An ethnographic study to understand the patient and nurse experience of rounding

Sue Langley

Student Roll No @00155807

DProf

School of Nursing, Midwifery,

Social Work and Social Science

University of Salford

February 2016

Contents

Acknowledgement

Many people have contributed to this piece of research. I am especially grateful to the patients and staff who took the time to share their experiences of rounding practice and hence providing the study with a wealth of rich data. My thanks also extend to the nurse participant observer/interviewers who provided their time freely in order to collect the study data and maintained their enthusiasm for the study throughout the data collection and analysis period.

I originally developed the idea of the research study from my own experiences of practice and therefore I must recognise the support and encouragement my colleagues within the work place have given to me during this time. They have regularly acknowledged my work and urged me forward in my mission to investigate rounding practice. Special thanks must also be noted for the Trust Librarian Team, who provided great support in my never ending search for literature.

Without my two supervisors this work would not have been possible. Both Paula Ormandy and Julie Wray have listened and developed my ideas in order to refine and clarify what is presented within the study. Their most important contribution and support have been invaluable.

My final thanks goes to my family, who have been fully understanding of my degree of absenteeism from family life whilst I completed this research journey and who have been full of encouragement as well. My mother took the time to proof read my chapters as spelling and grammar have never been my strengths. Also I must thank Ian as my partner who has provided a constant stream of support, has listened, offered helpful suggestions and comments but importantly to me has had great forbearance whilst this study has been completed.

Abstract

Background

Nurse rounding has been widely practiced in the UK since 2012, transferred from the US as a nursing intervention which positively impacts on patient outcomes. Current evidence highlighted a dominance of quantitative studies tentatively linking rounding to impact measures of reduced falls, pressure sore incidence and reduced use of call bells. Outcome measures fail to elicit an understanding of what rounding means from the perspective of the patient or the nurse, moreover applied research evidence in the UK was limited. This study was designed to understand how the practice of rounding impacts on patient experience and nursing care in the NHS.

Method

Ethnographic methodology was used to see, listen and talk about rounding with nurses and patients. Data collection involved participant observations (38), nurse (34) and patient (34) interviews alongside the analysis of documentary data across two NHS in-patient wards.

Findings

Findings exposed a culture of rounding practice different from the process described in the literature, encapsulated within four themes: Presence, Actioning Care, Playing the Routine, and Engagement. Reduced falls rates and pressure ulcer prevalence were flawed outcomes of rounding practice, rounding had both social and clinical outcomes depending on the person delivering the round, and patients valued the regular presence of the rounder particularly the nurse in charge. The rounding model generated defined the outcomes of nursing rounding.

Conclusion

The new knowledge identified rounding practice in its current form was in danger of becoming a tick box exercise with limited impact on patient experience and patient safety. However, recommendations identify opportunities exist for nursing to develop rounding as a mode of care delivery or as a way of offering social presence and engagement to patients. The constituents and constructs of the rounding process need to be further understood to find the true value of the practice to nursing.

Chapter One: Introduction to a thesis on rounding

1.1 Introduction to the thesis

Patient Rounding is the focus of this thesis, in particular the investigation of the practice of rounding within an acute NHS teaching hospital describing the patient experience of care. This thesis brings together a critical analysis of rounding; as a concept, the aim, and current evidence, then explores patient care and experience through focused research. This introductory chapter firstly provides an overview of the structure of the thesis chapters and the aims of my research study. I then introduce myself as a researcher, practitioner, and senior nursing lead and explain why and how the topic of patient rounding came to be the focus of my Professional Doctorate (DProf) journey. The chapter also scopes the different meanings of the term rounding and provides a brief overview of the rounding process.

1.2 Structure of the thesis

This thesis is structured around seven chapters. Chapter one being the introduction and establishment of the terms used in relation to rounding.

Chapter two examines the background and origins of rounding, in particular where it fits within the context of NHS nursing practice, and a detailed assessment of the practice of rounding in the study setting. I explore the underpinning questions regarding the impact and outcomes of the practice of rounding providing further context for the thesis.

Chapter three critiques the current rounding research literature and I begin to identify the gaps in current thinking that this thesis seeks to address. I draw attention to the ways in which the literature is dominated by the positivist, quantitative paradigm, promoting the cause and effect link to rounding practice in seeking to be favourable towards patient safety and patient experience outcomes.

In chapter four I discuss the ontological perspective of the research and the details of the ethnographic approach and study methodology are presented. Patient, ward and staff recruitment is described and the methods of data collection, observation, interviews and audit explained, alongside the collaborative analysis and the construction of meaning from the data.

Chapters five presents the key findings: crucially, four themes are identified as elements of the rounding culture within the study setting, Presence, Playing the Routine, Actioning Care and Engagement. The rich qualitative data exposed the existence of social and clinical rounding patient and nurse reported outcomes, the value placed on rounding and the rounder by patients, impact which cannot be measured or captured through quantitative rounding metrics.

The social and cultural themes are critically examined, discussed and synthesised in chapter six, alongside the current rounding evidence base exposing an original theoretical and nursing practice process contribution to knowledge. Chapter seven draws together the study conclusions, methodological considerations and most importantly the recommendations for practice.

1.3 Introduction of self

I initially embarked on my DProf journey because I wanted to balance my role as a nurse leader which has sharp focus on targets and performance with the concept of the art and science of nursing. I thought the DProf would provide the time and space to refocus on the nature of nursing and its contribution to healthcare. I had commenced my Dprof without any specific thoughts about a research project except the aspiration to learn how to undertake and perform research that could influence basic nursing care at ward level. My personal thoughts were that often nursing research is inconsequential in relation to basic nursing care on wards plus as a senior nursing leader I wasn't sufficiently well positioned in clinical practice to understand the realities of day to day nursing practice to ensure evidence based quality care was consistently being delivered. From my position as a nurse leader I saw the prospect of studying rounding as my opportunity to bring research to ward level

and examine the basics of nursing practice. It appealed to me to try to prove the effectiveness of rounding as a nursing intervention to strengthen the nursing evidence base and improve the quality of nursing care at a time when it was being scrutinised.

1.4 Concept of rounding

This chapter begins to describe and explain the process of rounding in order to promote conceptual clarity for the practice of rounding. The concept of rounding utilised in practice within this research study is based on the work of Meade et al. (2006) and the Studer Group (2007). Their work originated from a pilot study in the US in 2005 and began to be published within the US nursing literature from 2006. This places the 'modern day' concept of rounding used today as mainstream nursing practice being less than a decade old. Meade et al. (2006) cites three main influences as the basis for reinventing and developing systematic nursing only rounds:

- a hostess role responding to patient needs (Sheedy 1989)
- patient comfort rounds in the UK (Castledine 2002)
- multidisciplinary (interdisciplinary) speciality rounds for example ward rounds by pain teams (Sterman 2003)

Through evidence synthesis Meade et al. (2006) developed the ideas of Sheedy (1989) and Castledine (2002), that structured interventions through interdisciplinary rounds by pain teams, medical teams, intensivists and physiotherapists positively affected patient care (Curley et al. 1998; Halm et al. 2003; Dutton et al. 2004). Meade et al. (2006) extrapolated the link between structured specialist ward rounds and greater patient satisfaction into the nurse only rounding process that we use in practice today. They developed nursing rounds as a timed, planned intervention by nursing staff in order to address specific elements of nursing care for patients. The effectiveness of the structured process of nursing rounds were measured by the reactive nursing response to patient call bells that sought to proactively meet patient's needs. For Meade et al. (2006) the process of rounding explicitly sought to identify and meet patients' fundamental care needs (the discussion of which is expanded in chapter two).

1.5 Aims of rounding

The aims of rounding are to have a positive impact on patient safety (reducing falls and pressure ulcers rates) and patient satisfaction outcomes (Meade et al.2006; Tea et al.2008; Woodward 2009; Blakley et al. 2011). It is postulated that timely staff responsiveness increases patient satisfaction (Meade et al. 2006; the Studer Group 2007; Halm 2009; Kessler et al. 2012). The process of rounding involves undertaking hourly checks on identified patient's needs, asking the question 'is there anything more I can do?' as well as indicating to the patient when the next round will take place. Improvements in patient satisfaction surveys scores related to rounding practice appear to be well documented (Tea et al. 2008; Gardner et al. 2009; Kessler et al. 2012). Fundamental to the aims of the rounding process is the reduction in patient call bell usage (Meade et al. 2006; Leighty 2007; Wood 2008). Theorists suggest that rounding reduces patient call bell usage as patient's needs are proactively met which in turn produces benefits for nursing staff; their time can be used more effectively without managing the 'interruptions' of call bells (Meade et al. 2006; Leighty 2007; Wood 2008).

1.6 Terms and descriptions of the rounding process

It is important to identify the different terms used to describe the process of rounding. There are several different terms used throughout the literature to describe the nurse only regular checking of patients, whether based on intention, activity, the person, or time (Castledine et al. 2005; Meade et al. 2006; Culley 2008; Tea et al. 2008; Gardner et al. 2009; Halm 2009; Blakley et al. 2011) (table 1).

Table 1: List of common rounding terms

Common Terms	
Intent based	Intentional Rounding, Pro-active Patient Rounds
Activity based	Falls Rounding, Comfort Rounding, I Care Model, Care Round the Clock
Person based	Nurse Rounds, Nursing Round Intervention (NRI), Structured Nursing

	Rounds Interventions (SNRI), Patient Rounds/Rounding
Time based	Hourly, Two Hourly Rounds
Generic	Rounding or Rounds

There is a lack of clarity as to exactly what is being referred to when variations of the term are used in practice. For the purpose of my research, from the outset is was important to seek clarification as to what is considered to be the practice of rounding.

1.6.1 Intent based rounding

Initially the term 'intentional rounding' transferred from its application within US nursing practice to the NHS in the United Kingdom (UK) through the work of Meade et al. (2006). Their initial paper used the term 'nurse rounds' however the intentional act of rounding was seen as a purposeful and proactive response to meeting patient's needs rather than a random and reactive response. Indeed, Meade et al. (2006) proposed demonstrable outcome results which other studies using the term 'intentional rounding' reproduced, hence the prominence of the term (Murphy et al. 2008; Gardner et al. 2009; Ford 2010; Harrington et al. 2013). The term 'intentional rounding' places a focus on the nurses having clear aims for undertaking rounds as well as ensuring progress towards the aim is monitored and measured (Fitzsimmons et al. 2011). Similarly, others emphasised the proactive attribute of rounding and used the term 'proactive patient rounds' (Studer Group 2007; Tea et al. 2008).

1.6.2 Activity based rounding

The work of Meade at al. (2006) verified an association with rounding and reduced patient fall rates. Moreover, subsequent studies concentrated on the specific link between rounding and falls reduction hence the introduction of the term 'falls rounding' (Miller and Limbaugh 2008; Quigley et al. 2009; Waszynski 2012). In the NHS 'falls rounding' has been adopted into practice through the High Impact Action (HIA) work of the then Chief Nurse and the NHS Institute for Innovation and Improvement (NHS Institute 2009). The HIA 'Staying Safe – preventing falls', documents a process similar to the US practice transferred and tested within a NHS hospital (NHS Institute 2009). Although, there exists earlier discursive work in

the UK which articulates 'comfort rounds' as a process based on old fashioned 'task rounds' to deliver nursing care (Castledine 2002; Castledine et al. 2005).

Some authors have developed in house or organisation titles to reflect their approach to rounding and in particular the activity of caring. Tea et al. (2008) developed the 'I Care Rounding' Model and in an NHS Nottingham Hospital their rounding is referred to as 'Care around the Clock' (Hutchings 2012; Hutchings et al. 2013).

1.6.3 Person based rounding

Nursing Rounds Interventions (NRIs) and Structured Nursing Rounds Interventions (SNRIs) are terms used to emphasise the nurse led aspect of rounding (Salch et al. 2011; Tucker et al. 2012). Like the term SNRI, NRI defines the nurse led aspect of rounding, in contrast to the term 'patient rounding' which promotes the patient focus of the process and appears to be more frequently used in more recent literature (Lucas et al. 2010; Neville et al. 2012; Kessler et al. 2012).

1.6.4 Time based rounding

The simple pre fix of a time descriptor such as hourly rounding is very common within the literature (Culley 2008; Murphy et al. 2008; Orr et al. 2008; Bourgault et al. 2009; Halm 2009; D'Alessio et al. 2010; Deitrick et al. 2012; Krepper et al. 2012; Lowe and Hodgson 2012). This could however, be misleading as rounding can be performed two hourly (Moran 2011). Berg et al. (2011) use the term hourly rounding with a purpose and Krepper et al. (2012) wrap hourly rounding within the term Standardized Hourly Rounding Process (SHaRP).

1.6.5 Generic term

A simple solution some authors appear to adopt common to all the terminology is the word 'rounding' or 'round' which transcends the intention, activity, person or time and gives meaning to the action being undertaken (Woodward 2009; Mower-Wade and Pirrung 2010). The term 'rounding' is frequently used in the study setting therefore it seems appropriate for the purpose of this research study that the term 'round' or 'rounding' will be adopted as the main generic terminology in this thesis.

1.7 The process of rounding

The concept of rounding initially appears modest, once an hour or once every two hours, a ward round is undertaken by ward staff to check on patients and ask a series of simple questions. Ford (2010) believes rounding is another way of organising existing work and that hourly rounding addresses patient's needs proactively, by anticipating and meeting their needs routinely ensuring patient safety. The rounding process as a method of care delivery is not arbitrary or unscripted; it has within the process defined checklists or protocols for nurses to follow

1.7.1 Checklists/scripted protocols

In most cases a checklist or scripted protocol, is used as a prompt, to ascertain if the patient needs assistance at that time, for example the '4 Ps' checklist focuses questions on pain, personal needs/elimination, possessions and position (Meade et al. 2006; Tea et al. 2008; Gardner et al. 2009; Halm 2009).

Murphy (2010 p189) details the questions that ought to be asked and the rounder's appropriate response:

- How is your pain? With the rounder offering appropriate measures as needed (pain).
- Do you need to use the bathroom? With the rounder offering assistance as needed (personal needs)
- Do you need us to move the call bell, water jug? With the rounder moving the patient possessions as required (possessions)
- How can I make you more comfortable? With the rounder re positioning the patient (position)

There is continued debate whether rounding protocols should focus on 5, 4 or 3 Ps. For example the inclusion of a 5th 'P' to represent presence or patient focus has been advocated to ensure a physical presence and interaction of nursing staff with the patient at timed interval to promote patient focused communication (Rondinelli et al. 2012; Sherrod et al.

2012). Indeed, within the US literature there is an emphasis on presence or visibility of nurses in the patient's room. The reason for this is that in many healthcare facilities patients are predominantly nursed in single rooms therefore nurses are not always visible to patients. Similarly, the presence and visibility of nurses is potentially an issue within UK healthcare, with the move towards more single rooms in newer NHS hospitals (Crossfield and Pitt 2012). However within the study setting there was the tradition mix of patient bays and side rooms.

Alternatively some authors only identify 3 Ps (Bourgualt et al. 2009; Berg et al. 2011; Kessler et al. 2012). The Kessler et al. (2012 p241) rounding protocol included attention to pain, position and personal needs (omitting possessions and presence) but incorporated the scripted response upon leaving the patient's room.

> *'Is there anything else I can do for you before I leave? I have the time. We'll be back in an hour to check on you.'*

The initial work of the Studer Group (2007) integrated the Ps in a process of introduction, the nurse greets the patient and explains the rounding process, at the end of the visit after checking the Ps the nurse asks the patient if there is anything further the patient requires before letting the patient know that someone will return every hour (two hours at night time). Rondinelli et al. (2012) used a completely different acronym developed by nurses within their study areas as ABCDE, A for activity, B for bathroom, C for Comfort, D for Dietary and E for Environment which potentially takes a wider angle of care than the 4 Ps as it addresses a patients dietary and mobilisation need.

Underpinning the varied rounding protocols the focus of the rounding process appears to be pain relief (comfort), personal need (diet, activity and bathroom), with some processes expanded to include people's possessions (environment) and ensuring the visibility/presence of the nurse.

1.7.2 Documentation

I found that the literature on rounding highlighted documentation of the rounding process in some format (Tea et al. 2008; Sobaski et al. 2009; Dietrick et al. 2012; Neville et al. 2012). However, the scripted documentation aspect of rounding was controversial with the burdensome associated paperwork leaving staff often dissatisfied (Deitrick et al. 2012; Neville et al. 2012). The checklist approach of the documentation makes the rounding process too rehearsed and detracts from delivering individualised care (Halm 2009). Like Snelling (2013) I felt concerned that if rounding was based on a checklist then nursing was returning to a more ritualised, routine approach focusing on task rather than individual patient orientated care.

It seemed that studies diversified in terms of who carried out the rounding process, either a registered nurse or a nursing assistant or both at different times (Murphy et al. 2008; Mower-Wade and Pirrung 2010). Indeed, the literature revealed variation in terms of the frequency in which rounding was undertaken but commonly rounding performed every one or two hours (Meade et al. 2006; Halm 2009; Salch et al. 2011; Sherrod et al. 2012)

1.8 Summary

This introductory chapter sets the scene with regards to the focus of the thesis and introduces the concept of rounding. The multiple terms used to describe rounding highlighted a potential problem in clinical practice for nurses; the potential for misinterpretation, a poor understanding of the concept, or very different iterations of rounding being introduced in practice of varying quality and focus. The chapter highlighted the issues with checklist or protocol driven rounding not least making nursing ritualistic or task driven detracting from a person centre approach to care.

In the next chapter (chapter two) I set the scene and context of the NHS and the introduction of rounding in particular my own experience of rounding practice that has greatly influenced this research study.

Chapter Two: Background and NHS context

2.1 Introduction

The concept of nurses performing rounds is not new but often within the rounding discourse only a few authors trace the historical concepts of rounding back further than Meade et al. (2006) (such as Moran 2011; Salch et al. 2011; Lowe and Hodgson 2012; Kessler et al. 2012; Neville et al. 2012; Forde-Johnson 2014). I found hints of acknowledgment that rounding was conceived from past routines, task orientated nursing and so this chapter begins to debate how this may impede the acceptability of modern rounding into professional nursing practice (Gardner et al. 2009; Berg et al. 2011; Rondinelli et al. 2012). The implementation of rounding within the NHS and policy context is examined particularly as within the UK literature the process of rounding appears to polarise nursing opinion as to its benefits in contemporary nursing (Bartley 2011; Fitzsimmons 2011; Barker 2012; Hunt 2012; Snelling 2013).

2.2 History and origins of rounding

2.2.1 Inspection and back rounds (prior to 1970)

For many years in the NHS the foundation of nursing care delivery was task based rounds (Fitzsimmons et al. 2011; Lowe and Hodgson 2012; Forde-Johnston 2014). Castledine et al. (2005) divides these form of rounds into inspection rounds and back rounds. Inspection rounds were carried out by Matrons and Ward Sisters with the purpose of monitoring the quality of basic nursing care, including the cleanliness and safety of the hospital environment. The second type of round was known as the back round (Castledine et al. 2005; Fitzsimmons et al. 2011; Lowe and Hodgson 2012; National Nursing Research Unit 2012; Forde-Johnson 2014) where two nurses would prepare a trolley and visit each patient: '*checking the patient's pressure areas, changing their position, and carrying out comfort actions, such as changing the sheets and pillow cases and puffing up the pillows at the same time'* (Castledine et al. 2005 p928).

It seems that the benefits of these types of rounds were concerned with giving patient's the opportunity to talk to nurses about their health concerns and comfort needs. Yet Castledine (2002) claimed that back rounds focused too much on a task approach and didn't promote evidence based practice for pressure ulcer care.

Nursing care, prior to the introduction of the nursing process was not only delivered through back rounds but regular observation rounds, mouth care rounds, medication rounds and wound care rounds (Castledine 2002; Castledine et al. 2005). These rounds were core to the delivery of patient care, indeed patient care was organised as tasks which were completed by nurses going round all the appropriate patients on the ward. Often the most basic tasks were allocated to the junior (often student nurses) or least qualified staff and the most difficult tasks were allocated to the most senior nurses (Castledine et al. 2005). Despite the progression to patient centred care many nurses did see the benefits of regular rounds on patients feeling they gave assurances that patients were being cared for and it gave an opportunity to build relationships between patients and nurses (Fitzsimmons et al. 2011; National Nursing Research Unit 2012).

It was post 1970 that the NHS saw radical changes in the way nursing care was delivered, the nursing process introduced individualised patient care plans and patient allocation. Ward patient care was delivered in more individualised holistic processes through Team Nursing, Primary Nursing or the patient's Named Nurse (Orlando 1993; Manthey 2002; Marquis and Huston 2009). These changes brought greater individual responsibility for the nurse delivering their allocated patient's care and remains the prevailing models of care delivery in practice. Following the advent of the nursing process both types of rounds were criticised as archaic processes, lacking an evidence base, and perceived to be detrimental to patient care, so by the 1990's they had disappeared from clinical practice (Castledine 2002; Fitzsimmons et al. 2011).

2.2.2 Hostess role, regular rounds and patient call bell response (from 1989)

Regular rounds emerged in the US from a significant but small pilot study (Sheedy 1989) which demonstrated improved patient satisfaction scores by introducing a unit hostess role (Meade et al. 2006; Sobaski et al. 2008; Woodward 2009; Ulunima and Ligott 2011). This

hostess role included set responsibilities however these were mainly performed by a process of regularly going round the patients to check if their needs and requests were being met. Sheedy (1989) implemented a small scale pilot study which ran over two months on a 58 bed medical unit to evaluate the hostess role, the aim of the role was to satisfy basic patient needs whilst nursing staff continued to provide complex care. The unit hostess had a set of 11 responsibilities these included providing information regarding the hospital and ward procedures, serving food and drinks, sorting out pillows and towels for patients. The role and responsibilities had been based on patient feedback that had highlighted a slow response time to call bells being answered by the unit nurses and examining the reasons why patients needed used their call bells. The unit hostess role was structured by carrying out regular rounds of the patients four times a day, to anticipate, check and be responsive patient's needs/requests plus to answer call bells within five minutes. By examining the reasons, from the research, why patients used their call bells the unit hostess carried out basic non nursing duties for the patients for example providing towels, making drinks, with patient requests and responses requiring a registered nurse reported to the patient's allocated nurse.

When scrutinised the research by Sheedy (1989) has limitations; the evaluation of the pilot study was subjective, it was based solely on anecdotal comments from patients to nursing management which were in the form of complimentary letters and general comments about the unit hostess position. Despite this limitation the nursing management were satisfied with the pilot study and went ahead to introduce the unit hostess role to other medical and surgical units within the hospital. Since its roll out the percentage increase of patient satisfaction for the timely response to calls bells is not fully conclusive, although there was a percentage increase in patients reporting call bell requests being answered within one minute or less after the introduction of the unit hostess. However, there was a high percentage of patients reporting call bell requests (pre and post unit hostess) taking two to five minutes or five to ten minutes to be answered (Sheedy 1989). It is worth remembering that within US healthcare settings, the process in many hospitals is that patient call bells are initially answered by an intercom clerk before a healthcare worker or nurse visits the patient's room. This dimension adds a further 'hands off' approach to the process

compared to the NHS where the patient call bell is answered by a nurse or nursing assistant directly attending the patient.

Sheedy's (1989) work was interesting for three reasons: it does seem to be the first examination of patient feedback in terms of the exact nature of why patients use their call bells; secondly call bell usage appeared to be for basic needs and requests such as for obtaining pillows or towels, thirdly, the timeliness of the response to patient call bells could be linked to increased levels of patient satisfaction. However even though these are interesting concepts they were not conclusively proven by this work.

2.2.3 Patient comfort rounds (from 2002)

In the NHS, a decade ago George Castledine, at the time a Professor and Consultant of General Nursing, University of Central England and Dudley Group of Hospitals NHS Trust cited patient feedback as well as observation as the basis for developing a new initiative in nursing, patient comfort rounds (Castledine 2002; Bates 2011; Lowe and Hodgson 2012; Dewing and Lynes O'Meara 2013; Forde-Johnson 2014). Castledine (2002) proposed 'Patient Comfort Rounds' (PCRs) had their origins in 'back rounds' however and importantly for Castledine PCR's where not to be confused with the old system of 'back rounds' but were complimentary to individual holistic nursing practice, supplementary to patient assignment and team nursing (Castledine 2002; Castledine et al. 2005) (table 2).

Table 2: Content of Patient Comfort Rounds (PCR)

(Castledine 2002 p603; Castledine et al. 2005 p929)

No	Content
1	Discussion with patient or relative about their care
2	Attention to cleanliness and toileting
3	Updating bedside documentation
4	Attention to patient's position, pressure areas, pillows
5	Checking on pain control, observations of patients appearance
6	Tidiness and safety of patient environment
7	Encouraging fluids, checking medical devices
8	Checking lines and cannula
9	Ensuring patients had their spectacles/hearing aid

It was proposed that PCRs should be carried out every two hours, at night a PCR should be carried out before patients go to sleep and again early in the morning (Castledine 2002). One member of the round should be a registered nurse. Subsequently Casteldine et al. (2005) discussed the implementation of PCRs in the Dudley Group of Hospitals as part of a programme of rounds which also included matron rounds, nurse management rounds and teaching rounds. However, there were no published protocols for carrying out a PCR. The aim of the rounds sought to improve patient care, involve patients and improve communication. Similar to Sheedy (1989); Castledine (2002) and Casteldine et al. (2005) identify meeting basic patient needs and the fundamentals of patient care as the justification for their work. Castledine et al. (2005) align their work to the then government's improvement guidance for nursing on the fundamentals of care, namely 'The Essence of Care' (Department of Health, DH 2001).

Castledine et al. (2005 p928) stated that:

> *'The difficulty of placing value on basic nursing care has been well documented and the recent Channel 4 dispatches programme, Undercover Angels, 31st January 2005, exposed this in a very graphic way. It showed that some nurses are ambivalent about the basics aspects of nursing care and are reluctant to get involved with essential patient comfort needs.'*

Thus, the whole driver for PCRs was to attend to patients' basic human need for comfort in the context of stressful healthcare situations by providing regular and improved nurse patient contact; focusing on and improving the essentials of care as well as more accurate patient observation and charting. Castledine et al. (2005) linked his work to the nursing theorists such as (Roy 1981; Orlando 1993; Henderson 1997; Watson 1999; Paterson and Zderad 2008) for their promotion of good nursing as the capacity to make a patient physically and psychologically comfortable. Unfortunately despite, some positive support from correspondence published in the British Journal of Nursing (Bassett 2002; Hatch 2002; Keats 2002; Scott 2002) it appeared that no further advocacy for PCR existed in UK practice and that no further information was published by Castledine et al. From examining the subsequent literature there appears to be no further specific research carried out to

measure the projected benefits or value of the PCR intervention. It is only with the work of Meade et al. (2006) that PCR re-emerges into prominence.

