the next round should take place, removing the need for all written paperwork (Hutchings et al, 2013). This was combined with an education programme and leadership rounds. A review of the new approach found initial improvements in outcomes, however staff engagement still varied and patients’ opinions varied from “reassuring” to “insulting” (Hutchings et al, 2013).

It seems the evidence to support hourly rounding is flawed, with uncertain impact reported on falls, call-bell use and patient experience. However, there remains a strong push in the UK to implement this unproven intervention, with an emphasis on education to reinforce hourly rounding when it is not achieving the desired outcomes. There is no literature examining the impact of “not rounding”, or of an alternative intervention.

**Case study trust**

The case study trust reported in this article had aimed to intentionally round on every patient hourly, since 2012. Noting lack of staff engagement and lower-than-average patient satisfaction ratings, the trust relaunched the tool with an hourly tick chart and an education drive in 2013. Although internal audit showed an initial improvement in outcomes – such as time to answer call bells, falls and patient satisfaction on pilot wards – this was not reported consistently and staff were neither engaged nor positive about the tool.

In addition, a staff survey on continence care found most staff did not relate intentional rounding to promoting continence – a key need that rounding should address. This raised questions about the process of rounding at the trust. Given the low-to-moderate evidence for rounding (Mitchell et al, 2014), it was decided to review the approach to hourly rounding again, opening the debate with an “adapt, adopt or abandon” premise. The aim was to empower individual ward managers to decide whether their team would:

- Continue to round using the available tool (adopt);
- Change the model and develop a new model of working (adapt);
- Abandon the process of rounding.

The review was also intended to help the trust to understand staff and patient views on the effectiveness of intentional rounding.

This article reports on the project’s planning stage – gathering patient and staff views – which was carried out between September 2014 and February 2015.

**Methods**

A “plan, do, study, act” quality improvement approach was used to guide the project, as advocated by NHS Improving Quality (NHS Improvement, 2013). Ethics approval was not required. All patient and staff identifiers were anonymised.

**Data collection tools**

**Staff surveys**

Staff surveys were carried out using yes/no and multiple-choice questions, which were informed by the intentional rounding literature. Surveys were promoted electronically to all nursing and healthcare assistant staff across the trust (approximately 4,000 people). Electronic and paper versions were provided.

**Patient surveys**

Face-to-face survey administration was used to ensure patients with a disability had equal opportunity to respond. The interviewees were a convenience sample of inpatients, who were identified by the nurses on duty on each ward as being well enough to participate.

Surveys comprised two yes/no questions and two multiple-choice questions. This was condensed to three yes/no questions for patients with a known diagnosis of dementia. Paper surveys were used to record responses.

**Interviews**

A semi-structured interview developed after reading the intentional rounding literature was conducted with staff and patients. Short interviews, which lasted 3-5 minutes, were carried out on six wards. The interviewees were a convenience sample of inpatients, identified by the nurses on duty on each ward as being well enough to participate, and nursing staff who were available to be interviewed during the visit.

Staff and patients were asked to share their thoughts and opinions on the current hourly rounding approach and to suggest ideas for future improvement. When a patient had not heard of rounding, a short description was provided before the interview commenced. Interviews were audio-recorded and transcribed; all personal identifiers were anonymised. A simple thematic analysis was performed.

**Paperwork audit**

A convenience sample of hourly rounding charts was audited to establish paperwork completion rate. The audit tool assessed the number of rounding charts where all hours were signed up until the hour of the audit on the day. The audit tool also asked whether there was additional documentation on the reverse of the chart where any actions were supposed to be recorded.
Nursing Practice

