Does intentional rounding practice improve patient safety and experience?

Key points

1. Rounding was introduced to improve patient safety and experience.
2. The rationale behind rounding is that patient needs are better met through responsiveness, action and a strong nursing presence.
3. A study conducted in two acute hospital wards in England revealed a practice of rounding that was dissociated from clinical care.
4. Although rounds were often rushed and their needs not always assessed, patients appreciated the conversational style of rounding.
5. More research is needed, and the evidence base needs to be strengthened, to ensure rounding adds value to care.

Authors
Sue Langley is deputy director of nursing, professional practice, Central Manchester University Hospitals Foundation Trust; Paula Ormandy is professor in long-term conditions research; Julie Wray is senior lecturer in multiprofessional post-graduate studies; both at the School of Nursing, Midwifery, Social Work and Social Sciences, University of Salford.

Abstract
Although widely used in UK hospitals, rounding is still a relatively new concept and the available literature fails to capture what it means from the perspective of patients and nurses. This article describes a study conducted to increase understanding of how rounding affects patient experience and nursing care. An ethnographic method was used to observe, listen to and talk with nurses and patients about their experiences of rounding. The findings reveal rounding practice was disconnected from clinical care, and sometimes appeared routine, ritualistic and at risk of becoming a tick-box exercise, with a hands-off approach and limited impact on patient safety. More research is needed to strengthen the evidence base for this widely used intervention.

Citation

Originally developed in the US, intentional or nurse rounding has been widely used in acute care settings in the UK since 2012. It gained a high profile in January 2012 when then-prime minister David Cameron participated in rounding during a visit to a large NHS trust, and announced a requirement to introduce it in all NHS acute hospitals (Department of Health (DH), 2012).

Rounding was emphasised in the policy document Patients First and Foremost, which was the initial government response to the Francis report into care failings at Mid Staffordshire Foundation Trust (DH, 2013). However, the literature and evidence base for rounding are limited, particularly in the UK, and most studies have not evaluated the quality of rounding interventions by observing rounding practice. We undertook a study to understand how the culture of rounding in a particular organisation may affect patients’ and nurses’ experiences. We used an ethnographic methodology observing and exploring the perspectives of patients and staff on the social processes involved in rounding.

What is rounding?
The concept of rounding is based on the work of the Studer Group (2007) and Meade et al (2006), and was developed as timed, planned and purposeful interventions addressing specific elements of nursing care. It involves nurses or healthcare assistants checking patients on an hourly or two-hourly basis, attending to identified needs, asking “Is there anything more I can do?”, and indicating to patients when the next check will take place.

Meade et al (2006) developed a 12-point checklist (Box 1). Rounding involves checking the four ‘P’s for each patient.
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- Pain;
- Position (checking that the patient is comfortable);
- Personal needs (offering help with toileting or hygiene);
- Possessions (ensuring everything the patient needs is within reach).

The aim of rounding is to improve patient safety - notably by reducing the incidence of falls and pressure ulcers – and patient satisfaction (Blakley et al, 2011; Woodward, 2009; Tea et al, 2008; Meade et al, 2006). A more specific aim is to reduce patients’ use of call bells by addressing their needs proactively, rather than reactively. This enables nursing staff to use their time effectively without interruptions from call bells (Meade et al, 2006).

The theoretical basis for rounding is that patients’ fundamental needs are better met through responsiveness, proactive intervention and a strong nursing presence. Woodward (2009) highlighted the concept of ‘help uncertainty’, arguing that when patients do not know when help will next be available, their experience is poorer. Tea et al (2008) found that patients who rated staff responsiveness highly were also more likely to report high overall satisfaction with nursing care. D’Alessio et al (2010) explored the concept of the nursing presence, noting key aspects and behaviours such as communication, respect, empathy and being seen.

Literature review

A comprehensive literature review of 36 studies highlighted a dominance of quantitative studies only tentatively linking rounding to impact measures such as reductions in fall rates, pressure ulcer incidence and use of call bells. There was little examining understanding of what rounding means from the perspective of patients or nurses. Only two UK studies (Snelling 2013; Forde-Johnson 2014) were included in the review – much of the NHS literature lacked analytical and scientific rigour, and it appeared that there was a large gap in the UK evidence base.

Quantitative studies

The quantitative studies mainly examined the ‘before’ and ‘after’ of implementing rounding and were based on the seminal study of Meade et al (2006). Their hypothesis was that rounds conducted on a regular schedule by nursing staff who performed a specific set of actions would reduce call bell use, increase patient satisfaction and improve patient safety by reducing falls.

