‘Rounding’ for better patient care: An evaluation of an improvement intervention implementation

ABSTRACT

‘Rounding’ is reported to be an effective intervention to enhance patient-centred care; nurses make frequent calls on their patients to ensure their needs are met and reassure them they are the focus of their care. In our hospital two clinical units implemented rounding as improvement projects and asked the research unit to evaluate the effectiveness of implementation. A qualitative descriptive study using focus groups and in-depth interviews revealed that while the idea of rounding was well intended it was not as effectively implemented as it might have been. Consequently, lessons have been learnt about the difficulties of changing clinician behaviour and will inform a new attempt at implementation.

Key words

Rounding, patient-centred care, implementation, practice improvement, intervention

Text

BACKGROUND

The Studer Group®, a US based proprietary company for healthcare improvement, works with over 800 healthcare organizations in the U.S. and beyond, teaching them how to achieve, sustain, and accelerate exceptional clinical, operational, and financial outcomes. The Studer Group® helps its partners install an execution framework called Evidence-Based Leadership that aligns their goals, actions, and processes. This framework creates the foundation to enable organisations to transform the way they provide care in this era of rapid change (Studer Group ®website, accessed 29.10.2012).

At a Studer Group® workshop in Sydney, Australia in mid-2012, a number of initiatives to enhance patient and family centred care, including rounding, were introduced to some of the nursing unit managers (NUM) at our hospital. On the basis of the evidence presented, two of the NUMs attending this workshop decided to introduce 'rounding' to improve patient satisfaction and make better use of the assistant-in-nursing staff currently deployed in their units.

The approach and methods used were decided by each of the NUMs independently and the practice of rounding was implemented locally using staff and resources within the units. After a few months the authors discussed the status of the new intervention informally with each of the nurse leaders and asked if they would value a formal evaluation of the implementation of rounding in their respective areas. Both NUMs were keen to have our researchers do so and on this basis we drew up a formal proposal to evaluate rounding for discussion with their staff. In what follows we report our approach, methods and results of this formal evaluation of rounding on two clinical units at our hospital.

Literature Review: history and justification of rounding

In Australia and New Zealand, nurses undertaking regular rounds of their patient was once a perennial feature of nursing practice in the hospital apprenticeship training days; it was primarily the responsibility of the junior (student) nurse to ensure patients' basic needs were being met, their room and surroundings were clean and tidy and that they felt attended to and cared for (Castledine et al 2005). Moreover, in these pre-university-based nursing undergraduate education days, the model of care was decidedly 'task focussed' with the supposedly more menial and less sophisticated tasks such as those just described falling to the newest members of the nursing team. That said, it could be argued that a very important function was fulfilled by this practice, as ritualised as it was. In Australia and New Zealand the hospital-based apprenticeship was phased out during the early 1980s and this 'rounding' work all but disappeared as an all registered nurse workforce and more sophisticated models of care

such as primary nursing, team nursing and the philosophy and practice of ‘continuity of care’ replaced the rather rigidly hierarchical and fragmented provision of care practiced in the old model of task oriented nursing.

Then, in the late 1980s, the idea of making routine rounds to improve patient satisfaction was instituted in the UK (where nursing training was still predominantly in the hospital sector) whereby a ‘unit hostess’ was scheduled to visit patients 2-hourly with set responsibilities to carry out (Woodard 2009). As a more formalised clinical intervention to improve patients’ expectations for and experience of hospital care ‘patient rounds’ became more prominent in the mid-2000s (Castledine et al 2005). A growing body of literature arising throughout the last decade reports that patient rounds can be an effective way of enhancing patient care quality and safety (Tea et al 2008; Meade et al 2006; Bourgault et al 2008; Woodard 2009; Vats et al 2012; Olrich et al 2012) as well as nurse job satisfaction (Bourgault et al 2008; Setia & Meade 2009; Blakley et al 2011). Of course, in the hospital apprenticeship model nurses had not yet developed a theory of care and it is somewhat ironic, that had they had the knowledge and skills to do so, the practice of rounding might never have faded from view and be in need of re-invention.