2.2.4 Nursing rounds, the work of Meade et al. and Studer Group in the US (from 2006)

The publication of the work of Meade et al. (2006) and the links to the Studer Group (2007) appeared to be the first systematic evaluation of rounding intervention and the basis for the development of an 'evidence based practice' which has been introduced widely throughout the US. The evidence base of rounding practice is discussed in detail in chapter three however as a historical examination of rounding Meade et al. (2006) acknowledged the work of others (Sheedy 1989; Castledine 2002; Castledine et al. 2005). Meade et al. (2006) explored patient call bell usage to a greater degree as well as expanding and then synthesising their ideas about multidisciplinary (interdisciplinary) rounds.

Table 3: The Meade protocol for nurse led rounding

(Meade et al. 2006 p60)

No	Protocol
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 position comfort, ask if the patient requires re positioning and is comfortable
5	Make sure 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 patients reach
8	Put the bedside table next to the bed
9	Put tissues and water within the patient's reach
10	Put the waste paper bag next to the bed
11	Prior to leaving the room ask "Is there anything I can do for you before I leave? I have time while I am in the room"
12	Tell the patient a member of the nursing staff will be back in an hour (two hours) to round again

The example used is pain rounds by pain teams suggesting they provide more effective pain management and improved patient satisfaction. The Meade paper produced a very structured intentional, proactive approach to nursing only rounds, providing a focused tool, which could be considered a checklist, for meeting patient's needs (Meade et al. 2006). The protocol for rounding by nursing staff covered 12 points, with similarities to Castledine's patient comfort rounds (Castledine 2002; Castledine et al. 2005) (table 3).

Meade et al. (2006) although highlighting a the reduction of patient call bell usage and improvement in patient satisfaction also considered the patient safety aspect of care and examined patient falls rates as an integral part of their rounding intervention. The work of Meade et al. (2006) and the Studer Group (2007) formed a catalyst for further large bodies of work performed by other US authors (Bourgault et al. 2008; Culley 2008; Sobaski et al. 2008; Weisgram and Raymond 2008; Tea et al. 2008; Woodward 2009) and was seminal in its positioning relative to rounding in the nursing literature, thus I will discuss further in chapter three.

2.3 Re-emergence of rounding in the NHS and UK

In the UK, following the publication of Castledine's work, I found a gap in the published literature about rounding (chapter three). That said rounding re-emerges within the Department of Health guidance on improving standards of care in 2009. At the same time the Chief Nurse and NHS Institute for Innovation and Improvement (NHS Institute 2009) supported rounding in the UK nursing practice through the HIA work. The HIA 'Staying Safe – preventing falls', documents a process similar to US practice at a NHS (Ipswich) hospital. A checklist for actions was devised to regularly review patients in order to prevent falls by examining local evidence from incident reporting. This hospital reported a reduction in falls following the regular checking of patients, linked to the work of Meade et al. (2006) which reported a reduction in patient falls following the implementation of rounding.

In Welsh healthcare rounding was introduced via the 1,000 Lives National Patient Safety Association Campaign (NPSA 2008) an initiative called 'Transforming Care at the Bedside' (TCAB). TCAB was developed by the Institute for Healthcare Improvement (IHI) in the US

with the aim of implementing simple tools and techniques to transform frontline clinical care for the benefit of patients and staff. In 2006 a UK IHI fellowship student visiting hospitals in the US, Annette Bartley, observed rounding whilst it was being tested at a TCAB site hospital and introduced rounding into the Welsh healthcare setting on her return to the UK. Bartley (2011) promoted rounding as a King's Fund Point of Care Programme project as an intervention which can improve a patient's experience of care. Bartley and her colleagues (Fitzsimmons et al. 2011 p20) reported that for rounding:

> *'Positive results were seen, particularly in relation to reductions in falls and pressure ulcers, and improved patient experiences.'*

Since then, in the NHS there has been an increasing profile advocating rounding (table 4). The literature focuses mainly on the implementation of the rounding process and the benefits rounding can bring to patient safety (Crossfield and Pitt 2012; Dean 2012; Dix 2012; Fitzsimmons 2012; Gillen 2012; Hutchings 2012; Lowe and Hodgson 2012; Mason 2012; National Nursing Research Unit 2012; West 2012; Dewing and Lynes O'Meara 2013).

2.4 Policy context

In terms of policy context the practice of rounding in nursing care delivery gained a high profile in January 2012 when the then Prime Minister participated in rounding on a visit to a large NHS Trust. He then announced a package of measures to improve standards of care in hospitals one of these being a requirement to introduce rounding nationally in all hospitals (DH 2012a). An emphasis on rounding was placed in the document 'Patients First and Foremost' (DH 2013a: p68) and the initial government response to the Francis Report (Francis 2013) stating *'that the majority of hospitals had introduced hour by hour nursing rounds on their wards'* and urged remaining hospitals to do so within a year.

Rounding was included in the work of the Nursing and Care Quality Forum (DH 2012b) a body of senior nurses set up by the Prime Minister to tackle issues of improving nursing care. Rounding was also embedded within the vision and strategy for compassion in practice, '*The 6 C's'* promoted the values of care, compassion, competence, communication,

courage and commitment published by the Chief Nursing Officer (DH 2012c). Two further initiatives which connect up with potential outcomes of rounding related to patient safety are Harm Free Care (DH 2011a). These included a drive to reduce patient harm from falls and pressure ulcers; and the NHS Safety Thermometer (Health and Social Care Information Centre, HSCIC 2015) which provided methods for surveying and analysing the results from patient harm associated with falls and pressure ulcers (Lowe and Hodgson 2012; McDonagh 2013).

Nineteen NHS Trusts have published anecdotal information about the benefits of rounding (table 4) and 50 hospitals in England have implemented rounding (Bartley 2011). However, there was an acknowledgement that there was still no robust research evidence in the NHS to suggest rounding improved nursing care (Bartley 2011; Mason 2012; Snelling 2012). I collated evidence in table 4 in an attempt to demonstrate a lack of consistent approaches to rounding leading to different types of rounding being implemented. I would suggest that this diversity of approaches hinders comparable large scale evaluation of patient outcomes, which leads to a poor and fragmented rounding practice, resulting in prospective patient benefits being lost and standards of nursing care failing to improve.

Table 4: Diverse approaches to rounding

Hospital	Published Information	Reported Outcomes
1. Aintree University Hospital	2 hourly rounding on 30 wards Acute provider Nursing and Care Quality Forum Demonstrator Site *Gillen (2012), Levenson (2013)*	Reduced call bells
2. Blackpool Victoria Hospital	Acute provider Nursing and Care Quality Forum Buddy Site *Levenson (2013)*	Reduction in falls
3. Croyden University Hospital	Hourly Rounding, Implemented summer 2010 *Duffin (2010)*	Nil reported
4. East Sussex Healthcare Trust	Intentional rounding, Pilot 2 stages on 6 wards initially 2nd stage full implementation across two hospitals, covered 6 months *Dewing and Lynes O'Meara (2013)*	Staff satisfaction questionnaire, increased visibility and patient contact time, Improved patient experience, Improved staff experience
5. Forth Valley, NHS, Sterling, Scotland	2 Hourly care and comfort rounds implemented June 2011, 29 bed ward *Stoddart et al (2014)*	Staff satisfaction increased, positive feedback from patients
6. Hommerton University Hospital, London	Comfort Rounds 4 hourly, Piloted one ward for 2 weeks 2010, being rolled out across the Trust *Negus (2010)*	Reduction in falls
7. Imperial College Healthcare Trust, London	Hourly rounding implemented 2012, review of the process on 4 wards *Kenny and Norton (2015)*	Staff and patient views on rounding, patients unaware of the process and staff do not value the process
8. Leeds Teaching Hospital	Hourly rounding in a high dependency unit Lowe and Hodgson (2012)	Compliance of rounding log documentation. Difficulty in comparing data
9. Lewisham University Hospital, London	2 Hourly Rounds, All adult in patient wards 2011 *Burke (2011)*	Positive feedback from patients and relatives
10. Musgrove Park Hospital, Taunton	Intentional Rounds 2 Hourly, Piloted 2010 on the Acute Medical Unit, implemented a third of hospital wards 2012, improvement methodology *Dix et al. (2012), Mason (2012), Braide (2013)*	Reduced call bell usage, improved detection of pressure ulcers, reduced falls and reduced complaints

11. Nottingham University Hospital	Caring Round the Clock, three types of round: Patient Rounding, Senior Leadership Rounding, Leadership Rounding on Patients Piloted 10 wards 2011, roll out to 79 wards 2012 *Hutchings (2012), Hutchings et al. (2013)*	Reduced call bell usage, falls reduction but concurrent falls prevention campaign, positive patient feedback
12. Queen Elizabeth Hospital, Birmingham	Hourly Care Rounds Rolled out across all wards 2011, use of DH rapid spread methodology *Crossfield and Pitt (2012) Mason (2012)*	Falls reduction, improved patient feedback
13. Salford Royal Hospital	Intentional Rounds, Piloted April 2011, organisational policy Nov 2011 Acute provider Nursing and Care Quality Forum Buddy Site *DH (2012;2012a;2012b), Gillen (2012), West (2012), Levenson (2013)*	Reduced falls and pressures but one of several interventions noted
14. Tameside Hospital, Manchester	Acute provider Nursing and Care Quality Forum Demonstrator Site *Levenson (2013)*	Quality account data
15. University College Hospitals, London	Acute provider Nursing and Care Quality Forum Buddy Site *Levenson (2013)*	Plans to measure patient feedback, falls and pressure ulcer prevalence
16. University Hospitals Coventry and Warwickshire	Intentional Rounds, Across Trust March 2012, focus on Pressure Ulcers and Skin Assessment *McDonagh (2013)*	Reduced incidence of pressure ulcers but several interventions noted
17. Wansbeck Hospital, Northumbria	Intentional Rounds Hourly, Trialled number of wards *Fitzsimmons et al. (2011)*	Reduced call bell usage, improvements in patient experience data
18. Whipps Cross Hospital, London	Proactive Patient Rounds 2 Hourly, Oct 2009 *Duffin (2010)*	Reduced falls but one of several interventions, patient survey patients more satisfied
19. Wrightington, Wigan and Leigh Hospital, Greater Manchester	Intentional Rounds All wards since May 2012, initial resistance from nursing staff Acute provider Nursing and Care Quality Forum Buddy Site *Gillen (2012) Levenson (2013)*	Improved scores National In-Patient Survey

2.5 Local context: Implementation of rounding at the study site

The adoption of 'falls rounding' at my place of practice (the host study site) was based on the checklist developed in Ipswich Hospital introduced into the hospital in 2010. The implementation aim was to reduce the number of patient falls, as these were the highest reported patient incidents from the 1st April 2009 to the 31st March 2010, the hospital recorded 1772 patient falls. Of these, 796 occurred within the one division, this was the highest number of falls within a single division. The Division participated in the hospital Falls Steering Group and had implemented a number of falls reduction techniques. Despite these measures no significant reduction in the number of falls was demonstrated. In response in June 2010, the Divisional Head of Nursing began the 'falls rounding' pilot project with the aim of reducing the rate and severity of patient falls.

2.5.1 '*Falls Rounding' project*

The process for 'falls rounding' was once an hour, every hour, the ward staff asked all patients a series of simple questions and checked the patient's level of orientation. The questions are asked in the order prompted on the 'proactive falls rounding' checklist, all with the aim of checking if there is anything the patient needed such as 'do you need the toilet?' or 'would you like a drink?'

1. Orientation, fully alert, mildly confused/disorientated/severe confusion asleep
2. Pain, do you have any pain?
3. Continence, do you need to go to the toilet?
4. Position/comfort, are you comfortable?
5. Drink/mouthcare, would you like a drink?
6. Nurse call bell within reach, if you need me press this button
7. Is there anything else I can do?

The questions were intended to prevent patients from mobilising without support or the awareness of ward staff. The Division piloted 'falls rounding' on three wards, from the 1st August 2010. The level of falls on each ward appeared to reduce although not proven statistically. 'Falls rounding' was trialled over August and September 2010 which were

typically quieter months and showed a reduction in falls in some wards. When the initiative was rolled out to other wards in October and November 2010, the impact of 'falls rounding' was perceived to be reduced but again this was not statistically measured.

2.5.2 Adaptation from 'falls rounding' to 'patient focused rounding'

In June 2010 - 2011 a particular ward (not a study site included in this thesis) that had been involved in the 'falls rounding' project recorded 71 low level falls, a higher number of falls compared to other wards within the organisation. On analysis these falls typically occurred at peak activity times on the ward, peak activity being defined by 'Productive Ward Activity Clocks' (NHS Institute 2008), between 05:00-07:00 hours and 10:00-12:00 hours. The increase in patient falls was despite the 'falls rounding' document being introduced in August 2010. On further investigation the compliance with the completion of the 'falls rounding' document was found to be inconsistent, ward staff reported that it was too prescriptive, the seven questions were time consuming and the process too long, with individual document sheets being kept in every patient's folder. Feedback from patients highlighted the repetitive nature of questions. On reviewing the national agendas at the time (Mid Staffordshire NHS Foundation Trust Inquiry 2010; Patients Association 2010; Care Quality Commission Report 2011; Health Services Management Centre 2011; Parliamentary and Health Service Ombudsman's 2011), the process of rounding was considered important by the senior nursing team and should be reviewed. In June 2011 the senior nursing team for the ward met to discuss a strategy for addressing many of the key issues raised by the policy documents/reports and how rounding practice could address these issues.

From the meeting consensus indicated rounding was the way forward and the process of rounding could encompass more issues related to patient care in addition to patient falls prevention, for example:

- Nutrition
- Improvements in pressure ulcer prevention care
- Improving patient experience on the Ward
- Engagement and communication of Nurse in Charge and patients/relatives

At this point changes within the hospital operational structure meant that the wards formed a new additional Division with a new nursing management team. Ward staff met with the new Head of Nursing and Clinical Effectiveness Manager for the new Division to review the 'falls rounding' process and documentation. The feedback from the meeting was that ward staff wanted a process and document that provided:

- Patient focus and sought to meet patient's needs in a timely fashion
- One document that could be used for all the patients on the ward
- A vision that all patients would be given access to a healthcare worker on an hourly basis in order to meet their needs, improve communication with patients and ultimately improve the quality of the care provided
- An improved patient experience, decrease the need for the patient to have to use the nurse call bell and improve patient outcomes, nutritional needs and pressure area care would also be managed within the rounding schedule
- A round for the nurse in charge to review all the patients on each shift was incorporated into the plan

A small implementation group consisting of the Ward Manager, Practice Educator, Clinical Effectiveness Manager and Matron worked together to oversee this new approach. As part of this process the Practice Educator produced a story board to explain to staff the background to rounding as a nursing practice, the process of rounding and the benefits to patient care which were potentially linked to rounding.

The 'falls rounding' was process mapped using a spaghetti flow diagram, to review the timeliness of the process and identify potential improvements. Following this work a new rounding process and document were launched on the ward in August 2011 which was called 'patient focused rounding'.

All staff were trained to follow the new process and documentation and this training continued on night shifts. During implementation in the first two weeks there were many amendments made to the process and document, including incorporating a code system so

that patient's needs could be categorised. This coding enabled an audit of patient's needs and more importantly looked at what needs were not being met by the current nursing processes on the ward. All staff had the opportunity to comment and discuss changes.

2.5.3 'Patient focused rounding'

The 'Patient focused rounding' process is completed every one or two hours starting at 04:30 by an identified member of the ward team which can include nursing assistants, registered nurses, housekeeper and dietetic assistant. The ward team decided which of the rounds were best completed by which member of the team. This allocation was based on the existing ward routine and the ward team also utilised data from productive ward activity clocks to highlight peak periods of ward activity (NHS Institute 2008). In addition, data was matched to most frequent patient requirements therefore for the periods of time when patient requirements were high for personnel hygiene assistance, towels, toothbrushes and the wards nursing assistants performed rounds at these times.

The document produced for rounding forms a single document for all patients rather than individual patient documents. Codes are used to document when a patient has a particular need, did not require any input from the person carrying out the rounding, or if the patient request required escalating to a more senior member of staff. For example if a nursing assistant was performing rounding and the patient requested medication this would be escalated to the registered nurse allocated to that patient. Figure 1 is an early example of the documentation devised by the ward. All rounding interventions included the question 'Is there anything I can do?' The process of rounding included a morning and an afternoon round (during visiting times) by the nurse in charge of the ward. This included the Ward Manager in order to provide patients and their relatives which an opportunity to address specific concerns they felt a more senior nurse needed to deal with.

Figure 1: Example of the study site rounding documentation

Is there anything I can do?

Date:

Bed No:	Patient's Name	08.30	09.30	10.30	11.30	12.30	13.30	14.30	15.30	16.30	17.30	18.30	19.30	20.30	21.30
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															
16															
17															
18															
19															
20															
21															
22															

Code:

X: Nothing Required **A**: Intervention actioned by rounder **B**: Intervention escalated – Comments required overleaf

At the time the Trust obtained inpatient feedback on their hospital experience using an electronic questionnaire loaded on a hand held tablet device (Patient Experience Tracker). The patient feedback questionnaire had an extensive set questions based on the National In-Patient Survey. For each ward in the Trust there were set upper (95%) and lower (85%) limits of tolerance regarding patient experience metrics measured from the patient questionnaire including a patient tracker feedback score for overall quality for the ward experience. For the ward which had introduced 'patient focused rounding' their overall patient experience scores for quality improved to 90%, nutrition was 90% plus patients reported high scores for involvement and communication, again approximately 90%. At the time these results were seen as noticeable improvements and patient feedback scores above the Trust average. The ward team were also looking at the measurement of call bell usage and anecdotally there was the perception that call bell usage on the ward has reduced as a result of 'patient focused rounding'. Unfortunately no formal survey of patient

or staff satisfaction with the process of rounding or of cell bell usage was performed at this time to link these improvements directly to rounding.

Despite the lack of robust measurement of 'patient focused rounding' the work on the ward gained a profile within the Trust and particularly as the timeliness of the work fitted into to the corporate nursing work stream 'Brilliant Basics' which aimed to improve the basic nursing care delivered to patients. Again this was in the context of the high profile national reports highlighting failings in patients basic care and lack of communication between nurses and patients (Healthcare Commission 2007; Mid Staffordshire NHS Foundation Trust Inquiry 2010; Patients Association 2010; Care Quality Commission Report 2011; Health Services Management Centre 2011; Parliamentary and Health Service Ombudsman's 2011; Department of Health 2013a; Francis Report 2013).

The quarterly 'Brilliant Basics' subject for April 2012 to July 2012 was communication and the focus for improving communication was the Trust wide introduction of 'patient focused rounding'. In addition, part of the drive to promote better communication was based on the 2008 results from the National In-Patient Survey (Picker Institute 2008), which suggested the time taken to answer patient call bells was a concern for patients across the NHS. The National In-Patient survey results for the Trust for 2010 showed that 40% of patients waited longer than five minutes for a nurse to respond to a call bell. Worryingly within the survey's national report the lack of responsiveness to call bells was linked to reports of patients and carers feeling isolated and anxious. A refined and modified round document was launched as part of the Trust wide introduction of 'patient focused rounding' (appendix 2).

In retrospect I have found it interesting reviewing the handbook produced by the Trust as part of the implementation of 'patient focused rounding' as this thesis highlights little clear evidence exists to support the benefits of rounding practice. Part of the rationale for rounding implementation across the organisation was to answer the Governments call to action for healthcare providers to review communication and seek new ways of providing essential nursing care in a safe and effective way. However at the time a potentially flawed evidence base was promoting rounding as a method of reducing falls, improving patient

feedback for the overall quality of care plus reducing call bell usage to promote calm ordered wards.

2.6 Personal location

I came into post as the new Head of Nursing for the Division of Medical Specialities in January 2011 and from that time I have been heavily involved with rounding practice at the study site. This has been through the 'patient focused rounding' project as a developer and advocate of the approach compared to 'falls rounding' and as a nurse leader implementing rounding across my 14 areas of responsibility (wards and departments) following the roll out of rounding across the Trust in April 2012. At this time, I admit as a nurse leader I was enthused about introducing a nursing initiative that appeared to positively influence the quality of nursing care patients received. I championed the positive results of the 'patient focused rounding' pilot at Trust level and promoted its adoption as a Trust wide approach to rounding. I felt a focus on the basics of care was particularly important at a time when there was criticism of nursing care standards (Mid Staffordshire NHS Foundation Trust Inquiry 2010; Francis Report 2013).

From my point of view, the process of rounding with its structured and regular patient contact despite the checklist approach did seem appealing as it gave a rigorous checking process for supporting basic care delivery, that conversely patient centred care did not seem to be achieving. I felt that the evidence base of rounding gave assurances about the quality of care being delivered to patients. I was also engaged with the concept that evidence based practice was being implemented at ward level and affected fundamental care delivery. The work of Meade et al. (2006) and the reported falls reduction was also of particular interest as reducing patient harm from falls had always been a vital safety priority influencing my practice as I feel it is one of the fundamentals of care that remains an intractable nursing problem.

My experiences in practice reinforced that very few interventions have impacted on reducing patient falls rates and therefore an intervention which appeared to reduced falls seemed an appealing proposition. I initially perceived that the inclusion of rounding

practice within the governments drive to improve the quality of nursing care as an endorsement the positive outcomes of rounding practice to patient safety and experience. I felt that rounding practice was supported by experienced senior policy makers within the government and nursing and as such was beneficial to nursing practice.

However, as I commenced my research journey, being in the role of a researcher provided me with the opportunity to begin to search and examine in detail the literature about rounding. This level of detail and critical analysis is not a process I would normally undertake as a nurse leader, particularly when a practice is advocated for and required by a national mandate. My initial reading and interrogation afforded me a degree of apprehension and thorny questions arose regarding the rigour of the evidence base; explored further in chapter three.

2.7 Summary

In this chapter I have provided an overview of the historical context of rounding practice, an examination of the background to the development of the practice, a context for NHS practice and important scene setting of rounding practice in the study site. I have also provided insights into my personal location and my initial views on rounding. At this juncture rounding emerges as a practice that appears to be the solution for improving some of the basic care failing documented in high profile investigation into hospital care standards. Rounding practice was rapidly being recognised within government policy as a positive nursing practice that improved care. Within the study site, time and attention had been given to rounding practice as it was seen as a nursing intervention that could improve both patient safety and patient experience. However, through the critical examination of available information from current NHS healthcare rounding practice was neither consistently implemented nor the impact well measured. Chapter one highlighted there was a plethora of terminology used to describe rounding and variable approaches as to how the practice is performed exists. Indeed the examination of the development of 'modern day rounding' as depicted by Meade et al. (2006) highlighted the process was born from a historical ritualistic approach to patient care delivery, considered routine and overly scripted not individually patient centred. Therefore although at initial review the positive benefits of

rounding practice appeared overwhelmingly good for patients and nursing, appropriate scrutiny had not been given to the implementation of the rounding process within mainstream NHS practice and the positive benefits of rounding were not as explicit as first realised.

Chapter Three: Rounding the evidence base

3.1 Introduction

This chapter presents the findings of a comprehensive review investigating rounding practice published literature. I have discussed in previous chapters how the implementation of rounding in current NHS practice has been underpinned by favourable patient outcomes (patient care and experience) predominantly measured within US healthcare studies. As noted rounding is a relatively new concept within nursing in the UK, even for myself, therefore it was important to synthesise what knowledge about rounding already existed. Of course I need to consider pre-existing research evidence to be able to identify possible gaps within the literature as an integral aspect of my own study into rounding practice. Moreover to have insights into the methodological issues within current literature will serve to influence my own research design and support the quest to generate new knowledge. Therefore the literature review aims are threefold:

1. To examine the outcomes measures of rounding in relation to patient safety and patient experience
2. To identify and describe component features of rounding which are potentially important for patients and staff
3. To determine the important factors within the current evidence base which have influenced the research approach to investigating rounding

To meet the aims of the literature review an extensive search of current literature was undertaken. A comprehensive search strategy and critical appraisal methods were utilised to determine the quality and relevance of the studies included within the literature review. The findings provide firstly a synthesis of the current literature into an overview of published information specific to rounding. Secondly an in-depth critical appraisal of the quality of the studies under review is presented, focusing on key component themes of the literature including study outcome measures and research methodologies. Finally, the

constructs of rounding are explored and the component features of the process that need closer investigation exposed.

The literature review reveals potential problems with the evidence base associated with rounding. The causation link between rounding practice and positive patient safety and experience outcomes does not appear robust. My literature review highlighted gaps in the current thinking and measurements of rounding. Therefore my study will be able to address these gaps and generate new and original knowledge about rounding practice.

3.2 Search strategy and overview of the literature

The importance of identifying, evaluating and synthesising the existing body of knowledge related to a study subject is an essential requirement of the research process (Hart 1998). Hence my literature search required a defined strategy to ensure appropriate rigour was applied to the search process in order to identify the existing body of knowledge related to rounding. A comprehensive literature search was undertaken in October 2012 and repeated in January 2015 with a final literature search in April 2016. The searches used the following databases NHS Evidence, CINHAL, MEDLINE, BNI (British Nursing Index), Google Scholar and bibliographies of identified articles. The key words and phrases utilised for the search (table 5) were aligned to the insights discussed in chapter one and two, using them as a basis to define a research question and identify components terms for the literature search (Brettle 2008).

Table 5: Search question and terms

Question	How does the practice of rounding affect patient safety, patient and staff experience?		
Population	In-patients and nursing staff	**Terms**	Patient Rounds/Rounding Nurse Rounds/Rounding Intentional Rounds/Rounding Proactive Rounds/Rounding Falls Rounds/Rounding Hourly Rounds/Rounding Comfort Rounds/Rounding
Intervention	Rounding		
Comparison	Patient safety, patient experience, staff experience		
Outcome	Improved patient safety, improved patient and staff experience		

In order to be explicit and systematic search inclusion and exclusion criteria were applied (Hart 2005) (table 6).