A limitation to the reliability of the Meade et al (2006) and Studer Group (2007) studies – as well as replicated studies such as Berg et al (2011) and Kessler et al (2012) – is that the quality of the rounding intervention was not measured directly, as there was little direct observation of rounding practice. The effect of rounding was measured through proxy measures that did not necessarily relate to what happened during the rounding interactions.

Qualitative studies

A small number of more contemporary studies using qualitative methodologies potentially provide insight into rounding in practice (Harrington et al, 2013; Deitrick et al, 2012; Neville et al, 2012; Rondinelli et al, 2012; Blakley et al, 2011). These studies investigated rounding through interviews with staff and patients, as well as nurse leaders who oversaw its implementation or directly observed it. They found that staff were not always compliant with performing rounding; that rounding required a defined implementation plan and training approach; and that staff did not always see the value of rounding for, and did not always link it with improved patient care.

Study methods

Data collection took place over a four-week period in May/June 2014, in two acute care inpatient wards (one male and one female), each with 28 beds in bays and side rooms. A total of 38 rounding interventions were observed and documented by five volunteer nurses, who were trained in observing and interviewing participants. Patients and staff who gave informed consent were included in the study. Patients who were unwell, confused or unable to communicate in English were excluded – as were temporary staff and student nurses. A total of 895 patients received a rounding visit during the study; not all were at their bedside to receive a visit at the time of the observed round. Of the 38 staff observed, 34 were interviewed. We planned to interview one patient for each of the 38 rounds, however, only 34 could be interviewed as some were receiving treatment or away from the ward.

The aim of the study was to generate new evidence about rounding practice. Data was analysed to identify cultural themes – or patterns of tacit and explicit knowledge – emerging regarding the practice of rounding in the study setting. The data was descriptive and observational, and a process of ethnographic analysis was used to uncover components of meaning and derive cultural themes and sub-themes. Four main themes emerged: presence; playing the routine; actioning care; and engagement.

Fig 1 summarises the four themes and sub-themes. This represents the new evidence generated by this in study of rounding practice. Ethical approval was gained from the university, the trust’s research and innovation division and the national research ethics service. A strategy was devised to enable the research team to inform ward matrons if they observed poor practice.

We also reviewed historical documentary data of falls rates, pressure ulcer prevalence, patient satisfaction scores and call bell usage before and after implementation of rounding (Table 1) in three six-month periods, the first of which covered three months before rounding was implemented and three months after. This proved inconclusive, with no direct link seen between rounding and improved outcomes. It is difficult to attribute any

Box 1. The Meade protocol for nurse-led rounding

1. Pain assessment and management so the patient does not need to use the call bell for pain medication
2. Check if the patient requires any other medication
3. Offer toileting assistance
4. Assess the patient’s position and comfort, ask if the patient requires repositioning and is comfortable
5. Ensure the call bell is within the patient’s reach
6. Put the telephone within the patient’s reach
7. Put the TV remote control and bed light switch within the patient’s reach
8. Put the bedside table beside the bed
9. Put tissues and water within the patient’s reach
10. Put the waste paper bag beside the bed
11. Before leaving the room ask “Is there anything I can do for you before I leave?”
12. Tell the patient a member of nursing staff will return in an hour/two hours

Source: Meade et al, 2006
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changes in patient safety or experience data solely to rounding as it cannot be isolated from other factors that may contribute to patient safety and experience – for example staffing levels, ward leadership – while low numbers of falls and pressure ulcers make analysis of any consistent long-term trend difficult. The response rate for patient experience data increased over time and so can positively affect the score as highlighted in 2014 data.

Study findings
Presence
Receiving a rounding visit
The study revealed that an important part of the presence of the rounder was that patients actually received a rounding visit. Rounding was an inclusive process whereby most patients in a busy acute ward setting received a visit. Patients recognised the presence and regularity of rounding visits, even if these were brief, as shown by some of their comments below:

“They come round every so often and ask you if you are all right and things like that.”
“They are always popping in and out.”
“They do it every two hours or something like that.”

The presence of the rounder could vary in length; sometimes one ward rounding could be brief and last only 10 minutes, at other times it could take longer than 30 minutes. This raises the question of whether rounding could be clinically or otherwise meaningful for patients in cases where little time (sometimes less than a minute) was spent with each individual.