Specifically, and by way of a definition, ‘rounding’, as its name suggests, requires a nurse to make frequent rounds of the patients in her/his care throughout the shift (although more usually only the morning and afternoon shifts) to check that the patient is comfortable, whether he/she has any unmet needs, and perform any tasks related to same (Woodard 2009). The patient visit is not intended to be protracted; rather, its goal is to provide a recurring point of contact with the patient so as to ensure they feel well attended to and to minimise the potential for patients to come to any harm (such as in needing to go to the toilet but also requiring assistance to do so, and in the event of which they did so unattended, may fall and injure themselves). Importantly, the literature emphasises that rounding is concerned with ‘proactively meeting

patient needs ... [and provides] an opportunity to involve patient in their care, and show care and concern for patient well-being and healing' (Blakley et al 2011).

AIM

This evaluation research aimed to:

1. Explore the process of implementing 'rounding' on each of the two clinical units;
2. Ascertain the effectiveness (or otherwise) of the implementation process;
3. Investigate nurses' perceptions of the practice of 'rounding';
4. Provide an analysis of each of the above with the intent of informing the future implementation of 'rounding' across all clinical areas of the hospital.

METHOD

Setting and Participants

The project was conducted in a medium-sized acute medical surgical private hospital in inner-city Sydney, Australia. All major specialities (with the exception of obstetrics and paediatrics) are provided, approximately 23, 000 discharges per year with an average length of stay of 5.2 bed days and a high acuity, mark the project site as a fast-paced complex environment in which to introduce change. Importantly, the hospital was recognised by the American Nurses Credentialing Centre in 2011 as a Magnet designated facility on the basis of excellence in nursing care quality and outcomes. The two units that implemented the practice of rounding comprised: a fifty-bed orthopaedic unit and a thirty-eight bed colorectal, vascular and gastroenterology unit. All nursing staff (a mix of registered and enrolled nurses and assistants-in-nursing) employed full- and part-time on the units were participants in the implementation and in the evaluation research. The rounding projects were led by the NUMs and their clinical nurse educators and they too participated in the evaluation. This evaluation research was conducted approximately three months post implementation.

Design

A qualitative descriptive (QD) methodology was chosen on the basis that it would provide rich accounts of participants' experiences of the implementation of the intervention and they would 'tell it like it was', in their own words. Similar to other qualitative methods the product or outcomes of the QD approach are 'coherent conceptual descriptions that tap thematic patterns and commonalities believed to characterize the phenomenon being studied and also account for the inevitable variation within them' (Thorne, Kirkham & O'Flynn-Magee 2004: 4). The QD approach is a response to practical needs and Patton (2002: 45) emphasises its practical nature by noting that 'well trained and thoughtful interviewers can get meaningful answers to practical questions without making a paradigmatic or philosophical pledge of allegiance'.

Consequently, a pragmatic approach to data collection to expedite the evaluation was taken. This involved two 30-45 minute focus groups conducted by one of the authors (JD) on each clinical unit with enrolled nurses (EN), assistants-in-nursing (AIN) and registered nurses (RN) and two in-depth interviews with each of the nurse unit managers (NUM) and their clinical nurse educators (CNE) conducted by another of the three authors (KW). Data were recorded digitally and then transcribed verbatim by a professional transcriber.

Analysis

Once the transcripts were completed the content was analysed thematically in order to derive the key issues and concerns of staff and their managers. Focus group and interview data were subjected to an iterative and inductive analysis (Pope et al, 2000; Thomas, 2006) with each of the researchers independently reviewing the data and then comparing findings in order to verify and validate them. The data were then organised into sections according to the challenges addressed in the theoretical framework by Dixon-Woods and colleagues (2012) as discussed below.