Table 6: Exclusion and inclusion criteria

Criteria	Definition	Evidence	Date	Language
Exclusion	Non nursing rounding	Non research	Before 2002	Non English
Inclusion	Nursing only rounding	Published research, peer reviewed	2002 to 2016 to capture literature following the publication of Castledine's work	English

3.2.1 Overview of results

The search initially yielded 121 references. A total of 30 papers were excluded based on the document focusing on multidisciplinary rounds and or doctors ward rounds. The terminology used within the US literature identifies physician rounding which is similar to medical ward rounds in the NHS, these references were also excluded as these types of rounds were different to the concept of nurse only rounds.

The remaining 91 papers all related to nurse rounding; 34 were personal comment on the concept of rounding via letters, news items or editorial analysis/comment regarding rounding and thus excluded from the review. From the 34 excluded papers, 19 were from the UK (18 from the NHS) documenting updates on the progress of the implementation of rounding (subsequent to the Prime Ministers call for its introduction) or brief news items within journals.

The English language papers from different countries demonstrated that the concept and practice of rounding could be considered to be on an international level; papers originated predominantly from the US but also Canada, Australia, Saudi Arabia and UK.

A breadth of healthcare specialities were encompassed within the papers demonstrating that rounding was not isolated to a particular field of nursing; involving rounding practice within obstetrics, cardiac/cardiology, gastroenterology, mental health, intensive care, oncology and orthopaedics.

From the remaining 57 papers peer reviewed only research papers with a defined research question and methodology or systematic reviews were included (36 in total) this distinction excluded those papers that simply described the implementation of rounding (21) rather than a research based study.

Following a rigorous research stance seeking high quality evidence it resulted in only two NHS published papers, met the criteria of having a defined research question and methodology. To provide a commentary of rounding documentation and a current discourse on NHS rounding practice 17 NHS papers were summarised at the conclusion of the research literature review. The papers provided a wider debate regarding the importance of rounding being implemented whole scale across the UK. Systematic literature reviews performed by the UK academics; Snelling (2013) and Forde-Johnston (2014) were included.

From the search a total of 36 papers were identified as relevant and thus critically appraised. Table 7 is presented as a collated brief summary of the key features and trends of the studies included within the critical appraisal.

Table 7: Summary of the included studies

No	Short reference	Date	Brief description of method	Setting (adult in patient areas)	Timeframe	Brief summary of main findings
1	Berg et al.	2011	Quantitative, Meade	Med – Surg Unit 28 beds, US	35 days	Decrease call bell usage
2	Bougault et al.	2008	Quantitative, Meade	X3 Campus Hospitals, US	7 months	Increase pt satisfaction
3	Blakley et al.	2011	Mixed methods, case study	Med – Surg Unit 37 beds, US	1 month	Inconclusive
4	Brosey and March	2015	Quantitative, Meade	Med – Surg Unit 24 beds, US	3 months	Pt satisfaction, falls +ve
5	Culley	2008	Quantitative, Meade, pilot study	Not specified, US	12 weeks	Decrease call bell usage
6	D'Alessio et al.	2010	Quantitative, comparison	Maternity Unit, US	Not noted	Improvements in patient care
7	Deitrick et al.	2012	Qual, ethnography	X2 units, 35 beds, US	1 month	Inconclusive
8	Fabry	2015	Quantitative, survey	X6 units, 186 beds, 67 staff, US	3 months	Variable staff satisfaction
9	Ford	2010	Quantitative - Meade	X1 unit, US	3 weeks	Reduced call bells, no falls
10	Forde - Johnston	2014	Systematic review	N/A	N/A	Gaps in evidence
11	Gardner et al.	2009	Qual, Meade, parallel, pilot study	X2 surgical units, Australia	8 weeks	Few significant findings
12	Goldsack et al.	2015	Quantitative, Meade, pilot study	X2 medical units, 75 beds, US	30 days	Reduced falls and call bells
13	Halm	2009	Systematic review	N/A	N/A	Call bells, falls, pt satisfaction +ve
14	Harrington et al.	2013	Qual, participatory action research	X1 unit, Australia	5+28 days	Inconclusive
15	Hicks	2015	Systematic review	N/A	N/A	Reduced falls
16	Kessler et al.	2012	Quantitative, Meade	Med – Surg Unit 30 beds, US	4 years	Pt satisfaction, falls +ve
17	Krepper et al.	2012	Quantitative, Meade	X2 Cardiovascular units, US	1 year	Inconclusive
18	Lyons et al.	2015	Systematic review	N/A	N/A	Questions value of rounding
19	Meade et al.	2006	Quasi experimental, non-equivalent	X27 units 14 hospitals, US	6 weeks+1 year	Pt satisfaction, falls, call bells +ve
20	Mitchell et al.	2014	Systematic review	N/A	N/A	Inconclusive
21	Murphy et al.	2008	Quantitative, comparison	X1 Medical Unit, US	6 weeks	Pt satisfaction, falls, call bells +ve
22	Neville et al.	2012	Mix methods, exploratory, pilot study	X5 med – Surg units, US	4 weeks	Inconclusive
23	Olrich et al.	2012	Quantitative - Meade	506 bed hospital, US	15 months	Pt satisfaction, falls, call bells +ve
24	Rondinelli et al.	2012	Mixed methods, action research	11 hospitals, US	18 months	Complexities to implementation
25	Saleh et al.	2011	Quantitative - Meade	26 bed unit, Saudi Arabia	8 weeks	Pt satisfaction, falls, call bells +ve
26	Sherrod et al.	2012	Quantitative – Meade, pilot study	Med – surg unit 36 beds, US	1 year	Pt satisfaction, falls, call bells +ve
27	Snelling	2013	Systematic review	N/A	N/A	Poor evidence
28	Sobaski et al.	2008	Quantitative - Meade	25 bed cardiac unit, US	3 months	Increased pt satisfaction
29	Studer Group	2007	Quantitative - Meade	27 Regional hospitals, US	6 weeks	Pt satisfaction, falls, call bells +ve
30	Tea et al.	2008	Quantitative, comparison	4 hospitals, US	2 years	Improved pt satisfaction
31	Toole et al.	2016	Systematic review	N/A	N/A	Barrier to implementation
32	Torres	2007	Quantitative – Meade, pilot study	X3 model of care units, US	1 year	Pt satisfaction, call bells +ve
33	Tucker et al.	2012	Mixed methods, RMD	X2 orthopaedic units, US	3+12 months	Inconclusive

34	Walker et al.	2015	Qualitative – descriptive study	X2 units 88 beds, US	3 months	Implementation challenges
35	Weisgram & Raymond	2008	Quantitative – Meade, pilot study	204 bed military hospital, US	30 days	Pt satisfaction, falls, call bells +ve
36	Woodward	2009	Quantitative - Meade	Med – Surg Unit 27 beds, US	9 months	Pt satisfaction, falls, call bells +ve

Abbreviations: Med – Surg = Medical – Surgical, Pt = patient, +ve = positive benefits, Qual = Qualitative, RMD = Repeated Measures Design

The publication dates of the studies spanned ten years, from 2006 to 2016; 12 papers were published between 2006 to 2009 and 21 published more recently between 2010 to 2016. This highlighted the contemporary relevance the practice of rounding had to nursing.

Most papers (29) were detailed investigations related to the process of rounding in a hospital settings, seven papers were systematic evidence reviews of the rounding evidence base (Halm 2009; Snelling 2013; Forde-Johnston 2014; Mitchell et al. 2014; Hicks 2015; Lyons et al. 2015; Toole et al. 2016).

The majority of the papers (22) were quantitative studies; four studies (Blakley et al. 2011; Neville et al. 2012; Rondinelli et al. 2012; Tucker et al. 2012) appeared to use a mixed methodology design (case study, descriptive exploratory design, action research and a descriptive repeated design); only three studies (Deitrick et al. 2012; Harrington et al. 2013; Walker et al. 2015) used a purely qualitative methodology, ethnography, participatory action research and a qualitative descriptive study.

Many studies (Culley 2008; Murphy et al. 2008; Sobaski et al. 2008; Weisgram and Raymond 2008; Ford 2010; Saleh et al. 2011; Krepper et al. 2012; Olrich et al. 2012) had chosen to follow the same quantitative methodology as Meade et al. (2006) and the Studer Group (2007) using a quasi-experimental non-equivalent research design, due to the difficulty in controlling variables in a hospital setting. Fabry (2015) utilised survey methodology and descriptive analysis to ascertain nursing staff perspectives and perceptions of rounding but acknowledge a low return rate of surveys was a limitation to their study findings.

Only one paper failed to clearly state a specific research methodology (Kessler et al. 2012) although there was a clearly articulated a study question. This made it difficult to categorise the study as being either quantitative or qualitative in its methodology, as the study question was quantitative, the same as Meade et al. (2006) but the study reported qualitative results but with no real methodology related to the qualitative data collection.

The papers reported seven pilot studies, all of which concluded their investigation into rounding suggesting the topic warranted further study (Torres 2007; Culley 2008; Weisgram

and Raymond 2008; Gardner et al. 2009; Neville et al. 2012; Sherrod et al. 2012; Goldsack et al. 2015)

As stated previously, the main body of recent work related to rounding emanates from the US, this is reflected in the fact 30 of 36 studies were carried out in the US healthcare setting; the remaining five papers, three from Australia (Gardner et al. 2009; Harrington et al. 2013; Walker et al. 2015), Saudi Arabia (Saleh et al. 2011) and the UK (Snelling 2013; Forde-Johnston 2014).

The length of the studies appeared arbitrary and varied considerably, nine studies had durations of only a few weeks (Culley 2008; Murphy et al. 2008; Weisgram and Raymond 2008; Gardner et al. 2009; Ford 2010; Berg et al. 2011; Blakley et al. 2011; Saleh et al. 2011; Deitrick et al. 2012; Goldsack et al. 2015) whereas eight studies reported results of a year or more in duration (Meade et al. 2006; Tea et al. 2008; Krepper et al. 2012; Olrich et al. 2012; Rondinelli et al. 2012; Sherrod et al. 2012; Tucker et al. 2012). In the case of Kessler et al. (2012) their study duration was the longest, spanning four years (2007-2011).

3.2.2 The study aims of the reviewed literature

Most of the quantitative studies (22) replicated the methodology used by Meade et al. (2006) therefore similar aims bridged across many of the studies plus the influence of the Meade study filtered into the aims of most of the remaining studies. I feel this highlighted a diachronic discourse within the evidence, a potential strength was that replicated studies demonstrated reproducibility but at the same time restricted the investigative lens through which rounding was being viewed which potentially weakened the evidence base.

The overarching aim which was presented by the majority of papers was to link rounding with improved patient outcomes, through patient safety and patient satisfaction. Five papers specifically linked their aim to staff satisfaction through rounding (Deitrick et al. 2012; Neville et al. 2012; Harrington et al. 2013; Fabry 2015; Walker et al. 2015).

The majority of the papers (36) define patient safety as reduced falls, reduced call bell usage and or reduced pressure ulcers. However it was noted that the purpose for undertaking research across the 36 papers varied in terms of emphasis on rounding. For example, some studies focused upon falls reduction (Murphy et al. 2008; Tucker et al. 2012; Brosey and March 2015; Goldsack et al. 2015), others sought to investigate the effect of rounding on enhancing patient satisfaction (Bourgault et al. 2008; Sobaski et al. 2008; Tea et al. 2008; Gardner et al. 2009; D'Alessio et al. 2010; Blakley et al. 2011; Kessler et al. 2012). Some combined a broader perspective to investigate the effect of rounding on patient safety (reduced falls, reduced call bell usage, reduced pressure ulcers) as well as enhanced patient satisfaction papers (Meade et al. 2006; Studer Group 2007; Torres 2007; Woodward 2009; Berg et al. 2011; Krepper et al. 2012; Harrington et al. 2013).

3.2.3 Study site modality

Excluding the systematic evidence review (Halm 2009; Snelling 2013; Forde-Johnston 2014; Mitchell et al. 2014; Hick 2015; Lyons et al. 2015; Toole et al. 2016) the remaining 29 studies were undertaken in hospital settings. Given the nature of rounding this is no surprise however where differences occurred this was in terms of the number of wards or units involved. For example Meade et al. (2006) being the largest study with 14 hospitals and 27 units and the multi-centre study by Rondinelli et al. (2012) involving 11 hospitals. The most prevalent care setting was a medical-surgical unit or ward, nine in total, with other care settings being a stroke unit, orthopaedic wards, haematology/oncology unit, a neuro-surgery setting, stand-alone surgical wards, cardiovascular surgery wards stand-alone medical unit, three cardiac telemetry units, a maternity unit and an (intensive care) step down unit. A noted omission was the lack of detail across most studies regarding staffing levels and patient dependency.

3.2.4 Sample size and sampling methods

I found it difficult to ascertain the number of patients involved in the majority of the studies. Only five studies (Tea et al. 2008; Gardner et al. 2009; Deitrick et al. 2012; Harrington et al. 2013; Brosey and March 2015) cited a definitive number of patients involved, ranging from 335 to 51 patients and six studies cited the number of nurses involved (Gardner et al. 2009;

Deitrick et al. 2012; Neville et al. 2012; Harrington et al. 2013; Goldsack et al. 2015; Fabry 2015).

It was not explicit why some study sites were selected, although, the rationale of increased fall rates and/or poorer rates of patient satisfaction influenced site selection for some (Murphy et al. 2008; Woodward 2009; Kessler et al. 2012; Brosey and March 2015). Differences in samples were also inconsistent; some studies took a hospital wide approach and included every ward and unit. Whereas Rondinelli et al. (2012) sought volunteer units across two different hospital groups.

The reporting of study samples, varied across the 36 papers in terms of detail of size, number of the hospitals and units, speciality and location. However less attention was paid to sampling methods. The majority of papers, particularly those who followed Meade et al. (2006) methodology used non-randomised samples due to the issues of controlling variables in the hospital setting however this was not overtly stated within the paper. Gardner et al. (2009) used two matched female surgical wards as a control and experimental site providing parallel groups for their study but the study design was non-randomised. Convenience sampling methods appeared to dominate many of the studies often seen as an easier approach to adopt.

3.2.5 Ethical approval

Ethical approval is integral to conducting research (DH 2011b) and a requirement for publication in many peer-reviewed journals. So it was no surprise that all studies that collected empirical data gained ethical approval. That said nine studies did not mention ethical approval however the design of the studies would suggest ethical approval was required.

3.2.5 Researcher bias

For the quantitative studies within the literature review there should be no evidence of potential researcher bias as the research design promotes an experimental field in isolation from the researcher. However, Snelling (2013) highlights some potentially serious researcher bias concerns in his critique of Meade et al. (2006). The allocation of the

hospitals into the control and experimental arms of the study was undertaken in collaboration with the principal investigator in conjunction with the hospital. This allowed the hospital and principal investigator to decide which arm of the study was suited to that particular hospital either the rounding or non-rounding arm of the study. This method of allocation could have led to potential researcher bias as the researcher was deciding on the allocation of study sites. Study sites showing more enthusiasm for implementing rounding could have been allocated to the rounding arms potentially affecting outcomes more positively than if a non-enthused site was allocated to the rounding arm.

Snelling (2013) identifies a further potential bias connected to the financial interest between the Meade et al. (2006) team and the Studer Group (2007). The Studer Group (2007) sell promotional material and educational resources related to rounding based on the work of Meade et al. (2006) which the Studer Group funded.

Six studies had the potential for researcher bias with the research teams, as part of their methodology, immersing themselves into the healthcare study setting (Blakley et al. 2011; Rondinelli et al. 2011; Deitrick et al. 2012; Neville et al. 2012; Tucker et al. 2012; Harrington et al. 2013; Walker et al. 2015). Under these circumstances researchers were potentially at risk of developing preconceived ideas of the patient and staff involvement with rounding, compared to quantitative methodology studies which do not directly involve the researcher with patients or staff.

3.3 UK literature

As stated previously, the UK literature on rounding is disappointing in terms of research rigour highlighted by three of the more critical authors Mitchell et al. (2013); Snelling (2013); Forde - Johnson (2014). It was difficult to include any UK literature in the body of the review as the papers highlighted a lack of robust research methodology. Some attention does need to be given to this literature in terms of adding to the context and voice of UK rounding practice, given its wide scale implementation. I therefore mention if only to make explicit the research evidence gaps in the UK literature concerning rounding practice.

The UK literature does have a contemporary context in terms of time span being from 2010 to 2015. The only exception is Castledine (2002) and Castledine et al. (2005) which define 'Patient Comfort Rounds' and their influence is discussed earlier in the historical context of rounding in chapter two. Castledine's work was not research but explains the context and process of an antecedent to the work of Meade et al. (2006).

Within the UK literature 19 articles document the implementation of rounding in a specific NHS hospital setting. The implementation appears to be within whole hospital settings (Crossfield and Pitt 2012; Duffin 2012; Gillen 2012) to specific units within hospitals; Orthopaedic Unit (Lucas et al. 2010) Medical Assessment Unit (Fitzsimmons et al. 2011; Braide 2013) High Dependency Unit (Lowe and Hodgson 2012). Hutchings (2012) and Hutchings et al. (2013) describe implementation on several speciality wards including oncology, stroke, orthopaedic, neurology and spinal. From the NHS literature rounding appears to have been implemented in a variety of ward settings similar to the review findings. However there is little discerning evidence in terms of speciality implementation, for example no comparison of rounding on a cardiac ward compared to rounding on a stroke ward. Interestingly, Duffin (2012) explains the implementation of rounding within the UK private sector; an initiative that covered 80 patients in units delivering paediatric, adult intensive care and post-surgical care; but failed to collate any outcome data only the promise of conducting a patient survey to see what patients thought of rounding.

Four of the NHS publications relate to rounding in one hospital on initially one unit with roll out to a further 11 areas (Phillips et al. 2011; Mason 2012; Dix et al. 2012; Braide 2013) pointing to an example of rounding in a discussion paper (Fitzsimmons et al. 2011). Between the papers there is some detail in their account of the perceived benefits of rounding and their implementation. In addition there are detailed accounts of rounding implementation (Lucas et al. 2010; Hutchings 2012; Hutchings et al. 2013; Stoddart et al. 2014), although Crossfield and Pitt (2012) focus on their use of 'rapid spread' implementation methodology in their practice of rounding. The government and nursing leadership support for rounding is demonstrated by Gillen (2012) who provides an insight into the views of the National Lead for rounding on the governments Care Quality Forum.

This emphases the political and policy context of rounding practice. According to Gillen (2012 p12) the national lead for rounding clarifies that;

> *'Rounding with intention to care is not the old back round. It is about being highly visible to your patients at least every hour and providing personalised care at that point should it be required.'*

Rounding according to the national lead is:

- The 4 Ps (checking patient's pain, personal needs, positioning, possessions)
- Requires professional judgement
- Is about communicating with patients
- Proactively delivers care to patients
- Patients won't be left ringing bells

The UK national lead positively promotes rounding by making clear its capacity to prevent poor care, and that rounding can give relatives reassurance that their loved one will receive good care (Gillen 2012). All of these assertions can be found in the literature review however within the UK there is no research evidence to substantiate these statements. Two further articles both examine the approaches to rounding, expose the lack of research evidence, but yet positively promote the practice of rounding (Fitzsimmons et al. 2011; Policy Plus document, National Nursing Research Unit 2012) Fitzsimmons et al. (2011 p20) encapsulates the UK approach to rounding:

> *'The evidence base is sparse but intuitively and anecdotally rounding makes sense. The question is: patients like it and it has benefits for all?'*

Through my own professional experience it is perhaps difficult to agree with this point of view and the literature reviewed potentially contradicts the assertion that *patient like it and it has benefits for all.*

Snelling (2013) is scathing in his critique of rounding and its implementation in the NHS, as he highlighted the misrepresentation of US evidence into the UK literature. I would argue that it is disappointing that the UK literature has a poor citation rate and upon wider examination of the US literature beyond three key studies: Meade et al. (2006); Studer Group (2007); Tea (2009). Crossfield and Pitt (2012) do not cite any studies on rounding; Duffin (2010) cites one; Fitzsimmons et al. (2012) two; Dix et al. (2012) and Hutchings (2012) cite four papers each; Policy Plus (2012) cites seven papers. A paper by Braide (2013) cites eight relevant papers related to rounding of which only four are considered of sufficient quality to be included in this review (Meade et al. 2006; Culley 2008; Halm 2009; Tea et al. 2009). The NHS studies cross cite each other; Braide (2013) cites Lucas et al. (2010); National Nursing Research Unit (2012) cites Dix et al. (2012). Stoddart et al. (2014) cite only UK literature apart from Meade et al. (2006) reinforcing a lack of UK studies within the literature on the process of rounding.

Eight NHS studies provide some audit type commentary on the outcomes of rounding but much of this is against the context of scant methodology in terms of any type of research design (Lucas et al. 2010; Crossfield and Pitt 2012; Dix et al. 2012; Hutchings 2012; Braide 2013; Dewing and Lynes O'Meara 2013; Stoddart et al. 2014; Kenny and Norton 2015). Dix et al. (2012) report on the pilot linked to the larger work reported by Braide (2013); all of the work adopts before and after measures used by Meade et al. (2006), but there is little debate of variables or equivalency of measurement. Similar outcomes are assessed; call bell usage, falls, and pressure ulcers but with less rigour. Three studies emphasise that other implemented interventions may have influenced results, for example training and awareness in pressure ulcers, falls prevention programme and the use of electronic patient assessment documents (Crossfield and Pitts 2012; Hutchings 2012; Braide 2013). Stoddart et al. (2014) present a detailed account of rounding implementation and percentage reduction in falls and call bell usage coupled with patient and staff satisfaction improvements however there is little detailed evidence and analysis of the data presented to provide confidence in their findings.

Four clear positive benefits of the implementation of rounding are articulated across some papers but these results are subjective as no paper provides any statistical evidence (table 8).

Table 8: Benefits of rounding implementation (UK)

Reported benefit	Studies
Reduced call bells	Lucas et al. 2010; Dix et al 2012; Hutchings 2012; Braide 2013; Stoddart et al. 2014
Reduced falls	Lucas et al. 2010; Crossfield and Pitt 2012; Hutchings 2012; Stoddart et al. 2014
Reduced pressure ulcers	Hutchings 2012; Braide 2013
Reduced complaints and better patient feedback	Crossfield and Pitt 2012; Dix et al. 2012; Hutchings 2012; Lowe and Hodgson 2012; Braide 2013; Dewing and Lynes O'Meara 2013; Stoddart et al. 2014

A strong theme within all the papers was the suggestion albeit subjective that the implementation of rounding was problematic. From the NHS articles large amounts of resources notably time was required to engage staff and implement the process of rounding but despite this staff were not always convinced of the benefits of rounding (Lucas et al. 2010; Crossfield and Pitt 2012; Dix et al. 2012; Hutchings 2012; Lowe and Hodgson 2012; Braide 2013; Hutchings et al. 2013; Dewing and Lynes O'Meara 2013). Kenny and Norton (2015) provide a review of the rounding process in their organisation as a first stage in planning a quality improvement project. Their feedback also concluded staff were not always convinced of the benefits of rounding as well as finding patients were not aware of the process of rounding.

For me the main conclusion drawn from the UK literature was the existence of a research evidence gap, a lack of high quality robust studies to measure the impact of rounding in UK practice. The suggestion that it was difficult for staff to engage with the process of rounding indicates to me that the process does not intuitively make sense to all nurses.

3.4 Critical appraisal of key components of the literature

The work of Halm (2009) classifies pre 2009 rounding studies in terms of the quality of the quantitative evidence the studies produced. Halm (2009) used an adapted 'classes of recommendation for interventional studies' based on international guidance published in the medical journal, Circulation. From the studies within this review all but the Meade et al. (2006) study is rated as third level evidence (Class IIb) in a system that has five levels of classification (Bourgault et al. 2008; Culley 2008; Sobaski et al. 2008; Tea et al. 2008; Woodward 2009). In the classification Class IIb evidence is considered to be acceptable and useful (intervention) to practice compared to Class I, a definitely recommended intervention for practice. Class IIB studies are supported by fair to good evidence with the weight of evidence and expert opinion not strongly in favour of the study. The intervention study is considered safe and useful but is not considered to be a definitive standard of care. The Meade et al. (2006) study is in one classification higher at Class IIa which would be considered an intervention of choice supported by good evidence but still not a definitive standard of care. The review by Hicks (2014) provided a more recent analysis of literature, 12 articles published between 2010 and 2014 however there is no critique of the quality of the literature methodology but rather a focus on the study outcomes which give an overall positive impact between rounding and reduced falls rates. The evidence review by Lyons et al. (2015) also fails to classify the quality of their included study's methodology however concludes that the impact of rounding on patient safety is questionable.

Snelling (2013) postulates numerous concerns which potentially exposes the fragility of the US evidence base related to rounding; one concern being that much of the evidence is based on studies that could be considered weak evidence according to the above classification. Mitchell et al. (2014) systematic review identifies eight subsequent studies published after the Halm (2009) review, which are all included within this studies literature review. Mitchell et al. (2014) concluded the evidence supporting rounding practice was from low to moderate strength hence the inclusion of subsequent studies would not improve the strength of the evidence base for rounding practice. Toole et al. (2016) provide the most recent systematic review of rounding evidence, categorising their levels of evidence from level 1 high level evidence from systematic randomised controlled trials to

level 7 opinion, qualitative studies are categorised as level 6. Their review focused on barriers to hourly rounding, concluding there were significant barriers to implementation but also acknowledging their level of literature quality was low and they had only focused on rounding in the medical surgical environment of care. I believe that this would imply, from the systematic reviews that the validity of the evidence base for rounding practice is a concern.

A specific evaluation tool was utilised in order to examine and appraise the quality of the literature. The evaluation tool needed to be able to interrogate the legitimacy and rigour of both quantitative and qualitative studies therefore an adaptive approach was used. An adaptation of the HCPRDU Evaluation tool for quantitative and qualitative studies developed at the University of Salford (HCPRDU 2002) drew on appropriate critical appraisal questions from both quantitative and qualitative evaluation tools. Hence its suitability for its application to this literature review which comprised of both quantitative and qualitative studies.