Research

**TABLE 1. STAFF VIEWS ON Rounding**

<table>
<thead>
<tr>
<th>Phrases</th>
<th>Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increases paperwork</td>
<td>22</td>
</tr>
<tr>
<td>Does not individualise care</td>
<td>14</td>
</tr>
<tr>
<td>Hourly rounding is not useful</td>
<td>14</td>
</tr>
<tr>
<td>Pre-empts patients’ needs</td>
<td>10</td>
</tr>
<tr>
<td>Inefficient use of time</td>
<td>8</td>
</tr>
<tr>
<td>Decreases patient risk</td>
<td>7</td>
</tr>
<tr>
<td>Hourly rounding is useful</td>
<td>5</td>
</tr>
<tr>
<td>Creates routine</td>
<td>5</td>
</tr>
<tr>
<td>Increases time by bedside</td>
<td>4</td>
</tr>
<tr>
<td>Has positive outcomes</td>
<td>4</td>
</tr>
<tr>
<td>Individualises care</td>
<td>3</td>
</tr>
<tr>
<td>Decreases time by the bedside</td>
<td>2</td>
</tr>
<tr>
<td>Disrupts routine</td>
<td>1</td>
</tr>
<tr>
<td>Efficient use of time</td>
<td>1</td>
</tr>
<tr>
<td>Increases patient risk</td>
<td>0</td>
</tr>
<tr>
<td>Has negative outcomes</td>
<td>0</td>
</tr>
</tbody>
</table>

Observations

A project-specific observational tool was designed to establish whether intentional rounding was being carried out on an hourly basis and as intended, including asking all five questions (toileting, comfort, fluid, call-bell reach and an update regarding care and treatment).

Two bays of four patients were observed over a 90-minute period on four occasions on two wards. Observation was authorised by the ward manager and carried out between 9am and 5pm. A convenience sample was used for observation bays.

Results

Patient surveys

Forty patient surveys were completed. In total, 31 (78%) patients reported never having heard of intentional rounding, hourly rounding or comfort rounding. Thirty-three (83%) patients said they would like to see their nurse “about the same” (ie, neither more nor less), and 19 (48%) respondents stated their nurse attended their bedside hourly.

Staff surveys

In total, 102 staff responded to the survey. Sixty-one (60%) of respondents had more than three years’ experience as a registered nurse, with 71 (70%) educated to degree level or above.

Nearly half (n=46, 45%) of respondents believed hourly rounding was achievable in their area, but 73 (72%) of respondents did not believe it improved patient experience. When given a range of positive and negative phrases that best described intentional rounding, the top three phrases chosen by respondents stated that it:

- Increases paperwork;
- Does not individualise care;
- Is not useful (Table 1).

Interviews

Fifteen patients and a total of 15 staff were interviewed from six wards. Three main themes emerged in both staff and patient interviews:

- Regular presence;
- Tick-box exercise;
- Nurse-patient relationship.

Table 2 outlines themes with staff and patient quotations.

Paperwork audit

A total of 40 intentional rounding charts were audited for completeness on four wards (10 per ward). On 30 (75%) charts, each hour had been ticked at the time of audit. Most charts (n=38, 95%) had no extra information written on the reverse, where interventions should be recorded.

Observations

During four separate 90-minute observation periods on two wards, rounding was not completed in full at any time: patients were not asked all five questions at any time. Staff, however, did ask patients as a group if they were “okay” and it was noted that they spent more than 30 minutes with individual patients who required help to meet essential needs.

Discussion

Findings from this project have highlighted that the majority of inpatients are unaware of the intentional rounding process. When they are informed about the process, most questioned its use or effectiveness. As discussed by Hutchings (2012), patients do not appear to value the intervention as a method of providing care or improving experience.

Patients overwhelmingly reported seeing their nurse “enough”, despite observations indicating that the process was not being carried out by staff as scripted. Responses from staff and patients implied that paperwork is a barrier to facilitating an effective nurse–patient relationship, with patients in particular emphasising this relationship as an element of care that is missing.

Comfort, talking and educating were identified as the most common aspects of “care left undone” in a recent study. Ball et al (2013) surveyed 2,917 nursing staff in 46 acute hospitals and identified statistically significant links between lower staffing levels and a perception that tasks such as developing a nurse–patient relationship were left undone at the end of a shift; this was viewed by nurses as a failing.

Person-centred care is often seen as the gold standard for nursing. Despite its intentions, rounding appears to have promoted task-orientated care and does not encourage an enabling relationship between staff and patients. Dewing (2004) suggested person-centred care is achieved by “knowing the person”, thereby facilitating the nurse–patient relationship. Both patients and staff have highlighted this as important in this project. Ball et al (2013) found that only 11% of treatments or procedures were left undone, but many aspects of relationship care could not be fitted into a shift. We need to better understand how nurses prioritise elements of “care left undone” if we are to optimise the patient experience.