Theoretical framework

Dixon-Woods and colleagues (2012), after reviewing evaluation reports of five large, Health Foundation programs to improve healthcare quality in the UK, derived ten challenges in the design and planning of improvement interventions. Our data herein will be categorised according to these challenges in order to provide a theoretical framework and enable others to learn from the issues and concerns raised in the focus groups and interviews. These challenges are clustered into three overarching thematics (of which we are able to address only the first two of these), namely:

1. Design and planning of improvement interventions
2. Organisational and institutional contexts, professions and leadership
3. Beyond the intervention: sustainability, spread and unintended consequences (Dixon-Woods et al, 2012:4)

The challenges themselves concern important behaviour change principals such as: convincing people there is a problem to begin with and then convincing them further that your solution will work (Dixon-Woods et al, 2012: 5). As obvious as it sounds it is an issue all too frequently ignored in 'top down', bureaucratic approaches to change management with the official 'edict' designed to simply over-ride any such notion of consensus building and staff engagement. In this style of implementation it is expected that staff will simply 'jump to it' and change their behaviour accordingly and adopt the new practice without question or hesitation. Also often neglected is the collection of data throughout the implementation phase and the development of robust and appropriate outcome measures to ensure that the changes requested are actually delivered as planned. Data-driven approaches to change are increasingly seen as much more likely to achieve their goals as those that are not (Dixon-Woods et al, 2012: 5).

Understanding the organisational culture and the specific contexts into which improvement is desired is equally as important as the issues discussed above. What Dixon-Woods et al describe as 'tribalism and lack of staff engagement' (2012: 6) can be significant impediments to effective and efficient change management and it is essential to have ownership of the problem

and its solution and the responsibilities and goals outlined at the outset of the quality improvement endeavour.

Effective leadership too, is an important prerequisite for improvement projects to succeed and often what Dixon-Woods and colleagues (2012:64) term 'quieter' leadership, oriented toward inclusion, explanation and gentle persuasion is more likely to result in the desired improvements than the obverse. A related issue is that of the 'carrot' or stick' approach to incentivising staff; Relying on the intrinsic motivation of staff is often not enough to effect change. However, if the hard edge' or stick is to be used, it should be used judiciously warn Dixon-Woods and colleagues (2012: 6) to avoid backlash and resistance too early in the process.

RESULTS

Design and planning of improvement interventions

Challenge: Convince people that there's a problem

Dixon-Woods et al (2012: 4) suggest that an important element in the design and planning of an improvement intervention is to use data, such as patient stories, to sell the need for the intervention; this will help engage the participants emotionally and secure a higher level of commitment to the change process than otherwise would be the case. Human actors are just as much invested with emotional intelligence as they are other more rational and 'means-ends' forms of intelligence. While the latter forms are necessary of course, they are simply not sufficient in themselves to motivate people toward changing long held beliefs and practices. People need to feel that the change is going to make them feel better about the care they provide as well as improve outcomes for those in their care.

As one focus group participant commented*: 'I know that I am seeing all of my patients a numbers of times a shift at least. I would see them at least every hour … at least every patient.*

So I feel I am doing the rounding'. This was echoed by another nurse who told us: *'Theoretically we are doing it automatically … we should be … every nurse should be automatically [rounding] when they go into a room [to] ensure that the patient has their bell … has their table next to them you now … everything they need … before they leave the room they have it at hand'*.

These nurses clearly remain to be convinced that rounding is new and different from their current practice. Their comments suggest that their work is not recognised or perhaps even valued as already involving a form of rounding and that therefore there is no need to change their practice.

From a slightly different perspective another nurse commented: *'it is [rounding] on this floor because it is so demanding and they [the patients] are so dependent. We are easily [in their rooms] every half hour'*. While yet another insisted*: 'you are just running all the time into different rooms constantly. That's why I find it bizarre [introducing rounding]'*.

These data point to the reality that there was little sympathy for the idea of rounding as many perceived they were already doing something very similar. Indeed, the general 'busyness' of the clinical units and time-consuming nature of patient care delivery all but precluded any notion that rounding could or would be a good idea to introduce (at least not without a more convincing rationale and justification that it would necessarily improve their job satisfaction and patient care).

Challenge: if you do it, will it work? Convince people of the solution

It is simply not enough to convince people there is a problem; it is equally important, if not more so, to convince them that what you propose to do to remedy the problem is the appropriate solution. As Dixon-Woods and colleagues note well: 'Come prepared with clear facts and

figures, have convincing measures of impact to demonstrate the advantages of your solution' (2012: 4).