In order to provide an in-depth focus on significant aspects relating to the quality of the evidence on rounding three key component themes set within the HCPRDU evaluation tool were comparatively analysed and discussed as they fit well with the aims of the literature review.

- A review of the context of the studies, focusing specifically on the outcome measures in the literature
- A review of the studies methodologies and methods of data collection
- A detailed examination of data analysis within the evidenced literature

3.5 Outcome measures

Outcome measures within the studies are mainly drawn from a narrow catalogue of three or four criteria. This appears to be because many of the studies are a replication of the Meade et al. (2006) study (Studer Group 2007; Culley 2008; Gardner et al. 2009). The focus of the outcome measures for these quantitative studies are:

- Improved patient satisfaction
- Reduced use of patient call bells
- Improved patient safety through reduced falls rates
- Improved patient safety through reduced pressure ulcer rates
- Improved staff satisfaction

3.5.1 Improved Patient Satisfaction

One of the concerns with the quality of the evidence I identified was that different measures of the specific outcomes were used in different studies which could limit the reliability of the outcome measure across the evidence base. This was particularly evident within the improved patient satisfaction outcome measure. A high proportion of the studies (15) used the outcome of improved patient satisfaction due to the implementation of rounding via the evaluation of a specific patient satisfaction survey (Berg et al. 2011; Blakley et al. 2011; Kessler et al. 2012; Sherrod et al. 2012; Brosey and March 2015). Ford (2010 p189) emphasised the importance of using a patient satisfaction survey that;

> *'Provides a nationally standardised and publically reported benchmark of patient's perceptions of their care'.*

However there was an inconsistency of which survey was utilised to collect patient satisfaction data, differing studies utilised different surveys (table 9), making the comparative benchmarking of patient satisfaction outcome data to rounding a difficult process which directly impacts on the quality of the evidence.

A further complication of patient satisfaction outcome data was that different studies measured different aspects and questions/themes within surveys. I highlighted this because this may indicate an arbitrary nature to detailing patient satisfaction outcomes for rounding which potentially weakens the evidence base further.

Berg et al. (2011) measures the responses of two survey questions pre and post rounding to indicate if rounding has improved patient satisfaction; promptness of response to call bells

and nurse attitude toward requests. Whereas, Ford (2010) used a survey which gathered patient satisfaction with specific areas of nursing care, addressed by rounding; pain management, comfort and safety. Patients reported superior care when rounding was in place. Similarly Bourgault et al. (2008) focused on nursing care themes, but included an overall rating of care as well as ratings for, would you recommend, how soon help arrived, help with pain and help going to the bathroom.

Table 9: Different patient satisfaction surveys used in rounding

Patient satisfaction survey	**Studies**
Press Ganey Survey (US National patient satisfaction survey, questionnaire, 5 point Likert scale)	Meade et al. 2006 x10 hospitals; Sobaski et al. 2008; Kessler et al. 2012; Sherrod et al. 2012
Hospital Consumer Assessment of Healthcare Providers and Systems (Similar to Press Ganey)	Bourgault et al. 2008; Ford 2010; Blakley et al. 2012; Krepper et al. 2012; Brosey and March 2015
National Research Corporation Picker Survey (Similar to Press Ganey)	Meade et al. 2006 x2 hospitals; Woodward 2009
Professional Research Consultants (Detail not specified)	Meade et al. 2006 x2 hospitals
Developed own patient satisfaction survey • Interviews with patients questions about rounding • Bespoke patient satisfaction questionnaire about the rounding process • Single question based on help uncertainty	Tea et al. 2008; Gardner et al. 2009; Woodward 2009
Specific survey type not identified	Culley 2008; Saleh et al. 2011; Harrington et al. 2013

For many studies satisfaction data was collected over a short time scale, a period of weeks or 1 to 3 months. This may reflect some of the studies were pilot studies (Culley 2008; Gardner et al. 2009). Kessler et al. (2012) analysed patient satisfaction with a degree of longevity through a pre rounding introduction in 2006 until the final collection of results in 2011 using 3 key questions:

1. How well was your pain controlled
2. Promptness in response to call bell
3. How well staff worked together to care for you

Overtime there was no definite increase in patient satisfaction measures, for the latter two questions pre rounding scores were higher than the scores recorded in 2011, although scores for 2007, first year post rounding implementation showed an increase in patient satisfaction scoring (Kessler et al. 2012).

3.5.2 Reduced use of patient call bells

The reduced use of patient calls bells was measured by some of the studies in the literature through feedback from patient satisfaction surveys which ask patients about the promptness of nurses to responding to call bells (Sobaski et al. 2009; Berg et al. 2011; Sherrod et al. 2012; Brosey and March 2015). The proposal from Meade et al. (2006) and the Studer Group (2007) was that if patients needs are met through rounding then patients use their call bells less, nurses can respond to the reduced number of call bells in a more timely or prompt manner which positively impacts on patients satisfaction.

Taking forward this proposal studies offer evidence in relation to rounding reducing the overall number of call bells rung in a specific time, the reduction being postulated as a successful outcome of the rounding intervention as less call bells mean those that are rung are answered more promptly or more quickly (Meade et al. 2006; Studer Group 2007; Woodward 2009;, Ford 2010; Berg et al. 2011; Salch et al. 2011). These studies specifically measure the time taken to answer call bells within their studies and provide a data analysis of their results, plus all show a statistically significant decrease in number of times call bells were rung post the rounding intervention. The rationale for reduced usage, was postulated that issues addressed by rounding would mean that patients would not need to use their call bells for attention for those specific interventions (Meade et al. 2006; Ford 2010; Salch et al. 2011; Harrington et al. 2013). However, none of the studies could draw conclusive evidence this was correct as results didn't show any significant differences in reasons for call bell usage because of the rounding intervention. Krepper et al. (2012) reported no significant difference between call bell use within a study unit and a control unit in an 18 months data collection period.

3.5.3 Improved patient safety through reduced falls rates

A reduction in patient falls is measured as an outcome of rounding in several studies with the aim of hospitals that have introduced rounding note patient falls occur less frequently (Meade et al. 2006; Studer Group 2007; Murphy et al. 2008; Woodward 2009; Ford 2010; Saleh et al 2011; Tucker et al. 2012; Brosey and March 2015; Goldsack et al. 2015). The work of Murphy et al. (2008) and Tucker et al. (2012) solely focus on falls reduction from the implementation of rounding as the main outcome of their studies. Ford (2010 p190) conveys the rationale for rounding to reduce falls:

> *'When staff members round on patients every hour and address basic needs, such as toileting and placement of personal items, risks for falls decrease. Patients are less likely to get out of bed when personal needs are met.'*

By proactively addressing the Ps of proximity of patients personal items which includes close proximity of their call bell so patients are able to call for help should they need to and meeting personnel needs (toileting) on either an hourly or two hourly basis rounding as a nursing intervention reduces rates of patient falls.

Within the Ford (2010) study reduced falls were noted as a potential outcome from the rounding intervention, the study was performed over three weeks involving 51 patients and no falls were reported during the study period. Ford (2010) postulated no falls occurred possibly due to the higher frequency of patient contact however the study collected no further data on falls because of the brevity of the study timeframe. Therefore I find it difficult to draw any significant conclusions from this study.

Halm (2009) strengthened the initial link made by Meade et al. (2006) between the implementation of rounding and falls reduction by finding that in seven out of the nine studies reviewed, falls rates were reduced. I feel this publication could be seen as significantly contributing to the populist but unsubstantiated view that rounding reduced fall rates and was therefore an effective patient safety intervention impacting on an intractable problem which other nursing interventions had not been successful in resolving.

Reducing harm to patients through decreasing falls rates was potentially a very appealing outcome from introducing rounding. Tucker et al. (2012 p18) highlights that:

> *'Patient falls are the most common adverse incident reported in acute care facilities and often result in morbidity, mortality and fear of falling.'*

Murphy et al. (2008) connected patient falls to nurse sensitive outcomes proposing that because nurses were in a position to heavily influence the patient care that may prevent falls. Therefore patient falls rates can be seen as an outcome of the quality of care delivered by nurses. Sherrod et al. (2012) estimated the additional monetary costs of patient harm due to falls as being several thousands of dollars per patient.

I believe a further flaw in the falls outcome evidence base was that those studies that proposed that an outcome of rounding was a reduction in patient falls, all used inconsistent measures for defining and recording their falls rates data pre and post the introduction of rounding, which made fall rates across studies difficult to compare. Tucker et al. (2012) defined their falls as falls with or without harm and used falls per 1000 bed days to measure their falls rate on an orthopaedic ward. Compared to the Studer Group (2007) who note a falls rate in terms of per 1000 patients as their study covered different wards on different hospital sites, so they amalgamated their data to show an overall reduced rate of falls. Brosey and March (2015) and Goldsack et al. (2015) compare falls rates per 1000 bed days as well noting falls reductions however both studies only cover short time periods, three months and one month respectively. Brosey and March (2015) note a decreasing falls trend prior to rounding and the implementation of a falls prevention programme. Hicks (2015) identifies from a review of studies specifically related to rounding and falls reduction that the limitation of sample size, study timeframes as well as non-randomised samples contribute to a failure to demonstrate the positive effect of rounding on falls reduction rates. Other studies used the actual number of falls occurring for their data analysis irrespective of the numbers of beds per ward making comparison between studies even more difficult (Meade et al. 2006; Murphy et al. 2008; Woodward 2009; Saleh et al. 2011).

3.5.4 Improved patient safety through reduced pressure ulcer rates

If the evidence for rounding reducing rates of patient falls is susceptible to scrutiny then the evidence linking rounding to a reduction in pressure ulcers is more tenuous. Snelling (2013) compellingly states the case for a misattribution of the link between rounding and reduced pressure ulcers in the seminal paper of Meade et al. (2006). The incorrect citation of the results of the Meade et al. (2006) study has meant a positive translation of the link between rounding and reduced pressure ulcer rates has been transmitted into the UK literature when actually there was no proven positive link.

Sherrod et al. (2012) articulated the harm from Hospital Acquired Pressure Ulcers (HAPU) in terms of cost to hospitals themselves through reduced fees, the cost of increased length of stay and prevalence of patients suffering from pressure ulcers.

It was the proactive nursing interventions which relate to the 'P' of "positioning" which potentially impact on reducing HAPUs. Therefore rounding provides a way to improve patient safety and reduce harm through HAPU reduction. Indeed the literature is consistent in its description of positioning with the rounding action aimed at assisting the patient to turn or change position to relieve pressure points through weight redistribution (Woodward 2009; Ford 2010; Sherrod et al. 2012). At the same time patients were checked for skin breakdown and their comfort assessed. In addition, Ford (2010) promoted fluffing pillows and straightening linen as part of the rounding process related to position.

Halm (2009) examined 11 reports in the clinical evidence review and it was only Meade et al. (2006) that identified a 14% reduction in developing pressure ulcers as a result of implementing rounding. However, there were no definitive results related to pressure ulcers or a consideration of pressure ulcers in the design and discussion section of the Meade et al. (2006) paper. It was perhaps the introductory section that mentions a specific study of interdisciplinary rounds (not rounding) and a reduction in pressure ulcers that gives a perceived impression of rounding reducing pressure ulcer prevalence.

The majority of studies do not examine the link between rounding and pressure ulcer reduction and/or pressure ulcer reduction as an outcome of rounding, despite describing

the use of positioning as an action of rounding (Culley 2008; Sobaski et al. 2008; Bourgault et al. 2009; Gardner et al. 2009; D'Alessio et al 2010; Berg et al. 2011; Blakley et al. 2011; Kessler et al. 2012; Neville et al. 2012). Some studies promoted the perception of rounding impacting on pressure ulcer prevention without providing evidence to support this notion (Woodward 2009; Rondinelli et al. 2012). For example, Rondinelli et al. (2012) highlight HAPU as a designated rounding outcome within their study but failed to measure or present data. Similarly, Woodward (2009) links skin integrity as a measurable outcome that is affected by the practice of rounding but does not include any measurement of skin integrity/pressure ulcer development in the study outcomes, choosing to focus on falls rates, call bell frequency and patient satisfaction. Ford (2010) promoted rounding as a nursing intervention that reduces pressure ulcer prevalence but again does not use pressure ulcer reduction as a measure in their study. The Deitrick et al. (2012) study posited a clear disconnect from the staff surveyed in terms of linking rounding to the specific patient safety outcome of pressure ulcer care.

A small number of studies identify a measured reduction in pressure ulcer development (Studer Group 2007; Salch et al. 2011; Sherrod et al. 2012; Brosey and March 2015). However none of the measurement is presented with any degree of statistical rigour and it is difficult to draw any conclusions as to the effectiveness of rounding in reducing pressure ulcer rates from their studies. The systematic reviews (Forde-Johnston 2014; Mitchell et al. 2014) could not find evidence of pressure ulcer reduction from their synthesis and both highlight that studies to date have been unable to prove a statistically significant decrease in pressure ulcer prevalence.

3.5.5 Improved staff satisfaction

Several studies note the link between rounding and improved staff satisfaction however few studies have actually applied any rigorous methodology to measure this outcome. Sobaski et al. (2008) refer to the study by Meade et al. (2006) when stating rounding has been found to increase employee satisfaction. Meade et al. (2006) presents anecdotal data verbally reported by staff from the experimental units in their study, that due to the implementation of rounding they had additional time to care for their patients, the units were quieter. This was because rounding reduced the number of call bells nurses had to answer thus freeing

up time for other duties. Additionally nurses were able to be more attentive and respond more quickly when call lights were used by patients. The Studer Group (2007) present a similar anecdotal link to higher staff satisfaction from the implementation of rounding. They suggest that staff were highly satisfied with the system of rounding due to fewer interruptions and more time for activities such as patient education and better documentation. Culley (2008) promoted the benefit of rounding to staff, he enthused that staff gain control of their busy workload by reducing 'busy work'. Whereas others suggested enhanced team work and communication was a positive effect rounding had on staff satisfaction, but did not measure this (Bourgault et al. 2008; Gardner et al. 2009).

Blakley et al. (2011) report on a specific hospital where the implementation of nurse rounding contributed to a decrease in call bell usage and an environment that was easier to manage and more rewarding for staff. This study was one of the few studies that focused on staff and as well as patient satisfaction with the process of rounding. Generally studies which attempt to link rounding to increased staff satisfaction suggest the link was inconclusive and there were numerous complexities and barriers to measuring staff satisfaction (Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012; Harrington et al. 2013). Recent evidence from the literature would concur that staff satisfaction with rounding is questionable and there are numerous barriers to implementation (Fabry 2015; Walker et al. 2015; Toole et al. 2016)

Kessler et al. (2012) provided a more deductive approach to measuring staff satisfaction with rounding, using year on year improved scores from a national employee satisfaction survey from when rounding was implemented (2006 to 2011), exceeding the National Database Performance Mean. The specific indictors measured were departmental efficiency; co-workers interest in satisfying patients, employee morale and overall satisfaction, but there was no robust data analysis of these indictors to confirm a statistical significance in the results. They also noted a progressive decrease in their unit vacancy rate from near to 20% in 2005 to zero in 2008 and their unit attaining internal and external awards for commitment to excellence, teamwork and patient care. There was no doubt from Kessler et al. (2012) that the introduction and the continuation of rounding has improved staff satisfaction however, there appeared to be a weakness in the causation link

and so their evidence felt more anecdotal than scientifically based. Fabry (2015) provides a more powerful quantitatively analysed survey data study which proposed an opposite perspective of a lack of ownership from staff and compliance with rounding practice was an issue.

Only six studies (Blakley et al. 2011; Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012; Harrington et al. 2013; Walker et al. 2015) use a qualitative methodology to explore staff satisfaction compared to most of the other studies which follow the quantitative methodology of Meade et al. (2006).

Rondinelli et al. (2012 p330) found that staff satisfaction was an unintentional outcome of rounding that emerged from interview analysis with their project leads, and whilst not a direct outcome of rounding it was an indirect outcome of increased patient satisfaction.

> *'What patients are left with (from rounding) is how attentive and compassionate nurses are. When people are visible and present, it gives the patient a feeling they're being well cared for. We can have them (staff) more satisfied as caregivers, thus retaining expert people at the bedside.'*

In contrast other studies investigating the link between rounding and increased staff satisfaction had less conclusive findings (Deitrick et al. 2012; Neville et al. 2012; Harrington et al. 2013). The Neville et al. (2012) in their descriptive exploratory pilot study specifically measured the understanding of nurse's values, beliefs and attitudes towards the practice of rounding at a specific hospital site. They found that nurses identified the benefits of rounding to patients but found significantly less benefit to their own practice. The negative attributes of rounding included the burdensome and unnecessary additional documentation of rounding. The rounding protocol also minimised nurses sense of professional autonomy and self-directed practice as well as the challenge of time constraints of being physically present with patients if other patients had increased acuity levels.

Similarly Deitrick et al. (2012) identified that staff did not see rounding as a positive benefit to themselves, but viewed rounding as more work, a similar conclusion to the studies by

Faby (2015) and Walker (2015). Documentation was again seen as burdensome, the study observed that documentation was often not performed hourly but completed at the end of a shift. However, the focus of the staff was on the documentation of rounding rather than the quality of the rounding experience for the patient. There appeared to be a disconnect with nurses and the process of rounding in that staff did not link hourly rounding with quality of care and therefore staff did not value the process (Deitrick et al. 2012; Fabry 2015). Harrington et al. (2013) reported similar staff anxieties about nurse patient allocation, lack of support and staff's inability the meet the needs of cognitively impaired patients affecting their staffs overall satisfaction with rounding practice. Toole et al. (2016) systematically identify themes of barriers to rounding practice relating to poor staff satisfaction with the process. These include workload, patient acuity, lack of education and burdensome documentation which act as barriers to implementation and need to be addressed before rounding practice can be sustained and potential outcomes realised.

However many studies propose an attractive and at face value a logical proposition that the structured proactive process of rounding can reduce the nursing workload, improve communication and teamwork which then improves staff satisfaction (Meade et al. 2006; Studer Group 2007; Bourgault et al. 2008; Culley 2008; Sobaski et al. 2008; Gardner et al. 2009). In contrast studies and reviews that have specifically focused on exploring the staff perspective of rounding have been unable to substantiate the claim that rounding improves staff satisfaction (Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012; Fabry et al. 2015 Walker et al 2015; Toole et al. 2016).

3.5.6 Outcome measures summary

The process of rounding was associated with several sensitive outcomes which have been used to evaluate its success as a nursing intervention. In my initial opinion the reported positive outcomes have made rounding an enticing intervention in that it can improve patient safety, patient satisfaction as well as improve staff satisfaction. However a more forensic examination of the outcome measures revealed to me there was the potential to challenge the proposition that rounding improves patient and staff outcomes due to the poor quality of evidence offered by many of the rounding studies.

3.6 Methods

My assessment of the studies in the literature review revealed a limited range of methodological designs and approaches. The most prominent approach, the quantitative/deductive studies focus on the measurement of identified outcomes pre and post the implementation of rounding. Interestingly six of the most contemporary studies reported a more inductive design proposing an exploratory approach to their research (Blakley et al. 2011; Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012; Harrington et al. 2013; Walker et al. 2015). These studies attempted to understand the concept of rounding rather than measuring its effect, focusing particularly on the implementation of rounding. The study by Deitrick et al. (2012) it could be argued utilised the most naturalistic qualitative methodology by applying ethnography as the theoretical and data collection approach.

3.6.1 Quantitative design – Meade study

As discussed previously the study by Meade et al. (2006) provides not only a comprehensive description of the 'modern day' process of rounding but the earliest published results from a large scale experimental/comparative design methodology. The study examined the before and after effects of implementing rounding. The influence of Meade et al. (2006) study and the subsequent publication of the Meade work by the Studer Group (2007) is very significant within the practice of rounding. It led to several other replicant studies which have resulted in an evidence base dominated by quantitative methodology and methods. The Meade methodology and methods therefore has to be forensically examined because of its seminal positioning with rounding practice.

Meade et al. (2006) use a quasi-experimental design with non-equivalent groups and non-randomisation of hospital units to experimental and control groups, the experimental groups performed either one or two hourly rounding. The study was a large scale covering 27 medical, surgical and medical-surgical units in 14 American hospitals although originally 46 units in 22 hospitals were included in the study, poor data quality excluded 19 units in 8 hospitals. The authors state the study is nationwide and included small, large, rural and

urban hospitals, summary details of participating hospitals are available directly from the author.

Being a quantitative study the hypothesis being tested states that nursing rounds conducted on a regular schedule by nursing staff who perform a specific set of actions would:

- Reduce call bell use
- Increase patient satisfaction
- Improve patient safety by reducing falls

The time period for the study was relatively short, a two week baseline measurement period and then for the experimental groups a four week period of rounding with two sets of call bell data collection. Data collection for patient satisfaction measures were provided by commercial vendors working for each hospital and although broadly similar they are potentially not strictly comparable, particularly as in the study the results do not appear to be cross checked or verified. Hospitals also produced their own data on falls rates which although they sent to the research studies principle investigator this could potentially reduce the reliability of the study due to differing definitions of what may be considered a patient fall within the different hospitals. It was difficult to delineate a consistent definition used for falls within the study were all falls recorded or if only falls resulting in harm were recorded. A further potential problem with the methods of Meade et al. (2006) was the lack of equivalence between experimental and control groups. Although Meade et al. (2006) acknowledged this in their quasi-experimental design their lack of randomisation in their empiric design does question if their comparative outcomes between their experimental and control units were fully valid.

A further problem was that there was no mention in the study that any changes in patient satisfaction may have been a placebo effect. The results may have been no different if the nurses had just seen the patient and said ‘hello’ without providing any intervention described in the checklist as this is not observed/measured within the study as the researcher has to be remote/detached from the study. A further constraint of the design methodology of not observing rounding in practice, and the short time frame for data

collection was the consideration of the 'Hawthorne' effect that may have led some nursing staff to change their behaviour for the study duration without it necessarily being related to rounding, but because they were involved in a study.

The study by Meade et al. (2006) does go some way to explain their control of variables, an important part of quantitative studies, as the experimental setting was required to be as regulated as possible in order to isolate the cause and effect of the experiment. For example the hospitals involved in the study had to have a less than 5% use of agency nurses, the units had to have strong nurse managers to oversee the study and supervise staff. All participating hospitals had to have one unit in the experimental group and one unit with similar types of patients in the control group. Within the research protocol Nurse Managers had to review 'rounding logs' and 'call bell logs' on a daily basis to ensure compliance with the research protocol. The principal investigator for the study visited all the hospitals during the various stages of the research to ensure compliance with the research design and methods. Specific training was delivered to the experimental group to explain the purpose of the experiment and demonstrate the actions to be performed while rounding. Nurses from the control group were not exposed to any training to prevent inadvertent implementation of the specific actions of rounding which were being performed by the experimental wards.

Meade et al. (2006) linked their rationale, for what could be viewed as a short time frame, to measure the effects of a significant change to practice, a 4 week study design, to cognitive-behavioural and learning literature based on humanistic approaches to psychotherapy. They basically felt it would take nurses four weeks to fully integrate this new process into their practice but they divided this time into two periods of two weeks for the purpose of the study to see how quickly the intervention of rounding affected patient call bell usage.

However, Meade et al. (2006) documents a one year follow up to their study in which they further prove the benefits and sustainability of rounding. Twelve hospitals remained in their study, with all of those hospitals expanding rounding to more units. Patient satisfaction

scores continued to increase by a mean score of 8.9 on a 100 point scale. There also appeared to be a further reduction in the falls rate, Meade et al. (2006).

Despite potential problems with the methods used by Meade et al. (2006) to prove the effectiveness of rounding on patient satisfaction and safety, their methods have been integral to other studies. The study crucially forms the cornerstone of the rounding evidence base. It potentially appears to have methodological flaws that could question the impact of the findings in relation to providing a robust link to the practice of rounding with improved patient experience and safety. The possible persuasive argument for the deductive study by Meade et al. (2006) despite its methodological flaws was the number of wards/hospitals which participated in the study. The study consisted of 27 units in 14 hospitals although the study originally covered more units/hospitals (the data from 19 units/8 hospitals was excluded from data analysis due to poor reliability and validity of data collection due to poor consistency of compliance with rounding as identified in the 'rounding logs'). However, the study does collate large numbers, data was collected on 108,882 instances of call bell use. There was a statistically significant reduction in falls in the one hour rounding group and a statistically significant reductions in call bell usage in both the one and two hour rounding groups.

Meade et al. (2006) acknowledged their study does have limitations and recommended the need for a longitudinal approach requiring at least six months of data collection. Data collection on pressure ulcers was also recommended and a more systematic measurement of patient and staff satisfaction. Meade et al. (2006) also recommended understanding if rounding reduced call bells then how did this impact on nursing time.

The two systematic reviews (Halm 2009; Snelling 2013) had opposing views on the methodological merits of Meade et al. (2006). Halm (2009) as discussed previously found the study the best quality evidence available about rounding. Snelling (2013) entirely disagreed finding several methodological flaws as well as raising concerns about misrepresentation of evidence. Snelling (2013) particularly highlighted how the Meade et al. (2006) study had been distorted to promote rounding as reducing pressure ulcer formation when this was not correct as it was not part of the methodological design of the

study. Forde-Johnston (2014); Mitchell et al. (2014); Hicks (2015) and Lyons et al. (2015) acknowledged the seminal position of Meade et al. (2006) rating the methodological design of the study to be comparatively good compared to other studies but both also noted the limitations of the pressure ulcer evidence.

3.6.2 Quantitative design – replicated studies

In many of the Meade replicated studies little attention was given to methodological considerations other than citing the use of the Meade et al. (2006) or an adapted methodology. Within these papers there was more attention devoted to how rounding was performed than to the methods of measurement of the study (Culley 2008; Murphy 2008; Sobaski et al. 2008; Bourgault 2009; Ford 2010; Berg et al 2011; Kessler et al. 2012; Sherrod et al. 2012). More methodological consideration was evident in the papers of Tea et al. (2008), Gardner et al. (2009), Woodward (2009), Tucker et al. (2012), Brosey and March (2015) and Goldsack et al. (2015). The study by Gardner et al. (2009) utilised an quasi-experimental design but used a parallel group trial design, they matched the two wards in their pilot study in terms of both being female wards and both being surgical wards. Tucker et al. (2012) specifically looked at falls reduction in an orthopaedic setting and utilised baseline measurements compared to falls rates during a 12 week implementation of hourly rounding and a three month period a year following introduction. The study not only measured falls rates but also the documented compliance of all aspects of their rounding protocol. It was interesting that both of these studies found contrary evidence to the Meade et al. (2006) study regarding the effectiveness of rounding.