Most staff believed intentional rounding did not improve patient experience. However, there was disagreement about the achievability of intentional rounding. Staff reported they were often too busy to round on every patient every hour and a more intuitive approach to meeting individual patients’ needs was necessary. This feedback was reinforced when audit and observation took place. Despite the fact that 75% of charts were completed in the audit, during observation the rounding process was not carried out in full at any time.

This variation between records and observation is interesting. Checklist compliance audits measure the extent to which staff “tick boxes”. By auditing records only, inadvertently there may be a perverse incentive to tick boxes, rather than completing the task in full at the bedside with the patient. Over time, teams learn they can demonstrate high reliability by ticking boxes. The potential safety improvements from a checklist are therefore lost, because monitoring shapes behaviour in unforeseen and unsafe ways (Vincent et al, 2013).

In agreement with Mitchell et al (2014), we conclude that intentional rounding is probably failing to achieve the desired improvement in patient experiences or outcomes. This poses a question of how to establish a model of care that both patients and staff believe is effective and has a posi-
approaches are required to improve patient care. Phase 2 of this project will now work to co-produce new ways of providing effective inpatient care with staff and patients.

**Conclusion**

Phase one of this quality improvement project has found that staff and patients do not value the process of intentional rounding as a method of improving patient outcomes or experience. Full rounding was not carried out on every patient hourly and was not always required for all patients. Both staff and patients focused on the value of the nurse–patient relationship, advocating a paperless approach that was intuitive to each patient’s needs, rather than task orientated. Staff and patients emphasised the importance of meaningful conversations that facilitate an enabling approach to care, and value the acquisition of useful knowledge about the person.

Unlike other projects that have aimed to re-engage staff with the rounding process through education, this project tried to understand the value of the process through the eyes of staff and patients. Having combined this data with the available evidence, we conclude that new approaches are required to improve patient care. Phase 2 of this project will now work to co-produce new ways of providing effective inpatient care with staff and patients.

**Table 2. Thematic Analysis of Interviews**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Staff comments</th>
<th>Patient comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular presence</td>
<td>“We are always on the floor; we don’t need it [intentional rounding] as a reminder”</td>
<td>“A nurse is always in the bay or around”</td>
</tr>
<tr>
<td></td>
<td>“We are always there doing the tasks without the chart”</td>
<td>“I would like to see my nurse less”</td>
</tr>
<tr>
<td></td>
<td>“Not every patient wants or needs you every hour”</td>
<td>“I see my nurse enough for me”</td>
</tr>
<tr>
<td></td>
<td>“We are in the bay anyway”</td>
<td>“When I press my buzzer, they come”</td>
</tr>
<tr>
<td>Tick-box exercise</td>
<td>“Staff do not complete the document hourly. It is completed as a ‘have to do or I’ll get into trouble’”</td>
<td>“We don’t need documentation, just better communication”</td>
</tr>
<tr>
<td></td>
<td>“We have other forms that are filled in instead, like observations, fluid, drug chart”</td>
<td>“I don’t need this, I just need them to be free when I call. Like when I need the toilet”</td>
</tr>
<tr>
<td></td>
<td>“The chart doesn’t make me do my job better, it’s an afterthought”</td>
<td>“Maybe there should just be an option for patients that need it”</td>
</tr>
<tr>
<td>Nurse–patient relationship</td>
<td>“It [the intentional rounding document] asks yes or no questions; it doesn’t ask qualitative questions for quality interactions”</td>
<td>“I just want them to speak friendly, not ask questions about my pain and drinks”</td>
</tr>
<tr>
<td></td>
<td>“It’s just good for documentation purposes, not for the patient”</td>
<td>“We don’t have conversations, we just answer questions”</td>
</tr>
<tr>
<td></td>
<td>“It doesn’t allow me to be patient centred”</td>
<td>“I can see they are really busy, I want them to know I’m OK and they can go to someone else”</td>
</tr>
</tbody>
</table>

**References**


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