It seems that a perception existed on these two clinical units that the need for rounding was not a high priority, indeed that it was already happening and that therefore there was no need for a solution. As one nurse stated quite forcefully: *'it [rounding] is counterproductive. What it is actually doing is taking me away from the patient. If someone could tell me there was a need for the intervention if they could show me some statistics we have complaints from patients that these services haven't been provided properly … like their possessions have been put near them … if there is documentation I would like to see it to say why we need to bring this intervention in. Do you understand? That's quite rational'.*

Similarly, another suggested that if it was a solution then why for only nurses and not other members of the multidisciplinary team: *'and the dietician, and the physio and like, why isn't everyone included in the rounding? Why is it just for us?'*

Challenge: Data collection and monitoring systems

Dixon-Woods et al (2012: 4) note that improvement interventions take more time and resources than often anticipated at the outset. It is well worth the effort in the design and planning of the implementation therefore, to invest in quality data as a way of evaluating the change. They also note that in order to improve the uptake of the intervention, training people and having quality assurance embedded in the change process is important for success.

Evidence that rounding had taken place in the two clinical units was manifest in a new 'folder' for each patient in which a number of sheets with the interventions undertaken by the nurses were to be signed off on the hour (or as the nurse rounded) and these were to be kept outside the patients' rooms along with the their medical charts. As many nurses noted however: *'It's too busy. For the RNs anyway. Especially to worry about more documentation of irrelevant stuff when we are already in there [the patient's room] like … I don't know how many times*

an hour. You don't need to actually go in and check every hour because we are in [there] more often than not in there'.

Similarly, another participant commented: *'But it was a bit of a pain because it was this bit of paper, we didn't know where to keep it so it would be visualised, we'd keep it in the front of the chart, it got messy, it was getting torn, all sorts of things, you know and people just hated it, which I could totally see as it was annoying and it was just more paperwork'.*

The managers too, soon realised that the 'paperwork' was an issue for their staff, as one reported in her interview: *'The main problem we've found is that all the staff didn't like the paperwork. They felt they were being checked up on, they felt that they weren't being trusted'.*

Organisational and institutional contexts, professions and leadership

Challenge: Tribalism and lack of engagement

Dixon-Woods and colleagues discuss how important it is to engender a sense of ownership of the improvement intervention and that overcoming a lack of ownership can be very difficult (2010: 4). This was very apparent in comments from the focus groups member of both units implementing rounding, as one nurse noted in relation to the 'busyness' of the unit: *'We just do not stop … the only time you sit on a weekday is when you sit down and write your notes and that is interrupted all the time… so I don't know when you're supposed to be able to get this folder to go in the room and ask them all the questions'.*

Another noted in respect of the introduction and implementation: *'we just had an in-service. I remember hearing in a meeting and they started to talk about rounding and we all said 'the rounding … what is the rounding?'* Yet another nurse remarks along similar lines: *'maybe we were told in a meeting … a ward meeting or word of mouth … if you missed that meeting … and then some people were doing it and some people weren't aware of it … it was maybe a bit half-baked the way it came in'.*

Planning and taking time to have the intervention adequately discussed before implementation is also important as some participants suggested: *'It was introduced pretty quickly … it came and all of a sudden it was slotted in and it seems the simplest thing to put someone's sticky label and have a new sheet every day with the patient's name on it but it is not … when you have seven patients and there are more important things to actually be at the bedside or you see someone writing and you think 'why aren't you answering that bell … because you are worried that you are not going to have it all documented?'.*

Challenge: incentivising participation

Another strategy suggested by Dixon-Woods and colleagues (2010) is to rely on intrinsic motivation by staff and providing 'carrots' as incentives. These however, may not be enough and it might be important to have a 'stick' as well, although the latter should be used judiciously.