I think it is important to note a particular obstruction to the reliability of both the Meade et al. (2006) and many of the replicated quantitative studies (Culley 2008; Murphy 2008; Sobaski et al. 2008; Bourgault 2009; Ford 2010; Berg et al 2011; Kessler et al. 2012; Sherrod et al. 2012) was that the quality of the rounding intervention cannot be measured directly because in these studies there was no direct observation of rounding practice. The effect of rounding was measured in isolation to clinical practice through proxy measures which don't relate to exactly what happened during the rounding interactions between nurses and patients. The pilot study of Goldsack et al. (2015) is a notable exception in that their study did provide observed compliance of the elements of rounding, reporting high compliance

rates, however their study covered only a short timeframe and concluded that unless specific attention was identified to ensure leadership engagement, frontline staff involvement and a champions role rounding did appear to be effective as a falls prevention strategy.

The quantitative studies do try to mitigate this to a degree by detailing measures within their studies which influence the quality of rounding practice. The measure include, teaching staff about rounding, providing a script or checklist for staff to follow when carrying out rounding and checking the compliance with the rounding schedule as detailed in the study protocol (table 10).

Table 10: Interventions to promote quality of rounding practice

	Study/Date	**Staff Teaching**	**Script/Checklist**	**Compliance Check**
1	Meade et al. (2006)	√	√	√
2	Studer Group (2007)	√	√	√
3	Bourgault et al. (2008)	√	√	√
4	Culley (2008)	√	√	X
5	Murphy et al. (2008)	X	√	X
6	Sobaski et al. (2008)	√	√	√
7	Tea et al. (2008)	√	√	X
8	Weisgram& Raymond (2008)	√	√	X
9	Gardner et al. (2009)	X	√	X
10	Woodward (2009)	√	X	X
11	D'Alessio et al. (2010)	√	√	X
12	Ford (2010)	X	√	X
13	Berg et al. (2011)	X	√	X
14	Saleh et al. (2011)	X	√	X
15	Kessler et al. (2012)	√	√	√
16	Olrich et al. (2012)	√	√	√
17	Sherrod et al. (2012)	√	√	X

18	Tucker et al. (2012)	√	√	√
19	Brosey and March (2015)	√	√	√
20	Goldsack et al. (2015)	√	√	√

However despite these attempts to mitigate the level of thoroughness of rounding practice I would argue that it is debatable that quantitative methodology could provide the direct cause and effect link between rounding and improved patient care.

3.6.3 Specifically developed research tools

Within the current research there were specifically developed research tools/instruments designed to measure certain aspects of rounding. The studies of Tea et al. (2008); Gardner et al (2009); Woodward (2009); D'Alessio et al. (2010) document the use of specifically developed research tools to assist with their studies, this potentially increases the reliability to their study compared to Meade et al. (2006). Meade et al. (2006) measured patient satisfaction by a pre-existing non specifically designed questionnaire which may not have captured a true reflection of the patient's satisfaction with rounding. Tea et al. (2008) developed the 'I Care Rounding Model' as a data collection tool based on 40,000 observations related to staff responsiveness. The quantitative tool of cause and effect analysis identified the root causes of inadequate responsiveness, the root causes were then developed into the 'I Care Round' patient satisfaction pre and post implementation of the round were then measured. Post implementation measurement covered 11 months of data collection points to allow statistical analysis. Gardner et al. (2009) developed a 'Patient Satisfaction Survey' (PSS) as a tool to specifically illustrate the effects of the rounding intervention. The instrument influenced by various published patient satisfaction surveys and was pre-tested for reliability. Gardner et al. (2009) also utilised a validated tool for the collection of data on the nurse perception of the rounding based on the nursing work environment.

The study by D'Alessio et al. (2010) did not develop its own patient satisfaction tool, however ensured content validity of the 'Patient's Perception of Satisfaction of Care Questionnaire' (PPSCQ) by asking experienced maternity nurses to evaluate the tool in terms of it measuring patient satisfaction. Woodward (2009) utilised Meade et al. (2006)

methodology to measure falls, patient satisfaction and call bells as outcome data usage however they also developed the 'Help uncertainty patient survey'. A single question *'How certain are you today that a caregiver will be available to address your immediate needs?'* which was utilised as a data collection tool based on the 'Uncertainty of Illness Model'. This model was examined and the single question developed in relation to rounding as a link to nurses' predictability and availability to help patients. The inclusion by Woodward (2009) of this additional measurement question into their study again appears to promote a greater reliability to their results which saw a positive association between rounding decreased use of call bells and increased patient satisfaction however the study was carried out only on a single 27 bed surgical unit.

The research by Fabry (2015) is unique within the literature as it is a quantitative study which has not replicated the methodology of Meade et al. (2006). Fabry (2015) designed an original survey to obtain staffs perceptions of rounding. The study reviewed the survey data in terms of staff experience, grade, education and types of shift patterns works. The study's conclusions focus on identified barriers to implementing practice which had not been as strongly identified within the other quantitative studies recommending that leadership and education were essential for implementation. In contrast to the other quantitative studies Fabry (2015) found that staff disagreed with the belief that the completion of rounding documentation was an indication that rounding was being performed as the staff felt they were often too busy to complete the rounding documentation.

3.6.4 Staffing

A variable only Meade et al. (2006) fully acknowledged as part of their study methodology was staffing levels and the potential effect it may have on their study of rounding. Meade et al. (2006) devote some methodological context in terms of providing a comparison of hours worked spent on direct patient care for the control and then one and two hourly rounding experimental units. The one hour experimental unit had the lowest amount of time spent on direct patient care. Woodward (2009) noted the ratio of registered nurses to patients throughout the 24 hour period ranging from 1:3 on the day shift to 1:5 at night. Sobaski et al. (2008) acknowledged that there could be a correlation between different nursing staffing ratios and patient satisfaction and suggested further research information

was required to examine this link. Snelling (2013) critiqued the work of Meade et al. (2006) in terms of the transferability of rounding to UK practice compared to US nursing practice which has legislated staffing ratios. Snelling (2013) made the important point stating that patient satisfaction was more connected to staffing levels not rounding practice. Harrington et al. (2013) identified concerns related to skill mix and the ability of a staff team to support rounding. This was almost an incidental finding of their study but it was highlighted as an important consideration with regards to effectively performing rounding in their conclusion. Similar considerations are noted within the studies of Kessler et al. (2012) and Sherrod et al. (2014) however this is anecdotal. The study by Fabry (2015) identifies there is a strong theme from their staff survey that staffing and lack of time are barriers to completing rounding. Toole et al. (2016) verify that workload, in more recent studies, is an identified barrier to rounding practice.

3.6.5 Leadership

From a professional leadership perspective the Meade et al. (2006) paper has an interesting stance which links to its positivist design. The research team were all aligned to a healthcare leadership and consulting company who then worked with a number of hospitals within American to implement rounding and then measured the effects of the implementation through remotely collected data. Papers report on the implementation of rounding from a management (leadership) led directive rather than research or systematic evaluation (Tea et al. 2008; Gardner et al. 2009; Kessler et al. 2012). From a leadership viewpoint the study was measuring a change rather than spending time in the clinical setting trying to understand the rounding process. Both Forde – Johnson (2014) and Toole et al. (2016) consider that lack of leadership support could affect the implementation and sustainment of rounding practice however the effect of leadership on rounding practice is not directly measured in any study.

The explicit difference from my own viewpoint Is that I hope to draw on my own reflexivity as a nurse leader within the clinical setting to gain a greater understanding of rounding. However I will need to be cognisant that my research study addresses the political and ethical problems of researching in my own area of practice.

3.6.6 Qualitative design

A small number of more contemporary studies potentially provide a more insightful view into rounding in practice by utilising qualitative methodologies within their studies (Blakley et al. 2011; Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012; Harrington et al. 2013; Walker et al. 2015). The change of focus for the methodology does appear to be a questioning of the current evidence base. The studies by (Blakley et al. 2011; Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012) acknowledged the wide spread implementation of rounding but raised concerns that there were gaps in the current evidence base regarding the effective implementation of rounding as well as the effect of rounding on patient and staff experience. Walker et al. (2015) stress the importance of adequately planning the implementation of rounding and importance of staff engagement.

Although the inductive based studies do not observe rounding in practice, the studies investigated rounding directly through either interviewing staff who performed rounding, interviewing patients who experienced rounding, and interviewing nurse leaders who have to oversee the rounding in the wards they managed (Blakley et al. 2011; Neville et al. 2012; Rondinelli et al. 2012; Harrington et al. 2013; Walker et al. 2015). Neville et al. (2012) developed a data collection tool, 'Nurses Perceptions of Patient Rounding Scale' (NPPRS) establishing face validity through asking staff nurses to evaluate the tool in terms of the content to explore nurse's perception of the rounding process. The content validity was established by a panel of advanced practice nurses as experts in rounding.

Rondinelli et al. (2012) established validity for their qualitative study by using the Donabedian Model of structure process and outcome to frame their data collection in terms of asking open-end questions concerning rounding definitions, contents, concerns, barriers, facilitators, process and outcomes. However it was unclear how these particular topic questions emanated directly from the literature. Blakley et al. (2011) utilised multiple methods to explore the impact of rounding within their bounded case study methodology. These methods included interviews, in-depth questionnaires and survey reports. It was noted that observation was also used but was not direct observation of rounding but related to asking nurses what they had observed, for example if they had observed a reduction in call bell usage. Again as with the papers by Rondinelli al. (2012) and Harrington et al. (2013)

there appeared to be little attention paid to the basis of the constructs for the interviews or questionnaires. However, these studies documented an action research component to their studies related to the implementation processes involved with introducing rounding as well as patient and staff outcomes. Walker et al. (2015) asked staff in two focus groups what rounding was like for them in addition to in-depth interviews with nurse managers, they wanted staff to use their own words to discuss rounding practice but again the focus was on the implementation of rounding. This methodology provided an interesting perspective on rounding practice but in my opinion still did not thoroughly investigate the actual nurse patient interaction of rounding practice.

I think it was important to note that the results of the qualitative methodology studies compared to some of the quantitative studies were less conclusive about the benefits of rounding in terms of patient and staff satisfaction and patient safety, questioning the rounding evidence base. All the studies noted different aspects to the process of rounding in their conclusion. Neville et al. (2012) acknowledged that rounding was perceived by nurses as being beneficial but was of greater benefit to patients rather than improving practices for nurses. Blakley et al. (2011) concluded there were benefits to rounding in terms of patient satisfaction but a difficult aspect of rounding was maintaining an effective process. Rondinelli et al. (2012) suggest their study highlighted a dependence on routine and standardisation regarding rounding but this did not ensure a successful process for sustaining improved patient outcomes over time. Walker et al. (2015) acknowledged that challenges with implementation may have prevented the effective implementation of rounding.

It was only the study by Deitrick et al. (2012) that provided a methodology that had direct observation of rounding in practice. The study by Deitrick et al. (2012) used participant observation, a recognised ethnographic method of data collection. Again along with Blakley et al. (2011) and Rondinelli (2012) this study focused on the implementation of rounding rather than the outcome measures of rounding. Their ethnographic study obtained data about what staff and patients said about rounding, the study observed what staff were doing and tried to understand perceptions of rounding. Observation of rounding took place over four weeks, giving a total of 40 hours observation, 48 staff were interviewed between

two speciality surgical units. By virtue of it being the only study of its type it is also provided the largest amount of direct nursing feedback about rounding. Both observations and interviews used ethnographic methodology and the researcher was a trained ethnographer. Observers cross checked observational data to promote observer reliability. There was also documentary analysis of rounding through the review of presentations about rounding and the documentation used to chart rounding. However, there could be potential bias in the study as the units involved were chosen for their less successful implementation of rounding. In addition the initial interviews with stakeholders in the rounding process may have influenced the researcher perceptions of rounding before the observations of rounding were performed. The study by Deitrick et al. (2012) concluded similar to the other qualitative studies that there were gaps in understanding the benefits of rounding and that unfortunately the link to hourly rounding and improving patient care did not exist for staff.

Despite the highlighted considerations regarding a degree of bias within this study setting, ethnographic research, utilised by Deitrick et al. (2012) had an important role to play in providing information about the effectiveness of rounding through intensive examination of contemporary practice. The methodology examined a complex setting and individual interpretation of constructed meaning within the context of the social situation of the participants. Ethnography examined the culture of the particular setting to generate knowledge about rounding. An appropriate methodology for the intensive investigation of rounding practice compared to the other research designs which focused on cause and effect or on the implementation process. Although the study of Deitrick et al. (2012) as an ethnographic study doesn't specifically mention the term culture the study examined an identified social situation and reported on the behaviours, attitudes and values associated with rounding practice.

3.7 Analysis

The data analysis of the studies naturally falls into the two group of quantitative and qualitative data analysis methods. In the analysis of quantitative data not all of the studies utilised methods of statistical analysis, and many studies were extremely poor with the findings unable to demonstrate statistical significance in terms of measuring cause and

effect associated with rounding (Torres 2007; Culley 2008; Murphy et al. 2008; Sobaski et al. 2008; Weisgram and Raymond 2008; Woodward 2009; Ford 2010; Kessler et al. 2012). These studies tended to use percentage or actual counted measures as a comparison to identify changes in their outcome measures.

Several studies using a quantitative methodology were analysed using different statistical tests (Bourgault et al. 2008; Tea et al. 2008; Gardner et al. 2009; D'Alessio et al. 2010; Berg et al. 2011; Salch et al. 2011; Krepper et al. 2012; Olrich et al. 2012; Sherrod et al. 2012; Tucker et al. 2012; Brosey and March 2015; Goldsack et al. 2015; Fabry 2015). Those studies which replicated the study by Meade et al. (2006) followed the same pattern of statistical analysis. Meade et al. (2006) employed Binominal tests for their data analysis. Comparison and non-comparison t tests utilised to test either differences or comparisons of their data in the comparison of falls in the baseline period to the study period for both the experimental and control groups (Bourgault et al. 2008; Gardner et al. 2009; D'Alessio et al. 2010; Sherrod et al. 2012). Some describe the use of simple descriptive statistical tests (Berg et al. 2011; Salch et al. 2011; Tucker et al. 2012), along with Tea et al. (2008) who used the Chi Square test, compared to the more powerful t test and Goldsack et al. (2015) who utilised an alternative to the t test the comparative Mann-Whitney test.

For the qualitative studies how data was analysed was poorly described and presented and overall generally disappointing, particularly the study by Blakley et al. (2011) where very little attention is given to data analysis and therefore there is very limited scope to assess the quality of the analytical approached implemented within the study. Whilst Blakely et al. (2011) offer some comparator figures of patient satisfaction scores, there is little content analysis of the interviews with staff. Indeed, a large part of their study results were devoted to the verbatim results of an interview with the Director of Nursing. Neville et al. (2012) and Rondinelli et al. (2012) scantily discuss analysis methods from which identified themes, Nevillie et al. (2012) from the saturation of data and Rondinelli et al. (2012) from a slightly more detailed approach of manual indexing, using independent coders and then a further volunteer group providing validation of emergent themes. Walker et al. (2015) indexed their data according to a framework based on the ten identified challenges involved in improvement interventions.

Deitrick et al. (2012) provide the most comprehensive qualitative data analysis, using a qualitative computer database and analysis package NVivo 7 for the coding and analysis of their data. Their processes describe a further step of independent coding to ensure the correct identification of thematic categories to identify component aspects of the 'culture' of the rounding process in their social situation. The use of independent verification for emerging themes in the studies by Deitrick et al. (2012) and Rondinelli et al. (2012) does minimise the potential bias of the researchers influencing thematic development. From reviewing the literature in terms of data analysis of the qualitative approaches overall it is only the study by Deitrick et al. (2012) that appeared to robustly extract and identify the processes which link to rounding implementation.

3.8 Theoretical Constructs

My literature review has highlighted the potential concerns with the methodologies used to measure the effectiveness of rounding in terms of patient safety, patient and staff satisfaction. A vast proportion of the literature devotes time to describing the process of rounding and also relies on the work of Meade et al (2006) as the basis for their process of rounding. However, some studies examine the constructs of the rounding process in order to explain their process of rounding and the links to the potential outcomes of rounding. These studies importantly ask the questions of the 'what' and 'why' of rounding as opposed to many studies which concentrate on the 'how' of rounding.

Examining the literature in terms of the theoretical basis for rounding is an important function of the review which I feel previously has not been adequately addressed. Understanding the theoretical constructs of rounding will again highlight potential gaps in methodological approaches applied to examining rounding. This will then illuminate potential alternative methodologies which may prove to be more effective way to investigate rounding.

As with other aspects of the literature review the Meade et al. (2006) has a dominant position within the examination of the literature in terms of the theoretical constructs of rounding and the identification of the 4 Ps. There are other papers which also offer a

constructionalist view of rounding (Gardner et al. 2009; Tea et al. 2008; Sobaski et al. 2009; Woodward 2009; D'Alessio et al 2010; Sherrod et al. 2012) these mainly compliment the work of Meade et al. (2006).

There isn't a correlation between studies with a robust methodological approach to the measurement of rounding and the examination of the theoretical constructs. Sobaski et al. (2009) follow on from Meade et al (2006) to examine patient's perceptions of care delivery related to the importance of timely answering of call bells but pay little attention to methodological rigour of their data analysis, call bell usage was not measured real time but via the patient satisfaction survey and only three months' worth of data collected, no statistical analysis was applied to the data. The underpinning theme of call bell usage is also explored by Tea et al. (2008) who note that patient satisfaction increases in relation to increased response to patients or a perceived responsiveness to patients. Woodward (2009) identify the term of 'help uncertainty' as a basis for the construction of rounding practice, patient experience was poorer when patients were not aware when help would be available for them. The constructs of rounding appear to come from the relatively simple premise of meeting a patient's fundamental needs. Tea et al. (2008) encapsulate this in highlighting that unanswered call bells of immobile orthopaedic patients can create a sense of helplessness and fear. Their construct related to proactive responsiveness to call bells promoting patient satisfaction. This was interesting to me as the construct began to examine the nurse patient relationship, rather than just examine how long it took to answer calls bells.

Other studies focused on the responsiveness of nurses and the presence of the nurse being a measure for patients in terms of their care experience (D'Alessio et al. 2010; Neville et al. 2012). Tea et al. (2008) make a link between patients who scored highly for staff responsiveness were more likely to score overall satisfaction highly. By examining the constructs of rounding crucial issues about patent experience are highlighted. Potentially rounding as a process is wandering into the territory of what nurses need to do to ensure a high patient satisfaction with care and importantly it is the patient voice dictating why this is important. Tea et al. (2008) examined 40, 000 patient satisfaction responses to determine their issues.

There was a further examination of what is timeliness with a further subdivide into timeliness for urgent and non-urgent patient requests. The other additional step Tea et al. (2008) defined was that faster reactions to call bells were not the answer but a more anticipatory approach was required regarding patient need. Again, they explored patient opinion with regard to what made certain staff excellent in the eyes of patients. Patients identified four main constructs:

- Knowing and listening to patients
- Frequently checking on patients
- Keeping important personal items within reach
- Proactively watching and responding to call bells

Importantly patients were not identifying issues such as clinical competence, for example techniques when changing dressings as important to them, they identifyied issues which were potentially seen as fundamental care issues. The most frequent need identified by the patients were bathroom toilet needs, mobility positioning needs, pain needs and their possessions in reach, the original work by Meade et al. (2006) also identified these needs.
To offset the valued constructs of timeliness and responsiveness Tea et al. (2008) deconstructed the process and examined the root cause of inadequate responses to patient's needs/requests. Tea et al. (2008) identified that the barriers to an effective staff response to patients were:

- Lack of a structured scheduled routine in place, staff in reactionary mode
- Lack of ownership of patent's requests
- Lack of team work making 'hand off' easy and expecting others to take care of requests
- Too many process steps in response to call bells

The pilot work of Sherrod et al. (2012) note the variation between different nurse and patient interaction demonstrating a potential lack of understanding from nurses about

important component features of rounding. Sobaski et al. (2009 p332) summarises the conceptual basis for rounding, as meeting the patient's fundamental needs:

> *'Rounding is a key to the patient's perceptions of care delivered. This allows the nursing staff to engage in personal interaction with patients, respond to any concerns and questions and correct a situation that displeases the patient.'*

Blakely et al. (2011) appear to further support the construct of rounding linked to patient perception of care delivery by meeting the patient's need for compassionate care. D'Alessio et al. (2010) also agree rounding is linked to patient's perceptions of nursing care they expand on this further but identifying the physical presence of a nurse and the attention a nurse gives to a patient is synonymous with caring as a construct of rounding. Again this was reiterated by Neville et al. (2012) who emphasise the importance of patient's perceptions of care as presence and visibility, interestingly they state this was more important than nurse competence. Gardner et al. (2009) have a similar underpinning construct that rounding focuses on immediate patient comfort and not higher level clinical care delivery, stating rounding relates to a nurse's ability to meet a patient's immediate physical needs in a timely fashion and provide a physical comforting presence. Kessler et al. (2012) extrapolates this further to identify that rounding may not produce any patient benefits if the underpinning components of rounding are not met.

Sobaski et al. (2009) is one of the few papers to make a theoretical link between rounding practice and an existing mainstream nursing theory. Their construct is that rounding increases face to face time with a patient and therefore the patient receives more individualised attention and so the patient's needs are more satisfied. Meeting patient's immediate need for help facilitates the delivery of patient centred nursing care and fits with Orlando's Theory of Disciplined Nursing Process (1993) in which the nurse's role is to find out and meet the patient's immediate need for help. Communication is a vital part of this process as it is essential that the nurse understands that their perception of the patient's need may not be what the patient perceives their need to be. The scheduled rounding means nursing staff have a reason to speak to patients on a regular basis, helping to form an

open communication and connection with the patient to better understand and meet their need.

Gardner et al. (2009) draw their theoretical base from the work Henderson (1997) and the identification of Nursing Needs Theory, which could be argued, is the most seminal of all nursing theories. Similarly, as with Orlando's Theory (1993) from this basis rounding is linked to the quality of nurse patient communication and interaction which in turn influences the patient's perception of care. The 14 fundamental needs identified by Henderson (1997) correspond well with the humanistic and concrete patient needs which Meade et al. (2006) identified from their analysis of call bell usage and form the basis of the 4 Ps and their rounding protocol. Meade et al. (2006) as well as identifying the importance of meeting patients concrete needs (pain management, toileting) identify the importance of humanistic needs (kindness, compassion and physical presence) to anticipate patient needs and attentiveness.

Only D'Alessio et al. (2010) explored the concept presence (as identified by Meade et al. 2006) further and examined the dimensions and behaviours of nursing presence. They make a similar link, as discussed previously, to patients not being able to discern whether nurses are providing technologically proficient care or care that even meets practice standards but they can identify behaviours that indicate care and compassion to them. The behaviours they identify included:

- Communication
- Respect
- Inform
- Aid
- Comfort
- Empathy
- Being seen

These behaviours fit well with the processes that many papers have described as their protocol for rounding but become somewhat lost in the Ps processes and the discussion about effectiveness of one hourly rounding compared to two hourly rounding. The relationship between the patient and the rounder in the social situation of rounding is lost within the protocol of rounding. The emphasis on values, attitudes and behaviours cannot be conveyed by ticking the 4 Ps list.

In my view the theoretical constructs of rounding potentially lack prominence in the literature, unless well searched for and in many papers are over shadowed or omitted in preference to author's description of the rounding process. However, within the constructs of rounding there was a clarity and consistency of message related to meeting patients basic/fundamental needs, the importance of nursing presence plus responsive/timely and proactive action to meet the patient's perceived needs. This was extrapolated from patient's perceptions of satisfaction with care, hence linking rounding to patient satisfaction. Although not fully explored in the literature it was the representation that patient satisfaction, as defined by patients, was influenced by the fundamentals of care rather than clinical expertise. Rounding as a concept aims to provide a proactive responsiveness to the delivery of the fundamentals of nursing care. However, it is vitally important that the constructs of rounding are understood by those performing the process otherwise the important concepts of meeting patient satisfaction which rounding can accomplish will be lost in a process of routine and standardisation.

3.9 Summary

Having examined in detail the quality of the literature I felt disappointed. Without question there was an over reliance upon quantitative methodology with little offered as an alternative to deductive studies. The NHS literature lacked analytical and scientific rigour and as noted there was a large gap in the UK evidence base specific to rounding. There was an over reliance upon the replication of the study by Meade et al. (2006).

Furthermore, many studies focused on describing the process of rounding and 'the cause and effect' measurement in the context of quantitative approaches and yet the expected

robustness of statistical methods was not present in many of the studies examined. This meant the link between rounding to positive patient care and experience outcomes was difficult to ascertain and was not as obvious as authors seemed to portray. The lack of evidence from studies that had either directly observed rounding or sought the opinions of patients and staff was a concern and questioned the quality and nature of evidence related to a commonly adopted nursing practice in the UK.

More recent studies and systematic reviews provide an additional commentary mainly based on the implementation of rounding practice highlighting barriers to the effective practice of rounding (Harrington et al. 2013; Fabry 2015, Lyons et al. 2015; Walker et al. 2015). These studies do not focus on measuring falls, pressure ulcers, call bells and patient satisfaction but sought the direct opinion of staff performing rounding. The results emphasise difficulties with staff compliance with the process due to workload, patient acuity and lack of education about the process.

From my perspective the literature review demonstrated that careful consideration of my own studies' methodology was required in order to identify meaningful new information about rounding practice. The examination of the theoretical constructs of rounding proved to be a useful consideration in determining a suitable method of enquiry for this study.

The results of the literature review also had a profound influence on myself as a nurse leader as I had highlighted and realised the fragility of rounding practice in terms of links to improving the quality of patient care. Until the evidence was examined in detail I had been a proponent of the practice because of its perceived benefits to patient care and as a nurse leader fully committed to rounding's on-going establishment as a core part of nursing practice. The review of the literature as a DProf student fundamentally challenged my ideas and assumptions about current rounding practice. Initially I had wanted to link 'the cause and effect' of rounding to improved patient experience and nursing care. However, the literature review process demonstrated this was a poor methodological design to follow and that my study would need to investigate rounding from a different perspective from the prevailing literature.