Position of the rounder
For patients, the presence of the rounder was mainly identified through their visible positioning in the room, rather than a physical closeness or touch. The rounder usually stood at the end of the patient’s bed, in the doorway of the side room, or in some cases in the middle of the bay. For most of the rounding observed, the rounder was positioned at a distance, with reduced proximity to the patient. This observation was reinforced by what both staff and patients said in the interviews.

The distant position of the rounder suggests a lack of time to perform the round, and in the interviews staff did say that rounding at times detracted already busy nurses from a heavy workload. A way of managing this workload pressure was to perform rounding quickly and at a distance. The current literature pays little attention to staffing levels with regard to rounding or the impact poor staffing levels may have on its quality.

Non-verbal communication
An important part of the rounding presence was the use of non-verbal communication, which has not been identified in previous studies. Rounders may not have been physically close to patients or introduced themselves consistently, but they regularly used non-verbal communication to signal and assert their presence. Smiling and eye contact demonstrated that there was an emotional connection, and awareness of each other. The culture of the acute ward setting meant that, although rounding was often rushed, a brief individual patient encounter had a caring value attributed to it.

Role of the nurse in charge
Once a day, rounding was undertaken by the nurse in charge (NIC) and this was found to have a significant influence. The NIC’s rounds were usually longer, used more verbal communication and gave patients more information than rounds conducted by other staff. The presence of the NIC appeared to benefit patients, as they were able to ask questions and seek information that other staff – particularly non-qualified staff – were not always able to provide during their rounds.

Playing the routine
Signalling and reduced process
As mentioned above, by standing at a distance or even outside the patient’s room, rounders signalled to patients that they were too busy to engage with the rounding process, which would have reduced the impact of the rounding visit for the patient. A rounding visit had taken place and the rounder had been present, but this did not necessarily result in any care being given, as communication with the patient had been minimal and the four ‘P’s had not been checked.

Rounding was found to be a reduced process, with the four ‘P’s checks largely absent. Halm (2009) makes the point that if the four ‘P’s are not addressed, rounding will make no difference to outcomes such as number of falls, pressure ulcer prevalence, call bell usage for toileting/hygiene needs, and pain management.

Documentation
Documentation was an integral part of rounding practice. Compliance with documentation completion was high, whereas this is highlighted as a challenge in the literature (Harrington et al, 2013; D’Alessio et al, 2012; Tucker et al, 2012; Meade et al, 2006). A possible reason for this is that rounding practice was observed, which
may have encouraged staff to complete documentation on the spot.

The rounding documentation used in the study setting was not an individual sheet or board kept with individual patients or in their rooms, but a single-sheet or board kept with individual documents covering all patients on the ward. It appeared that documentation gave a visible routine and ritual to the practice of rounding. The documented rounding was introduced in the first place in order to examine some of the issues about the delegation of rounding and its effects on patient safety outcomes (Toole et al, 2016; Fabry, 2015; Deitrick et al, 2012; Tucker et al, 2012).

The study also exposed a hands-off approach to rounding. Many rounds resulted in only a few interventions from staff or requests from patients, and these were mainly non-clinical. It appeared that rounding mainly responded to requests from patients, which suggests that practice in the study setting created a modified form of rounding. Generally, no hands-on care was performed and no interventions occurred that could have improved patient safety outcomes normally associated with rounding, such as reduced fall rates and pressure ulcer incidence.

### Teamwork

Rounding observed during the study was equably shared between registered and non-registered staff, who each performed it approximately half of the time. Rounders’ potential to fully assess and address patients’ needs could therefore be limited. However, it also appeared that registered nurses could be as non-clinical and hands-off in their approach as non-registered staff. Patients reported that there could be a lack of teamwork, which would delay actions needed in response to their requests during rounding.

Deitrick et al (2012) and Rondinelli et al (2012) reported that a lack of teamwork impeded the process of rounding and that issues about the delegation of rounding needed to be addressed to ensure a robust rounding process. One of the reasons why rounding was introduced in the first place was to respond to patients’ needs in a timely manner, but in our study, patients sometimes experienced inconsistent and delayed responses.

### Tea round

Perhaps the most surprising finding was that rounding resulted in high numbers of patients requesting drinks, in particular cups of tea. It may be that this small service increases patients’ overall satisfaction with their hospital stay, but this practice of rounding is a long way away from the ideals of rounding as a proactive model of care.

### Patient response

The study revealed an important aspect of rounding that is not examined in the literature: the fact that not only staff, but also patients can play the routine of rounding practice. It was observed that patients sometimes decided not to take part in the rounding process; for example, by feigning sleep or purposely wandering off.