It would appear from the focus group participants that neither of these strategies was employed as one nurse notes: *'It is irrelevant on this floor because it is so demanding and they are so dependent…. It doesn't serve any purpose'*. Another was confused about the rationale for implementing rounding as she states: *'it's come from a couple of comments or complaints from patients that they haven't been seen by any nurses for a period of time or a couple of hours, bells going off all the time'* whereas another thought if patient bells 'going off all the time' was the real reason for its introduction then it was counterproductive because*: 'a lot of them [patients] say that they don't want to disturb you, and it's like that's what the buzzer's for and that's what we're here for …'*

As discussed above, the prevailing feeling amongst focus group participants was that it was unnecessary to implement rounding in so far as*: 'I know that I am seeing my patients a number of times a shift at least. I would see them at least every hour … at least every patient'*. And yet another nurse commented*: 'theoretically we are doing it [rounding] automatically … we*

should be … every nurse should automatically [round] when they go into a room [and] ensure that the patient has the bell … has their table next to them … you know … everything they need … before they leave the room they have it at hand'.

DISCUSSION

The theoretical framework through which we viewed our data and conducted the analysis was confirmed in our data and analyses: implementing quality improvement in healthcare is a complex, time consuming, energy intensive and a rather more fraught process than is often appreciated. The Studer group® initiative of rounding is reasonably well-supported by empirical data from a range of settings as a method to enhance patient and staff satisfaction with the nursing service. The hard work of transferring the idea and intent of rounding into actual clinical practice however, requires a thorough understanding of the barriers and enablers to change, if implementation is to be successful. Indeed, as the focus group participants and the managers/educators themselves suggest, an analysis of the barriers and enablers appeared not to have been conducted prior to implementation. Consequently, the implementation struggled to gain traction with the staff who should and could have been most invested in the success or otherwise of the initiative. Importantly, it seems that undertaking such an analysis at the outset would have been a good place to start the project in order to overcome the resistance to change that is given voice so resoundingly in the data.

It has been said that there is no higher court than the court of perception and it is clear in the reported perceptions of the staff on the two clinical units implementing rounding that they felt they were either too busy or were indeed, already conducting a form of rounding in the normal practice of delivering patient care, to be convinced that rounding was the solution to the problem. That said, a major concern of the staff was that there was no problem to begin with or that if there was, it was not sufficiently elaborated by the leadership to convince them that rounding was the most appropriate solution. Certainly, it appeared to be a bone of contention that the resultant extra paperwork required by the implementers, which was designed to provide

evidence that rounding was actually taking place rather than measure its effectiveness or otherwise, did not help but rather impeded nurses' willingness to adopt rounding without complaint. The NUMs' observation that their staff felt they were being 'checked up on' and not trusted led them to abandon the practice on one of the units in the hope that rounding might be better embraced. This was not reported by the nurses themselves however.

These failures of adequately planning for the implementation process were compounded by a lack of incentives to help staff engage with the project and to overcome the likely resistance and antipathy toward the change. Indeed, as the data suggest, staff felt that the initiative was simply imposed on them from above which induced feelings of powerlessness and diminished self-worth. These undoubtedly further contributed to the resistance, if not potential sabotage of the project. Magnet hospitals are noted for their consistency in empowering nurses to make decisions and act on them. That this seemed to be contradicted by the way in which rounding was implemented almost certainly was a factor in its failure to succeed. That said, we do not believe this was an intentional or malign act, it nevertheless would have been helpful if in their zeal to implement this improvement a more collaborative and collegial approach had been used instead.

Our evaluation suggests then, that it was not so much a bad idea to introduce the practice of rounding on these two clinical units. Rather, it was a lack of careful planning and the development of evidence-based strategies to enable the implementation to be as smooth and effective as possible that thwarted this quality improvement activity's success. There are lessons to be learnt here however; failures of implementation are not necessarily the end of the world. They can instead, create a space and place from which to re-energise and re-craft the initiative and its implementation based on the new insights gleaned from evaluations such as this. While some momentum and interest might have been sacrificed in the original attempt at introducing rounding as a way to enhance patient and staff satisfaction with nursing, having

had the opportunity to reflect and reconceptualise the 'how' of such an idea is a worthwhile and good end in itself.

CONCLUSION

In conclusion, we recommend that the leadership of the units involved in this project take the time to discuss the evaluation with their staff and use it to create a space for critical dialogue about how best to undertake such an initiative again.

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