Chapter Four: Rounding ethnography: the study design

4.1 Introduction

The literature review and previous chapters have highlighted that rounding was a relatively new concept to UK nursing practice and was only starting to be widely introduced into NHS practice from 2012 (DH 2012). Since this time rounding has been visibly associated with the national care and compassion nursing agenda, included in the National Nursing Strategy 'The 6 C's Our Culture of Compassionate Care' (DH 2012c); despite my interrogation of the literature highlighting no consensus definition of what rounding actually entailed. Whilst studies may emerge during the writing of this thesis, at the outset of this journey there appeared to be no UK evidence base measuring the impact rounding on the nursing care and practice in the NHS. There was no high quality baseline evidence of how the concept of rounding from the US had been translated into UK practice and whether patients and nurses actually understood the purpose of rounding. My own communication with other nurse leaders and anecdotal evidence highlighted that different concepts of rounding were being implemented in different ways across NHS organisations, to reduce falls provide pressure area care, or improve patient satisfaction (table 4). It was from this context the methodology of the study was considered, indeed the need to explore what rounding looked like when translated into UK practice and what we didn't understand, as well as to extend the limited US evidence base.

This chapter provides a comprehensive overview of the proposed research study methods and progresses in three distinct sections:

- Methodological and research design considerations
- Ethnographic study design
- Data analysis and identifying themes

Methodology and design considerations are examined first in particular the exploration of both my underpinning philosophy and critical explication of rounding concepts that

influenced the selection of an ethnographic research design. The second section takes the reader through the ethnographic research design, and the justification for the decisions taken regarding the selected approach, study site, sampling frame and data collection methods. Finally, the complexity of the intended analytical process is explained to ensure transparency as far as possible that trustworthy findings were exposed.

4.2 Section 1: Methodological and research design considerations

The philosophical origins of my study were based on the assumptions from my own investigation and practice that rounding is a process constructed by individuals through social conversation and interaction. The epistemological stance promotes an interpretivist theoretical perspective that meanings are constructed by individuals as they engage with the world they are interpreting (Crotty 1998). The chosen methodology of the study is ethnography and focuses the study on the interpretation of meaning of human action within a particular culture. Data collection methods concentrate on a descriptive and exploratory approach to examining the process of rounding to promote in-depth inductive and qualitative data collection through observation, interviews and documentary analysis. The approach to the investigation of rounding was not an arbitrary decision or random direction of travel; how best to investigate the phenomena of rounding, and my decisions of which methodology and research design to adopt were influenced by a number of crucial factors:

- Rounding was a relatively new concept to NHS nursing practice and the practice arena of the researcher, it was introduced into wide scale NHS practice in 2012
- Rounding was embedded and included in the National Nursing Strategy 'The 6 C's Our Culture of Compassionate Care' (DH 2012c)
- There appeared to be no NHS research that had investigated the process of rounding
- Within a professional leadership role in a clinical setting I had a degree of reflexivity that would potentially contribute to an investigation process
- I started the study with a positive assumption in terms of the potential of rounding to improve patient care and experience, seeking to prove the link between practice and beneficial outcomes.

In the examination of the literature concerning rounding concepts about the process and outcomes of rounding emerged from the differing approaches which were used to investigate rounding as a process (Meade et al. 2006; Gardner et al. 2009; Deitrick et al. 2012; Harrington et al. 2013). Therefore, it was important for my research to understand how differing and diverse forms of investigation were either appropriate or inappropriate as scientific methodology to develop an understanding of rounding. In choosing an investigative approach I needed to be able to determine how my chosen study perspective would; expose the phenomena of rounding, how the knowledge of rounding would be generated, evaluated and be applicable to nursing practice.

My systematic review of the existing evidence related to the investigation of rounding indicated a bias towards a quantitative approach (Meade et al. Studer Group 2007; Culley 2008; Olrich et al. 2012). Therefore, it was important to examine why this research perspective was used and its effectiveness in revealing and generating knowledge about rounding. Intrinsic to this examination was the appreciation of the diversity of methodologies within nursing science and the necessity to debate alternative approaches to the investigation of rounding rather than accept the prevalent and accepted approaches promoted in the reviewed literature.

By threading these considerations into the philosophical debate regarding the research approach for my study a complete and full discourse about methodological considerations can be appreciated.

4.3 Philosophical perspective underpinning this doctoral study

Seminal research texts emphasise that clarity and effectiveness of a research study design are crucial for defining the focus of the research topic (Crotty 1998; Creswell 2007; Mason 2010; Streubert and Carpenter 2011). A sound philosophical underpinning provides a formulated framework on which to explore the phenomena, in this case the practice of rounding in nursing. The process challenges the researcher to question their own assumptions about the research topic, what the research is actually about, and indicates how theory guided the development of the research investigation. Creswell (2007)

proposes the two most fundamental philosophical underpinnings for any researcher is firstly defining their stance towards the nature of reality being investigated, the ontological assumptions of the research. Then in so doing the research's epistemological position, what represents the evidence or knowledge of the entity/reality being investigated can follow. For this study my philosophical challenges were to identify:

- Ontological - what is the nature of the phenomena or essence of rounding as a 'reality'
- Epistemological - what would be acceptable evidence/knowledge to show rounding as a 'reality'

What we believe, what constitutes social reality (ontology) and epistemological underpinnings form the basis of the philosophical building blocks for a research design (Blaikie 2000; Mason 2010). Although, there is often ambiguity with the concepts due to problematic aspects of language, meaning and misrepresentation of terms (Lowenberg 1993). Crotty (1998) is of the view that ontology and epistemology are often combined together when informing the theoretical perspective of the research. To minimise confusion and ambiguity Crotty (1998) proposes four elements need to be articulated, understood and utilised within the design framework of any research study, the epistemology underpinnings, theoretical perspective, methodology and methods utilised within the investigation.

Creswell (2007) identified research viewpoints (philosophies and assumptions about the nature of reality, known by the term paradigm) on which research architecture is based. Two polemic paradigms, have been identified from reviewing the research designs applied to current rounding research. The objective paradigm views rounding as an ordered measurable reality (Meade et al. 2006; Studer Group 2007) and as the opposite the subjective paradigm views rounding as an interaction from which meaning emerges, often different for each person involved with the interaction (Rondinelli et al. 2012; Harrington et al. 2013). An alternative perspective, a middle ground, is that of constructionism, a paradigm which brings together objectivism and subjectivism, acknowledging for rounding that some concepts can be measurable but also believing '*meanings are constructed by*

human beings as they engage with the world they are interpreting' (Crotty 1998 p43). An objectivist or positivist ontology necessitates an ordered observable reality, promoting the use of a deductive and quantitative approach to research design that looks for cause and effect (Schneider et al. 2007). For example, this approach to this research would seek to find the cause and facts related to rounding, patient safety and patient satisfaction but is less concerned with staff and patient experience, preference and opinions of the process. Within the literature there was an overwhelming dominance of the positivist science however within these studies narrative, little attention was devoted to the epistemological context of the research approach. This could be because the majority of the studies replicated the approach set by Meade et al. (2006) to scientifically measure the cause and effect, the facts of the rounding process (Culley 2008; Murphy 2008; Sobaski et al. 2008; Weisgram and Raymond 2008; Ford 2010, Saleh et al. 2011; Krepper et al. 2013, Olrich et al. 2012; Brosey and March 2015; Goldsack et al. 2015).

In these quantitative studies attention was paid to the methods of measurement used to gather and analyse their data and the choice of methodology was not debated, with an underlying assumption that only an objectivist approach would provide the measurement the studies required. The objectivist ontology has the appeal of proving fact, logical inference plus replication from the results from the quantitative studies (of Meade et al. 2006; Studer Group 2007) leading to the development of a rounding evidence base which has only latterly been questioned (Snelling 2013; Forde-Johnson 2014; Mitchell et al. 2014; Walker et al. 2015; Toole et al. 2106). From my own review what appeared to be missing from this approach to investigating rounding was the absolute ability to measure of defined outcomes (falls, pressure ulcers and patient satisfaction) through the inability to isolate these outcomes from other ward variables, for example as highlighted by Hutchings (2012) training programmes and patient assessment processes could impact on reducing falls rates as equally as rounding practice but in a complex ward setting it would be difficult to completely isolate the interventions in order to assign objective measurement. Objective knowing is that scientific measurement creates knowledge, if objective measurement cannot be assigned to a phenomenon, the importance and the actual existence of the phenomenon (subject of the research, in this case rounding) could be questioned (Crotty

1998). If rounding is only viewed through the lens of measurable outcomes then it's value to nursing practice and patient care could be lost, as it cannot be objectively measured.

Initially as a professional leader of nursing practice there was an attractiveness to using an investigation process which could prove whether rounding is an effective nursing intervention in terms of patient safety, patient and staff experience. Furthermore, the measures used to compare and contrast the process of rounding were already monitored within my practice setting (falls rates, pressure ulcer prevalence and patient satisfaction). Indeed, such an investigation would have complied with the current prevalent research approach that appeared to provide a prodigious body of evidence declaring the effectiveness of rounding as a nursing intervention (Meade et al. 2006; Studer Group 2007; Culley 2008; Murphy 2008; Sobaski et al. 2008; Weisgram and Raymond 2008; Ford 2010, Saleh et al. 2011; Krepper et al. 2013, Olrich et al. 2012; Brosey and March 2015; Goldsack et al. 2015).

However, in my experience objectivity is almost impossible when examining interactions between patients and staff in the complex setting of a ward environment. Even what may appear to be a simple outcome for example measuring falls reduction is a multifaceted process which cannot be isolated to the one intervention of rounding. From my greater understanding and examination of research philosophy, for rounding as a new process to NHS nursing practice, the relationship between the nurse and patient when rounding occurs first needed to be explored and understood. This exploration and understanding would inform how rounding affects patient safety (falls and pressure ulcers) patient experience as a first step in developing NHS nursing evidence about rounding practice as well as enlightening the nurse/patient care and compassion relationship as rounding has an important role within the 6C's agenda (DH 2012c). For this reason, it was necessary to explore different approaches.

At the opposing end of the spectrum the subjective approach aims to understand, describe and or translate what is happening from the researcher's own frame of reference. The ontological preposition focuses on the individuals meaning of the world rather than explanation or prediction events through measurement of cause and effect (objectivism).

Rondinelli et al. (2012), Harrington et al. (2013) and Walker et al. (2015) used the subjective paradigm to explore rounding, their studies sought the meaning of rounding practice through interpretation and reflection of the individual. As a nurse I believe subjective lines of inquiry add deeper insight into situations that would aid the understanding of the rounding. Similarly, there is a strong belief and argument conveyed in the research literature that patient experiences cannot be objective (Crotty 1998; Creswell 2007; Schneider et al. 2007; Streubert and Carpenter 2011; Parahoo 2014). There are potentially too many intervening variables when the focus of the research is the human social context. The subjectivist or naturalist epistemology is based on the lived experience of the individual through the perception of reality (Schneider et al. 2007). Indeed, nursing knowledge is often gained through understanding and viewing the nature of humans and their condition (Kim 1992). I would propose that in the context of rounding nursing knowledge is gained by describing the everydayness of what is happening between the patient and the nurse in the practice of rounding, which a more subjective rather than objective approach would help to uncover.

In comparison, constructionism is a paradigm in which knowledge is constructed by the understanding of perspectives between people and within societies, exploring social and cultural mechanisms, examining and comparing similarities and differences to generate a greater collective meaning not individual meaning (subjectivism) (Crotty 1998). Constructionism can be seen as a social process whereby reality emerges from ongoing conversation and interactions, and is influenced by the connected relationship of the researcher and the participants (Guba and Lincoln 2004). The purpose is not to evaluate the investigation in terms of true or false but attempt to uncover informed and complex perspectives, for example gaining a deeper understanding what rounding means for both staff and patients. This I would argue provides the most appropriate philosophical perspective to underpin my study. Deitrick et al. (2012) provided an example of a constructionist approach, although not described as such, where the research process listened to what people said, gained an understanding of perceptions and observed what staff were doing, and compared it with documentary evidence to construct the process of rounding for their investigation. Constructionism acknowledges that the governing behaviour (for example how nurses deliver rounding and whether patients find it useful) can

influence the way meaning is constructed and cannot be viewed in isolation (Silverman 2013; Creswell 2007; Streubert and Carpenter 2011). Within this perspective the world view is neither wholly objective or subjective, but researchers generally use qualitative not quantitative research methods to investigate the phenomena (Crotty 1998).

Although many studies have demonstrated that the process and outcomes of rounding can be measured through the objectivist lens using quantitative methods (Meade et al. 2006; Studer Group 2007; Culley 2008; Sobaski et al. 2008; Gardner et al. 2009; Tea et al. 2009; Woodward 2009; Ford 2010; Berg et al. 2011; Saleh et al. 2011; Olrich et al. 2012; Sherrod et al. 2012; Brosey and March 2015). Only a small number of studies have considered rounding from the subjectivist or constructionist ontological and epistemological perspectives (Blakley et al. 2011; Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012; Walker et al. 2015) and attempted to generate an evidence base of what is rounding and what does it mean to patients and staff. I believe the process of rounding cannot be independent/isolated from the human (patient/staff) experience.

Fundamental to the methodology is the identification of a problem (Streubert and Carpenter 2011), but I would propose that given the limited evidence base, the research question about rounding practice is still exploratory, both what it is and what it means to the individual and the collective (patients and nurses). Research is needed that adequately describes rounding practice and constructs meaning to NHS nursing practice before we can fully examine or identifying a problem with rounding process and implementing change plans.

4.4 Theoretical perspective

Articulating the theoretical perspective provides further underpinning to the framework and context of the research study (Parahoo 2014). Theoretical assumptions are bounded within the methodology that the researcher uses in order to bring context and logic to their whole research process (Robson 2011). By exposing the theoretical perspective, the researcher creates the important link to identifying the concrete techniques, tools and procedures utilised within the research study.

The investigation of rounding to date can be divided into potentially two distinct theoretical perspectives, positivism and interpretivism. Positivism underpinning assumptions advocate a quantifiable and measureable approach to investigation, where data and evidence shape knowledge (Crotty 1998). However, within the current evidence base there is little attention or understanding shown of social processes and no allowance for the unseen or the discovery of meaning (Meade et al. 2006; Studer Group 2007; Berg et al. 2011; Krepper et al. 2012). Explaining how and why things happen through measurement, correlation and statistics is paramount and research methods include sampling, measurement and scaling. The quantitative studies would all logically follow the premise that their objectivist roots develop into positivist methodologies (Meade et al. 2006; Studer Group 2007; Culley 2008; Sobaski et al. 2008; Gardner et al. 2009; Tea et al. 2009; Woodward 2009; Ford 2010; Berg et al. 2011; Saleh et al. 2011; Olrich et al. 2012; Sherrod et al. 2012). In contrast interpretivism assumes that investigation seeks to understand context and then make interpretations of what is identified through their own experience and background, facilitating an understanding of how and why (Robson 2011). Interpretisivm is a theoretical perspective supporting many differing methodologies including ethnographic study and seeks to understand the phenomena under investigation through observation and in-depth interview. The qualitative studies, although not explicit within the research design, were subjective in nature and favoured an interpretivist theoretical perspective (Blakley et al. 2011; Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012; Harrington et al. 2013; Walker et al. 2015). For these studies their theoretical perspective valued a study design that sought to elucidate meaning, utilising observation and interviews to examine social processes in their context and complexity, particularly the ethnographic study by Deitrick et al. (2012).

It was clear that there is the potential to measure elements of the rounding process with respect to what activity people do and scalable impact on outcome measures linked to that activity. However, the over reliance of quantitative studies in the current evidence base would appear to be inappropriate with a flawed philosophical underpinning. Despite this the value of the rounding process from the interpretative theoretical perspective also remains unclear and its importance to nursing practice overlooked. There was a definite lack of use and application of an interpretative approach exploring rounding.

4.5 Summary and choice of methodology

Within nursing there is a need to review the impact of rounding, as it is a widely adopted practice, with no current NHS research investigation into the effectiveness of the process. Therefore, it is important to understand how knowledge about the practice has so far emerged and its influence on application of rounding currently within the NHS. Despite its wide spread acceptance, the existing evidence base when examined appears to be biased and limited. The methodological overview illustrates the dominance of particular approaches to measuring the effectiveness rounding; examining aspects of patient safety, patient and staff experience to demonstrate rounding as an effective process. The primacy of the deductive cause and effect approach has latterly been challenged by studies embracing more inductive methodologies (Blakley et al. 2011; Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012; Tucker et al. 2012; Harrington et al. 2013; Walker et al. 2015). At the start of this study, there was no UK nursing evidence to establish the effectiveness of rounding or indeed to explore and understand the concept of rounding as a new practice to NHS nursing. This was disturbing given that notion the practice had been so widely adopted within NHS nursing practice, particularly when rounding was instigated in response to policy directives (DH 2012; DH 2012b; DH 2012c; DH 2013a).

For professional leader's like myself responsible for implementing and sustaining rounding in the clinical setting, to understand what difference it makes for people; both staff and patients, in the social context of the ward, is paramount. It is from this interpretive perspective, believing that 'real' knowledge about rounding will only emerge through the examination of the social interaction and the constructed meaning of individuals who are experiencing the rounding, that the study methodology was formed. Indeed, from the review the ethnographic methodology used to see, listen and talk about rounding in order to provide a description of patient experience and nursing care, matched my underlying value of interpreting meaning. The ethnographic methodology was synonymous with my desire to seek for understanding of how rounding is constructed, and the culture of rounding practice on my wards today.

4.6 Section 2: Ethnographic research design

The ethnographic study aimed to understand how the practice of rounding, in a particular organisation, may impact on patient experience and patient care. In my view an ethnographic approach was valuable when a sociological emphasis is the foundation of the study. The constructionist core of the study was that knowledge is generated by understanding and exploring the perspectives of patients and staff about the social process of rounding. To this end the ethnographic research design works well and is based on seeing, listening and talking about rounding with patients and staff as well as the reflexivity/personal orientation of the investigator. The reflexivity of the researcher was important to the research design to better understand the experiences and insights of the participants within the social setting or culture of the study site, the researcher immerses themselves in the 'world of rounding' to describe the complexity of the reality.

The research study aim was to describe the process of rounding as a method of delivering nursing/patient care by exploring the culture of the social situation of the ward setting. This was achieved through four objectives:

1. To understand the culture of rounding practice in a particular social situation
2. To identify the component features of rounding practice
3. To collate situational documentary evidence from patient care and experience metrics to describe the influence of rounding practice
4. To add to the theory of nursing knowledge related to rounding practice by understanding the patient experience and nursing care

The remainder of this section focuses on the research study approach, the methods and techniques utilised to achieve the study aims and objectives. The study draws extensively upon ethnographic methods to understand the practice of rounding, and particularly the application of a descriptive matrix (Spradley 1980). The study builds on a complete lack of exploratory evidence related to the culture and practice of rounding in context, from the perspective of the nurse and the patient, and adds depth and meaning to a predominantly quantitative rounding evidence base.

4.7 Ethnography

Ethnography is considered to be an interpretive form of social research concerned with understanding (Crotty 1998) rather than the causality links of empiric research studies such as the studies of Meade et al. (2006). According to ethnographic methodology (Hammersley and Atkinson 2007 p1) involves:

> *'The ethnographer participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact, collecting whatever data are available to throw light on the issues that are the focus of the research.'*

The use of ethnography in the health care setting is promoted for its capacity to understand the organisation of healthcare as well as accessing beliefs, behaviours and practices of those within the healthcare organisation (Savage and Scott 2005). Ethnography provides data with richness and depth in order to understand the social meaning of a particular setting, showing the everydayness that surrounds us; which can make a significant contribution to understanding a particular strategy or intervention (Brewer 2000). This methodology is particularly useful where information is new and unfamiliar or, where the special focus of the work is describing a culture, in a complex setting, to understand and capture different viewpoints (patients and staff) (Brewer 2000; Spradley 1980).

The over reliance of quantitative studies has already been discussed in this chapter as a rationale for choosing my differing ethnographic approach for the study. However further justification for utilising ethnographic methods to meet the study aim and objectives relates to the culture of rounding in the NHS and the local organisational context. The background to the study locally and in the NHS has been explored in chapter 2, rounding practice was championed by government policy and national senior nurse leaders. This led to a Trust wide implementation of rounding in 2012. However on examining the literature there is also a body of work, ableit a small body of work which prose a differing view to Meade et al. (2006) and replicant studies. These studies raised concerns which highlighted barriers to the successful implementation of rounding and the sustainment of effective rounding

practice (Deitrick et al. 2012; Harrington et al. 2014; Fabry 2015; Walker et al. 2015; Toole et al. 2016). Staff feedback identified problems associated with rounding practice as burdensome documentation, lack of staff engagement, ritualistic processes and lack of time (Deitrick et al. 2012; Harrington et al. 2014; Fabry 2015; Walker et al. 2015; Toole et al. 2016). These studies were uncovering the beliefs, behaviours and practices of staff who performed rounding. The findings of the studies warrant further exploration as potentially they are exposing a different paradigm of rounding practice. Rounding processes could be subject to local assertions and beliefs which influence rounding practice. Therefore utilising an ethnographic methodology, with its capacity to understand social meaning would meet the aim and objectives of the study by describing and understanding the culture of rounding in the study setting.

A further important consideration is the context of the NHS and the local organisation as part of the NHS to the chosen study methodology of ethnography. Within the NHS literature the potential of rounding as a quality improvement tool for safety and quality is clearly articulated (Lowe and Hodgson 2012; Dewing and Lyons O'Meara 2013; Forde-Johnson 2014; Stoddart et al. 2014). In chapter 2 the link to rounding practice is made to other approaches used to improve patient safety and quality, Harm Free Care (DH 2011a), the NHS Safety Thermometer (HSCIC 2015) and the 6 C's (DH 2012c). Therefore rounding practice is promoted as a means to improve practice and is located within main stream policy for the NHS and my own organisation. However this opinion of rounding may only be the case for senior nurses and managers. The understanding of rounding as a quality improvement tool and its policy context to frontline clinical staff may be different, particularly if the implementation of rounding practice lacked staff engagement. It maybe that staff viewed the implementation of rounding as additional documentation, additional work and a move away from individualised care. Therefore understanding the culture and value attached to the practice of rounding was an important way of meeting the study aim and objectives. The ethnographic method allowed for the observation of practice and seeking the viewpoint of staff and patients within a robust scientific framework.

Within my organisation, as discussed in chapter two, rounding or a version of rounding had been implemented prior to 2012, however the organisation wide roll out was in 2012.

Within the organisation as with many other NHS organisations the Trust used service improvement methodology as a tool to improve patient safety and quality, the organisation was signed up to Harm Free Care (DH 2011a), the NHS Safety Thermometer (HSCIC 2015) and the 6 C's (DH 2012c). Plus there was a degree of training to promote the use of quality improvement methods with staff. Attention had been given to the implementation of rounding and initially some training did take place, as discussed in chapter two, however within the organisational processes little emphasis was placed on appreciating the relationship between the nurse and patient to understand the process of rounding. Hence my studies aims and objectives sought through ethnographic methods examine and identify this relationship in order to seek its impact on patient safety and quality.

Ethnographic studies have been utilised in nursing previously when the examination of nurse/patient relations and practice has required in-depth observation (Sorrell and Redmond 1995; Burden 1998; Manias and Street 2001; Hill 2003; Savage and Scott 2005; Dixon–Woods et al. 2012). The focus here has been in relation to exploring fundamental aspects of nursing/patient care, including patient safety, nutrition, communication, privacy and dignity (Sorrell and Redmond 1995; Burden 1998; Manias and Street 2001; Hill 2003; Savage and Scott 2005; Dixon–Woods et al. 2012). These studies have congruence with my study on rounding which also investigates the meaning of actions and events related to nurse/patient care, communication and safety.

Ethnographic methods have the scope to examine a complex series of relationship interactions within the clinical setting. As such the nature of rounding can be explored in depth over a sustained period, potentially uncovering hidden practices associated with rounding that have previously remained unacknowledged. Methods of data collection involve observation, informal and formal interviews plus the collection of texts and imagines. This provides data from field notes, transcripts and documentary evidence designed to discover the cultural meaning of a social situation.

4.8 Participant observation

Extended participant observation of the phenomenon forms a significant part of ethnographic methods and aims to help the researcher learn and expose the perspectives held by the study population (Spradley 1980). Evidence suggests participant observation advances understandings of the physical, social and cultural contexts of the participants within the study setting by observing and participating in the daily activities under investigation (Burden 1998; Manias and Street 2001; Hill 2003; Savage and Scott 2005; Dixon-Woods et al. 2012), in particular the study of Deitrick et al. (2012) in relation to rounding. Burden (1998); Hill (2003) and Savage and Scott (2005) have provided nursing research with high quality examples of ethnographic studies which utilised observation/participant observation as a method of first hand data collection.

The aim of participant observation is to understand the meaning of behaviour, language and interaction of a culture sharing group. Lowenberg (1993) promotes the interactive nature of participant observation and the value of their everyday accounts of the social situation, particularly the challenge of examining the often taken for granted assumptions of other participants.

Burden (1998 p18) defined her role as a 'participant-as-observer' gathering information from discussions with new mothers following her initial introduction to them as a midwife offering advice on antenatal care. Not all the ethnographic studies reviewed defined their degree of participant observation (Mannis and Street; Hill 2003; Savage and Scott 2005; Dixon-wood et al. 2012) however Spradley (1980) offers a range or types of participant observation which facilitate the collection of data. The study by Burden (1998) has a high degree of involvement allowing for active participation observation whereas an observer who has no involvement with their study subjects or activities is nonparticipant. To provide for complete participation observation means a high degree of involvement in the study setting, the researcher seeks to become integrated into the group and its activities (Robson 2011). This was not realistically manageable within the resources of my study. A low level of involvement in participant observation appeared a more attainable approach. Passive participation (Spradley 1980 p59) allows observation at the scene of the activity with a

limited degree of interaction. Passive participation enables close observation of the phenomena (participating on a round with a ward nurse) with some limited interaction within the study scene (limited patient interaction) and note taking.