The reviewed literature documented staff’s concerns that the rounding process might be too onerous or even too oppressive for patients, as structured protocols did not fit in with all the patients’ needs (Toole et al, 2016; Fabry, 2015; Tucker et al, 2012).

### Actioning care

Non-clinical and hands-off

The study uncovered a reality of rounding that did not consistently promote patient assessment or clinical care activities. In contrast, the literature consistently described rounding as including checks and interventions relating to the four ‘P’s (Halm, 2009; Meade et al, 2006). In our study, rounding was experienced as separate from the main care activities and system of nurse-patient allocation. This echoed findings that there could be a lack of clarity from staff both about the purpose of rounding and its effects on patient outcomes (Toole et al, 2016; Fabry, 2015; Deitrick et al, 2012; Tucker et al, 2012).

### Research

**Table 1. Patient safety and experience data**

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<td>Pressure ulcers2</td>
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* February to April 2012 = pre-implementation of rounding; 1 = All recorded falls, with or without harm; 2 = all recorded pressure ulcers, with or without harm; 3 = measured for 1 hour per month; 4 = Yes answer to “did you find somebody on the hospital staff to talk about your worries and fears?; 5 = Yes answer to “Did you have your pain assessed and reviewed during your stay?”
clinical care delivery promoted in the literature. This finding also hints at the fact that staff education and senior observation of the rounding process are important to ensure the rounding process is performed correctly on a day-to-day basis (Toole et al, 2016; Fabry, 2015; Neville et al, 2012).

Engagement
Consideration
The consideration given to rounding was at times nominal, as shown by the following factors:
- Gaps in allocation of staff members to do the rounding;
- Lack of staff volunteering to do rounding when no one had been allocated to the task;
- Separation of rounding from main care delivery processes.

Snelling (2013) suggested that there is only a slim chance that nurses will leave more important work to perform rounding. Our study confirmed this is the case in practice – rounds often started late, and in some instances, nurses wanted to finish their allocated care activities before rounding commenced. The conflict between patient workload and staff rounding duties could provide an explanation for why the rounding process was often rushed. Neville et al (2012), Harrington et al (2013) and Walker et al (2015) provided some corroborations in that they reported staff being frustrated when their allocated patient care duties conflicted with the requirement to perform rounding.

Information requests and conversational style
Receiving information was one of the most frequent patient requests made during rounding visits, and this is not emphasized in the literature. Several studies have examined the rationale for call bell use, however, information has not been highlighted as a specific need (Woodward, 2009; Tea et al, 2008; Studer Group, 2007; Meade et al, 2006).

Patients used the opportunity of rounding to engage in banter and jokes with staff, as well as to thank them. This finding may further emphasise that patients did not experience rounding as a clinical process. However, the detail of the data does show that patients valued a conversational style of interaction during rounding. These interactions became part of the everydayness of passing time while in hospital – therefore, this added to patients’ satisfaction with their care and hospital stay.

Box 2. Key findings from the study
- Presence
- Patient contact minimal, usually carried out from end of bed or side-room door
- Round carried out by nurse in charge is seen as valuable
- Playing the routine
- Staff play the routine to minimise the workload of rounding
- Completing the documentation is seen as important
- Rounding is a patient request process, not an assessment or care delivery process
- Actioning care
- Rounding is not performed as originally intended, the four ‘P’s are not part of the process
- Rounding does not appear to influence fall rates, pressure ulcer prevalence or patient satisfaction
- Rounding is not seen as integral to patient care delivery
- Rounding is a glorified tea round
- Engagement
- Patients value brief regular visits from staff
- Patients see rounding as caring
- Social element to rounding

Conclusion
The study findings – summarised in Box 2 – generate a new understanding of the relationships and interactions between staff and patients during the rounding process. In the study setting, rounding was mainly a hands-off, non-clinical process. The study reveals a divergent and modified style of rounding, raising the question of the importance of rounding in nursing practice in the study setting. It emphasises that rounding practice and culture do present challenges in their everyday application. These challenges can make rounding seem routine and ritualistic.

The study has contributed to the detailed understanding of the constraints and adaptations that occur in everyday practice rounding. The evidence generated from it shows rounding as an information-giving process, and perhaps also an additional drinks round, which is a long way from the ideals of improving patient safety and experience. More research is needed into a practice that is widely used in the NHS and the evidence base needs to be strengthened to ensure that rounding adds value to care.

References