The challenge of ethnographic data collection can be a feeling of being overwhelmed with the process of observation and recording (Spradley 1980). To overcome this Spradley (1980 p82) identifies nine major dimensions of social situation which are designed to guide participant observation, these are:

1. Space – physical place
2. Actors – people involved
3. Activities – related acts people do
4. Objects – physical things that are present
5. Acts – single actions people do
6. Events – related activities people carry out
7. Time – sequencing over time
8. Goal – thing people are trying to accomplish
9. Feelings – emotions felt and expressed

The nine dimensions create a framework for increased awareness crucial to the effective collection of rich field data and the basis for describing a culture (Spradley 1980). The framework provides the ability to focus on detail in a broad and complex social setting. Indeed, Burden (1998) found this particularly useful to collect data regarding curtain positioning strategies within the maternity ward environment to record a detailed picture of that particular social situation.

Informed by Spradley's dimensional framework (1980) I generated a descriptive matrix (appendix 3) for rounding based on the concepts gleaned from the current literature and my own reflexivity with implementing and performing rounding in practice. Before adopting the matrix within the research the content and structure was peer reviewed and adapted, based on the critique by patients and staff to ensure the tool presented a grounded and comprehensive perspective (appendix 4).

To determine an appropriate length of time for participant observation I reviewed similar studies and identified wide variation (Burden 1998; Manias and Street 2001; Hill 2003; Savage and Scott 2005 Deitrick et al. 2012; Dixon-Woods et al. 2012). The time periods reflected the differing size of the studies (table 11). Dixon-Woods et al. (2012) was an extensive multicentre study generating the largest amount of participant observation time (855 hours in total) compared to Deitrick et al. (2012) a single centre study which generated 48 hours of observation, and used as a benchmark to inform the development of a realistic rounding study.

This ethnographic study observation was planned to take place over a four-week period, comparable size and length to Deitrick et al. (2012). Rounding would be observed at least forty times during the study period, generating approximately forty hours of rounding practice observation, which has previously generated rich data (Savage and Scott 2005; Deitrick et al. 2012).

Table 11: The time period of participant observation within nursing ethnographic studies

	Study	Length of Participant Observation
1	Burden (1998)	12 episodes over an extended time period, actual hours of observation not stated, Single site, 1 maternity ward
2	Manais and Street (2001)	6 participating nurse, observed during the course of one shift on three occasions, total 18 episodes, Single site, 1 ICU
3	Hill (2003)	18 hours, Single site, 1 ICU
4	Savage and Scott (2005)	10 episodes, maximum of 4 hours per episode, maximum 40 hours, Single site, 1 medical ward
5	Deitrick et al. (2012)	48 hours of observation over a 4-week period, Single site, 2 surgical wards
6	Dixon-Woods et al. (2012)	855 hours approx. 48 hours per Intensive Care Unit, 17 sites, 17 ICUs

Data within ethnographic methods can be generated through *'field notes'* (Hammersley and Atkinson 2007 p141) a simple technique ethnographer's designed to record field note data is a *'double entry notebook'* (Driscoll 2011 p153). The double entry notebook assists the observer recording what is actually occurring from what is their interpretation of those facts (Driscoll 2011). Raw or *'concrete'* data what the observer saw is separated from what the

observer thought or interpreted, subjective observation to ensure specific detail is recorded (Spradley 1980 p68). Therefore, I developed a specific field note record based on separating the concrete observation from the interpretive observation (Appendix 5).

4.9 Patient and staff Informal Interviews

Alongside participant observation, interviews are an important data sources for ethnographic studies. The interview is used to understand what participants think and how one participant's perspective compares with another. For this to be useful there is the need for careful structuring of the interview format to help yield rich descriptive data for analysis (Sorrell and Redmond 1995). Savage and Scott (2005) utilised semi structured interviews, pre-determined by national and local guidance. Manias and Street (2001) and Hill (2003) emphasise the in depth nature of the interviews utilised within their studies, up to 40 minute interviews but these interviews were small in number and only performed on staff. Whereas, Burden (1998) used a discussion or conversational approach with individual women (patients) within her study and found this beneficial.

The informal interview method used for the study was a way to speak about and discuss the 'lived experience' or 'everydayness' of rounding, from both a patient and staff perspective. The interview questions and the participant observation focus on the observational matrix which separates the data collection from the interviews into actors, activity, space, event, time and goal. The purpose was to explore the nature and extent of nurse and patient involvement in rounding and factors that influenced their perceptions of the rounding practice. The informal interview questions (appendix 6 and 7) followed a pattern of descriptive and structural questions (Sorrell and Redmond 1995) with the aim of providing a general view of the participant's perspective of the rounding process, their understanding of the process, and verifying data collected during the participant observation.

Ethnographic studies demonstrated a wide variety in the number of interviews performed and the time taken for each interview (table 12) (Burden 1998; Manias and Street 2001; Hill 2003; Savage and Scott 2005; Deitrick et al. 2012; Dixon-Woods et al. 2012). Dixon-Woods et al. (2012) identified a large multisite study generated the largest amount of interview

data, 93 interviews with staff, compared to a single site study which generated a more realistic 48 staff interviews and was used as a benchmark for the rounding study (Deitrick et al. 2012).

Table 12: Interview information from nursing ethnographic studies

	Study	Interview data
1	Burden (1998)	Number of patient discussions not stated
2	Manais and Street (2001)	2 in depth interviews with each of the 6 participating nurses (12 interviews)
3	Hill (2003)	8 interviews of 40 minutes
4	Savage and Scott (2005)	20 staff interviews, 10 patient's interviews
5	Deitrick et al. (2012)	48 staff interviews
6	Dixon-Woods et al. (2012)	93 face to face interviews with nurses and doctors, 29 telephone interviews.

To develop a realistic and achievable study within the time frame of the DProf and ensure the study was comparable to other ethnographic nursing studies a minimum of 40 hours of participant observation was planned, alongside 40 patient and 40 staff interviews. This was consistent with other single site nursing ethnographic studies and larger than some (table 12).

It was planned that after each observation period one member of the rounding team and one patient after each round observed would be interviewed for 15 minutes to capture their experience of delivering rounding at that time (minimising the interruption/disruption to clinical care). Patient involvement and selection was dependent upon their availability, for example not away from the ward having procedures or tests, their wellness and ability to give consent and participate in the interview. Agreement to interview a patient was gained by the nursing staff caring for the patient prior to them being approached to take part in the study. It was important to state there was minimal risk to patients and staff from the study and there was no benefit to either patients or nurses from being involved. However, informed consent was obtained for both patients and nursing staff prior to any observation and interview taking place.

4.10 Documentary evidence

Within my study of rounding practice information was required to build a picture of the possible outcomes of rounding that could influence patient safety, patient and staff experience. Within ethnographic methodology documentary evidence is seen as an essential element of data collection. Hammersley and Atkinson (2007 p128) suggest that:

> *'In some settings it would be hard to conceive of anything approaching an ethnographic account without some attention to documentary material in use.'*

Burden (1995) specifically included documentary data within her study to build a picture of extenuating factors which could influence the way her participants acted within their environment. Savage and Scott (2005) focused on strategy and guidance documents to inform their fieldwork as well as the informal documentation of ward communication books. Both studies appeared to use documentary evidence as supplementary to their main data collection methods. Whereas, Manias and Street (2001) used professional journaling as their main data collection modality for its value in providing comprehensive descriptions of experiences and the interpretation of experience.

Hammersley and Atkinson (2007) include official statistics as relevant sources of documentary evidence even if it appears at odds with a social scientist approach to research, indicating that such documents have considerable importance in the social setting. It was proposed that the researcher could investigate the validity and reliability of data from first-hand experience and this would add to the richness of the investigation.

From the earlier review of rounding literature most studies focused on measuring specific outcomes of rounding related to patient safety and experience. Although the aim of this study was not to prove the cause and effect of rounding it was important that the identified outcomes of rounding practice were considered as part of the study, to give situational context to the study site. Indeed, Robson (2011) promoted the use of data records as a valuable supplementary resource, if relative to a specific organisation, but added caution that they were unlikely to provide direct answers to a research question.

Monthly local (Trust level) reports documented patient fall rates and pressure ulcer prevalence per ward. In addition, reports were published on patient feedback. Approximately 20 to 30 patients were surveyed per month per ward (via an electronic patient survey, the Patient Experience Tracker based on the Friends and Family test and National In-patient Survey questions). Historically as rounding was introduced into the Trust data were collected on patient call bell usage. Therefore, I collated the documentary evidence available from the Trust for the study site to provide a longitudinal aspect to data collection. The data collection periods were divided into three comparable time periods February to July over three subsequent years, 2012, 2013 and 2014. The time periods were set to capture data three months prior to rounding implementation in 2012 and three months post implementation. The data were used to compare and contrast the historical patient safety and satisfaction documentary evidence with the interview data and observational data of rounding to generate a more comprehensive understanding of rounding (table 13).

Table 13: Summary of documentary data collated for the study site wards

Documentary/audit data	Time period measured over
• Falls rates - All recorded falls per month, falls with or without harm	Data period 1 – 6 months Feb to July 2012 (3 month pre rounding implementation, 3 month post rounding) Data period 2 – 6 months Feb to July 2013 Date period 3 – 6 months Feb to July 2014
• Pressure sores incidence – All recorded pressure ulcers per month, with or without harm	Data period 1 – 6 months Feb to July 2012 Data period 2 – 6 months Feb to July 2013 Date period 3 – 6 months Feb to July 2014
• Call Bells – Measured for 1 hour per month, number of call bells heard ringing recorded	Data period 1 – 6 months Feb to July 2012 (3 month pre rounding implementation, 3 month post rounding)
• Patient Experience Tracker Questions - patient responses per month, percentage scores to three questions Communication – Did you find somebody on the hospital staff to talk about your worries and fears? Pain – Did you have your pain assessed	Data period 1 – 6 months Feb to July 2012 (3 month pre rounding implementation, 3 month post rounding) Data period 2 – 6 months Feb to July 2013 Date period 3 – 6 months Feb to July 2014

and reviewed during your stay? Overall score from the survey	

4.11 Reflexivity

A central element of ethnographic activity is the reflexivity which relates to the researcher and at the same time this is often the main criticism of ethnographic research and the introduction of bias (Mason 2002; Creswell 2007). Traditionally it has been assumed the researcher has no effect on the research environment and vice versa. However, in ethnography research the researcher and site participants are in frequent interaction, the researcher interference is acknowledged rather than hidden. Creswell (2007) considers the visibility of the researcher and their relationships fundamental to the research process, as conscious, reflexive awareness of interactions contributes to the richness of data obtained. Similarly, Hammersley and Atkinson (2007) promote the value of reflexivity, acknowledging that bias and subjectivity are a risk but positioning of the researcher within the research process allows for richer data to be appraised. In Spradley's early work (1980) he used the term introspection, advocating that the researcher uses themselves as a research instrument and that this will greatly enrich the data an ethnographer collects. Burden (1995) debates the advantages of reflexivity as facilitating data collection but also cautions of the problems of being blinded by familiarity and having to abandon her research to assist with midwifery practice.

In terms of this research I was very familiar with the process of rounding from my role as a senior nurse leader within the organisation, however as a researcher ethical approval (page 117) highlighted a concern about my role in the line management of the ward staff being observed and interviewed as part of the study. In expressing my 'self' as a senior nurse leader my role was too involved, and could introduce bias, which the ethics panel perceived would ethically compromise and influence the culture of the ward. Therefore, as a researcher I was required to distance myself from the direct field work. I used my own reflexivity of the rounding process to develop the descriptive matrix (appendix 3) to provide a framework for observation, train independent nurse observers, conduct the pilot test and

to examine/analyse the data they collected, but drew on their collective experience as an important part of the research process. The unintended consequence of this change to the research design provided an originality of approach to the study and I believe generated a deeper understanding of the phenomena of rounding because my removal from the actual data collection minimised bias and my role as a nurse manager did not contaminate the fieldwork data.

Researcher bias can mean that my own values and beliefs affect the research process (Parahoo 2014). There is also the close relationship between the researcher and the setting which can introduce the issue of bias (Robson 2011). Although both these issues are positive in terms of reflexivity they are potential threats to the validity of the study, particularly in my role as an internal member of the organisation. A potential source of bias highlighted by Robson (2011) is a loss of neutrality, the change in role from the unbiased researcher to biased advocate. My reflexivity within the research setting/organisation could influence how positively or negatively I view the data findings moving me to advocate a particular view about rounding. There is also the potential to be drawn into the existing organisational viewpoint or for the research to be manipulated by a particular facet of the organisation/setting. However the explicit openness of my research journey has detailed how the research study has influenced my thinking rather than the study setting/organisation. In addition, I have ensured a robust dialogue with my managers throughout the research process to pre-empt the issue of political/organisational bias (page 120).

4.12 Pilot test

The descriptive matrix, developed as a framework for observing the research social situation was discussed as part of a presentation and workshop I was selected to deliver at the Trust's Annual Nursing and Midwifery conference. I used the opportunity of the conference workshop to canvass the participants, nursing staff and service users on the specificity of content and relevance to the process of rounding. Appendix 4 provides the detail of the event, generally the consensus of participants was that the matrix covered the requirements for the process of rounding. Five members of the workshop identified that that the matrix

didn't specifically state the patient call bell should be in reach of the patient and therefore this was added to the matrix.

The matrix was then piloted in practice to ensure reliability of both use and application between users of the tool. Two of the nurse observer/interviewers piloted the tool, twice each in the month prior to the study commencing. They both found the tool easy to use as it provided a focus for a detailing their observations which were then captured on the field note record. Following this successful pilot no further changes were required to the data collection process.

4.13 Research team and expertise

Embedded within my research design was the importance of collaboration with nurses and patients to ensure the study was relevant and had meaning to clinical practice. An important focus of the nurses' participation within the research design was the development of a specific team of trained nurse participant observers/interviewers. The aim of using a trained team of nurses was to facilitate the collection of a significant amount data, over a short time period, simultaneously across the study setting. But more importantly through collaborative training increase the concordance and precision of the observation and interview data. Hence promoting as far as possible, researcher agreement and interrelated reliability within the study. The importance of the collaborative nurse research team to the data collection was further emphasised when my own role, as service manager, was considered a potential bias to data, and thus to receive ethical approval I had to be distance myself from the act of data collection.

The research team, or nurse observers as I later referred to them, consisted of five registered nurses working in the Trust, interested in rounding, who were trained for the purpose of the study in ethnographic research methods: how to use the descriptive matrix, undertake participant observation and informal interview techniques as data collection tools. The nurses came from various backgrounds (two education nurses, one research nurse, one specialist nurse and a matron) but did not have ward based roles or direct care giving experience within the study site wards, none were part of the study site ward staff

establishment. To ensure high standards of research practice and meet requirements of the Trust research standards each nurse had completed their Good Clinical Practice (GCP) Certificate and submitted their Curriculum Vitae for the Trust's Research Department's approval as well as attending a 'research preparation workshop' (table 14).

Table 14: Research participation requirements of nurse observers/interviewers

	Name	Department/Title	GCP Cert	CV	Workshop attendance
1	RN A	Research Nurse	Y	Y	Y
2	RN B	Education Nurse	Y	Y	Y
3	RN C	Education Nurse	Y	Y	Y
4	RN D	Specialist Nurse	Y	Y	Y
5	RN E	Matron	Y	Y	y

I facilitated the research preparation workshop for the nurse observers which lasted 90 minutes (appendix 8). This included of an overview of the research project, discussion about the use of the matrix, the ethical and practical issues of carrying out research observation in a ward setting plus practical tips to undertake participant observation and informal interviews including the use of digital recorders. To supplement the workshop, I developed a reference pack for each member of the team (appendix 9) the content included background information about the study, research design and copies of data collection records. Feedback suggested that the nurse observers found the preparation from attending the workshop and reference pack extremely useful throughout the data collection period.

4.14 Study site and sample

The study site was two acute wards within a large teaching acute NHS teaching hospital. Both wards were similar in that they were 28 beds, mixture of side rooms and 7-10 bed bays. Each ward had similar staffing ratios, numbers of staff and skill mix, on a day to day basis. One ward was predominately a male ward the other female, however there was usually a higher proportion of male patients within the speciality and hence on the female

ward there was always a bay of seven male patients. My rationale for using a small study site was to enable depth in study data consistent with ethnographic methods within the time and resources available, reflecting other ethnographic studies in nursing (Burden 1998; Manais and Street 2001; Hill 2003; Savage and Scott 2005; Deitrick et al. 2012).

The study followed a purposive or judgement sampling method used by both Hill (2003) and Burden (1998). The participants in the study were all patients and staff on the ward that had consented to be involved with the research, therefore the study had representative participants of the study population. Rounding was observed on both wards depending on the availability of the nurse observer, the interviews took take place with a selection of patients and staff, immediately post rounding. The patients were selected for the purpose of describing the experience of rounding in which they had participated (Robson 2011). There was also a judgement by the nurse observers as to the interest of the patient to the study after the rounding observation had taken place. On all occasions where possible the staff member delivering the rounding was invited to a post round interview.

Inclusion and exclusion criteria were applied to the study sample to define the participants who took part in the study (table 15). The criteria were applied to ensure the balance of obtaining relevant knowledge and insights from staff and patients with ethical rigour (Parahoo 2014). The rationale for the inclusion criteria for the study was that the process of rounding was applicable to all patients and staff within the study site setting, therefore the study had wide inclusion criteria. However, within the wards there were also patients and staff who were excluded from the study. The rationale for the patient exclusion criteria included patients who did not give their informed consent due to the patients being too unwell to undertake the informal consent process (as determined by their consultant) asking a patient about their participation in a research study whilst unwell would go against maintaining high ethical standards. A further rationale for patient exclusion related to the fact that a large part of the data collection involved post rounding interviews and there were no resources available for interpretation, therefore patients who did not speak English were also excluded from the study as were patient with communication difficulties.

An additional rationale for the exclusion of certain patients was that patients needed time to assimilate the information about the study prior to giving informed consent. A further priority was that patients needed time to adjust to their admission to the ward and their clinical care, hence informed consent was not immediately sought from patients who were new to the ward. Patients who had previously given their informed consent at pre admission clinics were given time to verify their decision, again this would ensure the study upheld high ethical standards.

All substantive staff within the study wards were invited to voluntarily participate in the study, because they performed rounding however the rationale for the staff exclusion criteria acknowledged and respected the rights of staff not be involved. Staff who chose not to provide their informed consent were excluded from any observations and interviews. The exclusion criteria for staff also included temporary staff and nursing students allocated to the wards the rationale for this exclusion criteria was the requirement of the study to focus on the culture of the substantive ward team in relation to rounding therefore non substantive staff were excluded.

Table 15: Study inclusion/exclusion criteria

Inclusion	Exclusion
Patients	
• *All patients within the two study wards who provided informed consent*	• *Patients who were unwell and unable to provide informed consent (determined by their Consultant)* • *Patients becoming confused or unwell, as the interviews were being performed will be withdrawn and excluded* • *Non-elective patients admitted to the wards who had not yet given informed consent, patients given 24 hours before being approached about the study with further time to consider their participation prior to giving informal consent* • *Elective admission patients who were given 24 hours to confirm their informed consent* • *Patients unable to communicate in English* • *Patients with communication difficulties not associated to a language barrier*

Staff	
• *All grades of staff (nurses and nursing assistants) within the two study wards who provided informed consent*	• *Temporary staff* • *Nursing students* • *Ward staff who did not give informed consent*

The target population for the staff participation in the study was all of the nursing staff within the two wards, this included a nursing establishment (for both wards) of 84 registered nurses, nursing assistants with a small number of housekeepers. From this total population four staff refused to provide their consent to be involved and were, subsequently excluded from the study. However not all staff were observed rounding or interviewed during the study period, it was dependent on their presence on the ward at the times rounding was being observed and whether they were allocated to deliver rounding on the ward at that time, so staff involvement in the study was random.

The target population for patients was all patients on the two wards during the study period. The numbers of patients who consented to the study was 75 with two declining consent. None of the patient sample were excluded from the study interviews as a result of becoming unwell and unable to continue the interview. The list of target patients for the two wards was checked on a daily basis throughout the study phase by me to ensure accurate identification of patient inclusion and exclusion criteria regarding patient's fitness, wellness and time on the wards to participate in the study plus that informed consent had been obtained.

The sample size was similar to a previous observational study on rounding (Deitrick et al. 2012) where similar numbers of observational and interview data generated findings that were considered satisfactorily trustworthy and credible to publish and thus used as a benchmark for this study.

4.15 Ethical considerations

4.15.1 Informed consent

To manage the complexities risk in relation to informed consent, it was important to produce clear information for both patient and staff participants (Streubert and Carpenter 2011). The informed consent process included an invitation letter, consent form and a participant information sheet for both patients and staff (appendices 10 to 15). The invitation letter introduced me as the researcher, stated the study was part of a Professional Doctorate research programme and linked the study to the cardiac wards. The information sheets took the form of a question and answer sheet detailing more in depth information about the study including contact numbers for more information and an independent advocate. The consent form for observation and interview detailed nine statements about agreement and understanding of the study.

The invitation to patients to participate in the research process followed two clear pathways, one for elective admission patients and one for emergency or non-elective admission patients. Elective admission patients were invited to participate in the study prior to their elective admission to the wards at pre admission clinics for either cardiac surgery or invasive cardiology procedures, a pre admission clinic takes several hours. The information about the study was discussed at the beginning of the clinic attendance and then followed up towards the end of the clinic visit giving the patient and their family/carers an opportunity to ask questions before signing the consent form. Following their admission elective patients were reminded of the study and had a further opportunity to ask questions and accept or decline participation, a period of 24 hours was given before participating in the study. The majority of patients on the wards were elective admissions however a smaller number of patients were admitted as non-elective patients usually through the emergency patient pathway. The patient would not have had the opportunity to attend any pre admission service and therefore no information about the study was given to the patients prior to their admission to the ward. Therefore informed consent for the patients was obtained after their admission to the ward. For this group of patients it was important that the approach to obtain informed consent didn't compromise their clinical care. This group of patients were not considered for the informal consent process until they had been

on the ward for 24 hours and their clinical condition was stable, as determined by their consultant. Following this time period the patients were given information about the study, a follow up visit was then made half a day or day later to answer questions and if the patient accepted sign the informal consent form.

In the event of a patient dying or becoming unwell and losing capacity in the period after they had participated in an interview it was decided that their data would still be used within the study as it was obtained when informed consent had been provided.

Informed consent was obtained from ward nursing staff prior to the period of observation and interview, taking the form of several information giving sessions, to staff about the study. Each member of the ward staff was individually asked if they wished to participate in the study and written consent was obtained from those who voluntarily came forward.

To assure patient and ward staff confidentiality and anonymity each participant was identified by a number/pseudonym throughout the process of data collection and throughout the data analysis and dissemination of findings. Written authorisation from the wards local management team was gained to undertake the study but the identity without changing any relevant characteristics of the research setting is disguised.

4.15.2 Observation of poor practice

The study used trained observers to collect observational and interview data, these nurses were also trained to ensure continuing patient and staff consent as well as being aware of complexities and risks of observational research. It was not anticipated at any time throughout the rounding study that participation or data collection should cause a risk or burden to the research participants as it is part of usual clinical practice on wards. However, it was identified that there were some potential risks if the observer/interviewers did not adhere to the research structure, such as:

- patient fatigue or disruption to clinical care if the interview process took over 15 minutes

- participant staff nervousness at being observed in practice if the staff member was unaware or not fully informed of the study
- a reduction in time available for clinical work and interruption of patient care if the staff member was taken away from practice area for an interview that was too long.

It was also important the observer nurses understood their role in intervention and advocacy for example in the event of observing poor practice the researcher would need to intervene as a patient advocate as data collection should not put patients in danger. A strategy was introduced that enabled the observers to feedback concerns to the ward matron immediately after observing the rounding, but this was not required during the study. As I was the principal investigator and a member of the divisional management team it was important to identify an independent advocate who staff could confide in if they had concerns about the study or did not wish to take part, again this was available but not used during the study.

4.15.3 Political consideration

Linked to the ethical implications of the study was the potential political connotation to performing research within the lead researcher's work place and being supported by the employer to perform the study. The researcher's reflexivity may compromise their independence, there is a potential vulnerability to the researcher position (Creswell 2007), particularly as the Trust in line with the national agenda was rolling out and supporting rounding as a positive aspect of nursing practice. As a senior manager in the Trust and the researcher I had to be cognizant of the messages the research study was emitting and from its early inception ensure a robust dialogue with my managers throughout the research process to feedback emerging messages and findings (Robson 2011).

4.15.4 Data handling and storage

A master list of patients and their identifying numbers was maintained on an electronic database, containing the patients name and age, to ensure an audit trail for the study. The database was password protected and the password only known to the lead researcher. The lead researcher collected all data (observational data and digitally recorded interviews) at the end of each day. The data from the recorded interviews was then immediately

uploaded onto a secure password protected personal computer of the lead researcher at the end of each day and removed from the digital recording machine. Written observational data was stored in a secure filing cabinet within a locked office and transferred to electronic copy as soon as possible, with the hard copy being destroyed after the study was completed.

Following completion of the study the data will be retained in a secure electronic database within the Trust's Research and Innovation Division for five years in line with current practice for non-invasive studies. The study product is for use within professional nursing and not the wider public domain but if participants wanted to know the results of the study they were provided with an email address to contact the lead researcher.

4.15.5 Ethical and R&D approval

Prior to the study taking place ethical approval was gained from the University's Research Governance and Ethics Sub-Committee, the study was also registered and approved with the Trust's Research & Innovation Division (appendix 16 and 17). The study was generating new knowledge about a major change to nursing care delivery. The study was asking patients and staff about the concept of rounding and exploring how it meets their needs, the study was more than an audit or service evaluation thus approval was also sought from the National Research Ethics Services through the completion of an Integrated Research Application Submission (IRAS). This approval was granted in February 2014 (appendix 18).

The research design and later findings peer reviewed by two experienced educational supervisors, successfully withstood the scrutiny of two doctorate progression panels with oral viva and critically appraised in my employing organisation by the Deputy Director of Nursing.

4.16 Data collection and issues experienced in the field

All periods of planned participant observation were completed. However, less 'out of hours' (late evening and in particular night observations) were performed because it became

impractical due to the existing commitments of the nurse observers. Table 16 provides an overall summary of data collection activity

Table 16: Data collection overall activity

Observation/interview data	***Documentary data***
• 4-week period of data collection • 38 out of 39 periods of participant observation • 34 out of 38 patient interviews • 34 out of 38 staff interviews	• Falls rates (6-month data x3) • Pressure ulcer prevalence (6-month data x3) • Patient satisfaction (6-month data x3) • Call bell usage (6-month data)

Unfortunately one whole participant observation had to be withdrawn because the field note proforma was spoiled by a fluid spillage and therefore destroyed before analysis could take place, and a staff and patient interview data was lost due to problems with the use of the digital recorder. In addition, three staff interviews could not be held after the rounding due to the ward being too busy for the interviews to take place. Two patient interviews didn't take place due to patients needing their continuing planned treatment/care. One patient interview did not take place as the participant observation was carried out at 22.30 hours and after the rounding was completed it was considered too late to then interview the patient. During the data collection period no untoward incidents occurred on either of the participating wards. No staffing issues were highlighted and both ward areas ran on their usual staffing numbers and skill mix. The nurse observers did report that on occasions their presence on the ward to observe the rounding did appear to prompt the allocation of a member of the ward staff to carry out the rounding activity. However, it was difficult to extrapolate whether the rounding would have been a missed if the observational study were not in progress but it was a possibility.

Originally the study had planned to investigate rounding practice during week days and weekends including night time hours. However the reality of the availability of the nurse observers meant most of the observation of rounding with the subsequent patient and staff interviews took place during week days within day time hours. As a further limitation of the nurse observer's availability the majority of the rounding observations took place during the first three weeks of the study, and some nurse observers participated in more rounding

observation episodes than others. A detailed account of the participant observation and interview study activity is presented in table 17: Patient rounding field work codes, shown in appendix 19. The table highlights the date of the observation, which ward, time, the nurse observer, patient ID, audio interview file ID, plus staff ID and audio interview file ID, the analysis code which links together the observation, patient interview and staff interview. The table also details some brief comments regarding the round from the investigator.

4.17 Quality and trustworthiness of the data

Each participant observation, staff and patient interview yielded differing amounts of data. Within the participant observation data from the nurse observers there were differing styles of annotation of their field notes with some of the nurse observers focusing on the actual scenes observed and others focusing more on the interpretation of their observation and participation. Within the patient and staff interviews data was increased related to willingness of participants to talk and expand their answers to questions, and the probing skills of the nurse researcher. For a minority of interviews the responses to questions were single word or short phrase answers, from the audio records the nurse observers could be heard probing for answers but were not always successful in their endeavour.

To ensure nurse observers consensus and accuracy of data, once the data was coded into the descriptive matrix (example, appendix 22) the nurse observers had the opportunity to review the data at a collaborative workshop (appendix 21) held after the data collection period had been completed. At the workshop attended by four out of five of the nurse observers there was group discussion and consensus agreement that the data presented was an accurate reflection of their data collection work and synonymous with their impressions of rounding practice. The workshop provided time for the nurse observers to consider and deliberate on the ethnographic data, and scrutinise the analytical process which the investigator had pursued in order to draw out the cultural themes of rounding practice in the context of the study setting. Although the account of the data analysis process was condensed into a brief resume for the purposes of the workshop, there was consensus about the truths and behaviours related to rounding practice. The substantiation

by the nurse observers of the emergent themes from the initial data analysis provided a considerable degree of credibility and authentication to the study findings.

4.18 Section 3: Data analysis process

I found it a challenge when writing up the analytical process to present it as a detached framework in the methods chapter without examples of the emerging themes and concepts, but have separated them and examples of the method used is presented at the beginning of the next chapter. This section provides an overview of what the data analysis process involved.

A comprehensive period of data analysis followed the data collection, which involved and thematic analysis and merging of three forms of qualitative data drawn from the participant observation, patient interviews and staff interviews, and quantitative documentary audit data. The field work codes of the observation and interview data strands was converged to achieve a single data set (table 17, appendix 19) then re-coded according to the date and time of the rounding observation, nurse observer, patient interview and staff interview to display the observation activity and participant characteristics (table 18). The additional strand of documentary data the ward's falls rates, pressure ulcer prevalence, patient satisfaction and call bell data, pre and post implementation of rounding was presented as a single table 19: Patient safety and experience data covering three data periods shown in appendix 20.

Transcripts from interviews and observations produced copious data (Streubert and Carpenter 2011) therefore it was essential to involve the nurse observers to assist with the management of the data analysis. This provided a further opportunity to develop their research skills and capability, inside of the research. The observer nurses alongside the researcher worked together to collaboratively validate and confirm the description and classification of data and then used consensus agreement to co-produce and authenticate the research themes and findings, a process I found reassuring than relying on my own interpretation.

4.19 From descriptive observations to cultural meaning

The aim of the ethnographic study was to understand the culture of a particular social situation, in the case the practice of rounding in the context of the two in-patient wards. Spradley (1980) identifies how social situations and culture differ as concepts: social situations refer to streams of behaviour which can be captured through participant observation, culture describes the organisation, symbols, patterns and meaning given to a social situation. In this study the social situation of rounding was the description of behaviour and events. The culture of rounding was the patterns of behaviour and knowledge that the patients and staff have learned and created towards the process of rounding. Data analysis facilitated the progressive movement of describing social events and processes related to rounding in the social situation of the study setting to enable the construction of culture (Hammersley and Atkinson 2007). Three stages of data analysis, description, analysis and interpretation were followed by a sorting procedure in order to transform data into cultural meaning (Manis and Street 2001; Hill 2005; Creswell 2007). Analysis of the field notes and interview data collected during the research process meant that description was transformed into discovering the meaning of behaviour through the analysis of what had been observed and described in the research setting. Importantly this process generated a deeper knowledge of the culture and the activity of rounding implemented in this context.

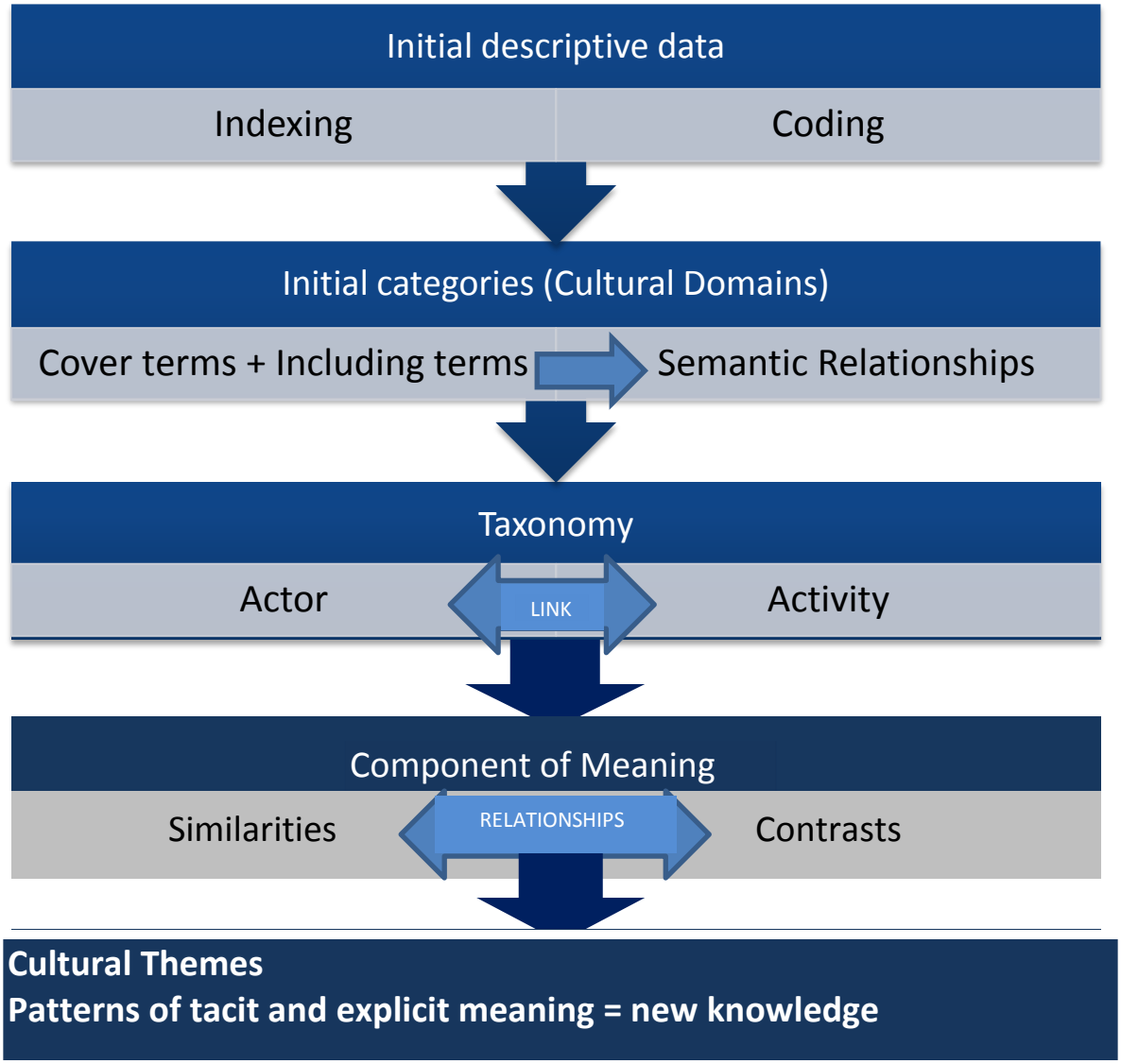
However, as Hammersley and Atkinson (2007) identify the difficultly of analysing ethnographic data is connected not only due to the volume of data collected but also that the data is not usually collected in any structured form causing the sorting procedure to be demanding. Usually in this type of research no prior categorisation has taken place compared to survey data which may already be pre themed. In my study ethnographic data was obtained from open ended observational field notes and transcripts of audio recording, with only a limited structure applied at the outset, using the descriptive matrix (Spradley 1980). Data analysis is an iterative process (Hammersley and Atkinson 2007) but required the introduction of some structural strategies in order to discover the cultural meaning from the social situation (Spradley 1980). Mason (2010) identifies this as slicing the data and for this study this was initially performed by myself as the researcher, which required focused

concentration and immersion into the data (Streuburt and Carpenter 2011). There was an extended period of reading of the data, re reading, studying the data, thinking about the data and identifying patterns and relationship within the data. The strategies of the ethnographic analysis process as:

- Indexing and coding the initial data
- Making a domain analysis – discovers cultural domains
- Making a taxonomic analysis – organisation of cultural domains
- Making a componential analysis – identifies patterns of similarity and contrast
- Discovering cultural themes – search for domain relationships and their link to the cultural scene being researched

The sequential phases of the analysis research sequence were applied to interrogate the data (figure 2). In classic ethnography methodology it is recommended to have periods of focused observation between periods of analytical strategy to help narrow the focus of the social scene under investigation (Spradley 1980). In my study from the outset, for the work to be both manageable and achievable a narrow focus was pre-determined (the gaps in the literature the interview data would provide additional selective data for the study). The first step of data analysis was the repeated reading of the descriptions from the field notes and interview data in order to understand the lived experience of rounding. All emerging themes were reviewed by the nurse observers to add credibility, trustworthiness, and robustness of the data analysis (appendix 21).

Figure 2: Ethnographic analysis: from descriptive observation to discovering cultural themes



4.20 Documentary data analysis

The documentary evidence analysed as part of this study reviewed the local (Trust level) historical data which included:

- Falls rates per month, all fall, with or without harm, during patient admission
- Pressure ulcer prevalence, all pressure ulcers, with or without harm, during patient admission
- Call bells

The specific data were extracted from incident forms submitted by ward staff as part of usual ward routine processes. The naturally collected data forms were then collated on a monthly basis to give an overall monthly total of falls rates and pressure ulcer prevalence per ward.

Supplementary routine collected data concerning patient satisfaction were extracted from the Trust wide patient satisfaction survey process which again was collated on a monthly basis. Three areas/questions were identified as useful data as they were comparative to patient satisfaction survey questions highlighted within the literature (chapter 3). These were worries and fears, pain and overall satisfaction.

4.21 Summary

The ethnographic methods of participant observation, interviews and documentary analysis enabled intense and focused examination of the phenomena of rounding in the social context of the ward setting. Exploring and examining the patient and staff experiences in real life day to day situations of nurse/patient interactions was the principle method of data collection, the data for the study was also informed and shaped by documentary data.

Throughout the study, from the choice of methods to the analytical techniques imposed upon the data, the approach focused on providing a rich and meaningful cultural description of the study setting and rounding practice.

To identify what rounding is without describing and understanding its purpose in the context of the social situation of the ward setting and its meaning to patients and staff has limited value to nursing practice. The practice of rounding would be at risk of becoming a task/checklist without constructed meaning. The data generated by this study focuses on the collaborative construction of rounding by nurses, as meaningful nursing practice in terms of the culture of the ward setting. The strength of this study lies in the facilitation of a deeper knowledge and understanding of the rounding process.

As a researcher the methods used to analyse the data were difficult processes to capture and articulate in written form. However, the data analysis process required the application of appropriately rigorous and robust methods to ensure an accurate view and trustworthy data emerged from the research methods adopted. The purpose of ethnographic methodology is to scientifically discover cultural meaning. Therefore the careful and systematic examination of the data collected from the study was required to ensure a rich, deep and illuminating understanding of the culture of rounding in the study setting. The process enabled the social situation of rounding in the study setting to gain a focus and clarity which is presented, interpreted and discussed as the findings of the study in the subsequent chapters.

Chapter Five: Discovering the cultural domains of rounding

5.1 Introduction

The previous chapter explained the ethnographic methodology and study process which combined participant observation, patient and nurses experience interviews and audit data to gain a deeper cultural understanding of the rounding process. An overview of the data collection, observation activity and participant demographics is presented to provide clarity on when rounding was observed, by who and how patients and nurses' experiences were captured within the study. The initial part of this chapter captures the individual and collaborative analytical process as it unfolded using examples from the data to guide the reader through analytical decisions. Exposing how data was broken down and rebuilt generates transparency in the process and increases the credibility of the findings.

The study findings are interpreted to facilitate the emergence of new truths and beliefs associated with rounding. The development of the cultural themes created new and unique knowledge associated with the study. Four key cultural themes emerged and are discussed in detail within the chapter:

- Presence
- Playing the routine
- Actioning care
- Engagement

The findings illuminated the implications for the development of nursing practice, conceptual knowledge related to rounding practice, and add depth and meaning to the wider rounding literature.

5.2 Observation activity and sample characteristics

Participant observation activity by the nurse observers and the characteristics of both patients and nurses involved in the study are captured and presented (table 18).

Table 18: Observation activity and participant characteristics

Observation round n=38	Nurse observer Code A-E	Ward (1 or 2)	Total number of patients rounded	Time	Day of week (4 week period)	Time taken for rounding (minutes)	Patient Interview		Male/ Female	Staff interview n=34		
							Code	ID		Code	ID	Band
1.	A	1	18	12.30	Mon	15	1	43	F	1	59	6
2.	A	1	22	18.35	Wed	13	2	20	F	2	72	2
3.	A	1	22	16.20	Thurs	25	3	41	F	3	62	2
4.	A	1	20	16.20	Fri	10	4	55	F	4	61	2
5.	A	1	18	13.25	Sat	20	5	33	F	5	26	2
6.	A	2	16	13.15	Mon	30	6	54	M	6	57	5
7.	A	1	23	16.40	Thurs	30	7	66	F	7	45	6
8.	A	1	22	12.35	Fri	15	8	64	F	8	30	2
9.	B	1	23	14.30	Mon	50	9	42	M	9	47	2
10.	B	1	25	10.40	Tue	30	10	47	F	10	67	6
11.	B	2	26	10.25	Fri	18	11	68	M	11	43	2
12.	B	1	26	14.35	Tue	40	12	63	F	12	22	2
13.	B	1	20	14.30	Thurs	15	13	77	M	13	55	6
14.	D	2	23	14.30	Mon	50	14	39	M	14	54	6
15.	D	1	24	10.30	Wed	15	15	46	F	15	17	2
16.	D	1	25	14.40	Mon	10	16	56	F	16	82	2
17.	D	1	26	14.30	Wed	15	17	65	F	17	92	5
18.	D	1	26	14.30	Wed	15	18	70	F	18	85	6
19.	D	1	22	10.35	Thurs	15	19	62	M	19	101	5
20.	E	2	25	14.35	Tue	25	20	49	M	20	60	2
21.	E	1	28	15.50	Fri	6	21	52	M	21	48	2
22.	E	2	25	10.35	Fri	30	22	57	F	22	6	6
23.	E	2	27	12.35	Thurs	30	23	61	M	23	95	5
24.	E	1	24	12.45	Fri	20	24	69	M	24	78	5
25.	C	2	25	10.40	Mon	20	25	36	M	25	56	2
26.	C	2	25	10.30	Wed	20	26	50	M	26	75	2
27.	C	2	24	14.30	Thurs	30	27	51	M	27	63	5
28.	C	2	28	16.50	Wed	10	28	58	M	28	75	5
29.	C	2	28	16.30	Fri	10	29	60	M	29	65	6
30.	C	2	25	16.20	Sun	10	30	59	M	30	7	2
31.	C	1	26	16.30	Wed	50	31	67	M	31	53	5
32.	C	1	28	20.30	Wed	25	32	71	F	32	97	5
33.	C	2	23	22.30	Wed	25	33	74	F	33	99	5
34.	C	2	24	10.40	Fri	15	34	75	M	34	5	5
35.	C	1	28	16.30	Tues	25	35	76	F	35	88	5
36.	E	2	24	14.30	Fri	15	36	73	M	36	32	2
37.	E	2	23	10.30	Tue	20	37	37	M	37	66	2
38.	A	1	26	10.30	Wed	15	38	53	F	38	91	5

There were in total 38 rounding observations completed, followed up with 32 patient interviews, 20 males and 18 females. In total 34 staff interviews were undertaken involving eight band 6 ward sister/charge nurses, 13 band 5 staff nurses, therefore a total of 18 registered nurses, 14 band 2 nursing assistants and two band 2 housekeepers. When a band 6 performed the rounding they were the nurse in charge of the ward. The majority of the observations were performed Monday to Friday between 10.30 and 18.30 with two observations being carried out later in the evening; two observations carried out at weekend. Twenty one observations were performed on ward 1 with 17 observations performed on ward 2. From the total of number of rounds observed 20 were performed by a registered nurse and 18 by non-registered staff. The 38 observed rounds had the potential to examine 1064 patient rounding's as each round was performed on a 28 bed ward, however as table 18 demonstrates not all 28 patients on each round had a rounding visit therefore from the 38 observed rounds a possible 895 rounding visits were included within the observations.

Nurse observer C was most active undertaking 11 observations compared to nurse observer A, 9 observations, nurse observer E, 7 observations with nurse observer D, 6 observations and nurse observer B, 5 observations.

In order to present greater clarity of data, the sequential data research codes (1-38) are used to link interview and observational data to the staff member (S1) performing the rounding, with the patient experiencing the rounding visit (P1) and observation of the rounding on the ward (Obs1) (table 18).

5.3 Applied analytical processes

An overview of the analytical process stages is presented in the previous chapter (figure 2) of data reduction and synthesis. These processes were applied to the data, and using examples to confirm credibility and trustworthiness of the data, analysis was progressed from the initial descriptive conceptual indexing and coding, cultural domain analysis, organising the taxonomy of the domains, analysing the components (patterns, similarities and contrasts) between cultural themes/domains, through to searching for links and

relationships within the cultural setting.

5.4 Initial descriptive data indexing and coding

In the initial analytical stage I indexed and coded the field notes data from each of the nurse observers using the social situation dimensions of the descriptive matrix (appendix 3) and table 20 provides an example of this focusing on the social situation dimension of Space. This was repeated for the nine major dimensions of social situation (Spradley 1980) exposed within the observational data (see examples for Activity, Goal and Feeling: tables 21-23 respectively, appendix 22).

The information in table 20 illustrates a complex and multi-factorial processes with both positive and negative attributes being associated to the practice of rounding in the study setting. From the indexing and coding of the descriptive data sets the next stage of the process was making a domain analysis.

Table 20: Concept of Space - descriptive indexing and coding

Nurse observer A	Nurse observer B	Nurse observer C	Nurse observer D	Nurse observer E
Stood next to patients in bays but didn't go inside rooms (Obs1) Didn't enter side rooms, asked is there anything I can do from the doorway (Obs2) End of bed didn't enter side rooms (Obs3) Didn't go into the side room (Obs4) Stood next to the patient, physical contact when needed (Obs5) Stood at end of bed, didn't go into side room (Obs6) Stood next to patients not at the end of the bed, went into side rooms (Obs7) Didn't walk in side rooms, stood at the end of the bed (Obs8) Swivelled round in the middle of the bay asking all patients if they were ok (Obs38)	Stood at end of bed, stood outside side room doors, no physical contact with patients except 2 patients (Obs9) Documentation completed at the bedside (Obs9) Stood next to the patient, documentation completed by the bedside (Obs10) Stood at door to ask patient if ok, no physical contact, documentation completed at bedside (Obs11) Physical contact with some patients (Obs12) Documentation completed at bedside, stood close to patients there was no physical contact with patients (Obs13)	Documentation completed as each patient visited, at bed space rounder stood next to patients and went into side rooms (Obs14) NA stood at end of bed, no physical contact documentation completed at each patients bed space (Obs15) Documentation completed as each patient visited, rounder stood at the end of the bed, no physical contact (Obs16) Rounder stood at end of bed, no physical contact, documentation completed at bed space (Obs17) Documentation completed at bed space, rounder stood near to each patient, door way for side rooms no physical contact with patient (Obs18) Rounder stood very close to each patient documentation completed at bedside, no physical contact with patients (Obs19)	For all but two patients stood at the end of the bed (Obs20) The NA stood at the end of the bed for patients inside rooms she stood in the doorway and did not go into the room she carried the clipboard with her (Obs21) When approaching patients in the bays the charge nurse went up to each patient and spoke to them at their own level (Obs22) When approaching patients in side rooms, the charge nurse spoke to them from the doorway (Obs22) Patients again in the side room was spoken to from the doorway (Obs23) Patients in bays was spoken to from either the end of the bed or the nurse stood next to the patients (Obs23) The nurse walked round with the clipboard and spoke to every patient (Obs23) The nurse spoke to the patients at their level and at the side of the patients bed or chair (Obs24) Patients inside rooms was spoken to at the bedside infection control precautions were followed (Obs24)	Patients in side rooms rounding questions done from the door on two occasions not very personable reduced interaction between nurse and patient (Obs25) Touched patients (Obs25) Approached all the patients calmly (Obs27) Interacted calmly professionally got close to all patients (Obs27) Posture nurse stood holding the clip board in front of her possibly gave the impression of creating a barrier (Obs27) Stood in middle of 10 bed bay, nodding at patients and asking if they were ok asked the question from the door way (Obs29) Into the side rooms to ask (Obs30) Knocked on the door of the side rooms, sat next to patients (Obs32) Staff busy too busy to go in the side rooms, all documentation completed at the bedside (Obs33) Asking questions at bedside seemed noisy in view of the quietness, Knocked on doors before entering (Obs35) Stood at end of bed in bays to ask question, didn't go into side rooms if door shut (Obs36) Asked if patients were ok stood at end of bed or doorway (Obs37)

5.5 Making a domain analysis and cultural domains

Domain analysis aims to discover small elements or categories of cultural meaning. This involved examining the indexed and coded descriptive data sets, and the smaller categories for terminology identified as a cover terms, which related to the practice of rounding in the social situation. The cover terms identified included;

- Rounder
- Patient
- Intervention
- Interaction

Using the cover term rounder for example different kinds of rounder were identified from the data, under the rounder domain table 24 provides examples of different terms used to describe rounders; revealing domain components (included terms) such as a brief rounder, a conversational rounder, a staff nurse, a housekeeper who were all kinds of rounder.

Table 24: Cultural domain rounder

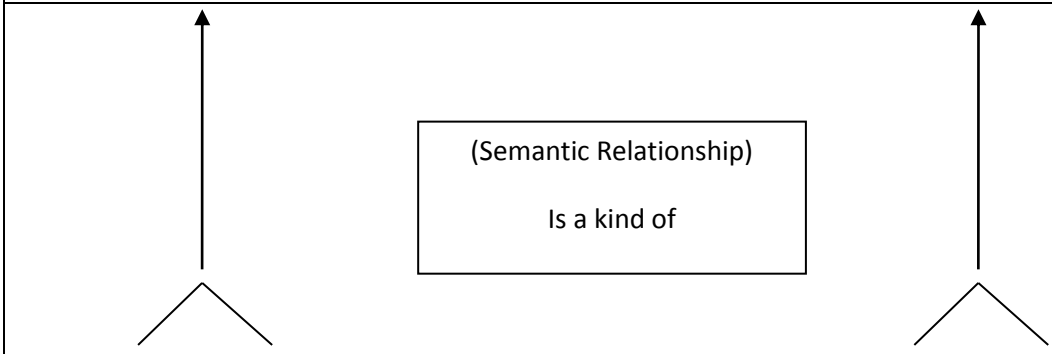
Main Domain - Rounder		
Component of Domain – Rounder (Included terms)		
Sister/Charge Nurse	Knows patients	Reassuring Nurse
Sorter out	Doorway Stander	Introducer
Single Question Asker	Caring Nurse	Chatty Nurse
Physical Contactor	Smiling Person	Staff Nurse
Eye Contacting Connecter	Delegator	Nursing Assistant
Brief Caller	Senior Nurse	Housekeeper
Rushed Nurse	End of Bed Stander	Experienced Nurse
Helpful Nurse		Organiser

Each domain required further definition identifying the semantic relationships or logic

linking between categories/cover terms and included terms within the rounder domain. For example, a semantic relationship was identified by linking brief rounder and rushed nurse in the domain of rounder. A brief caller, a rushed nurse, a doorway stander describe a different type or kind of rounder from housekeeper, senior nurse and experienced nurse, however the cover term, included term and semantic relationship give more meaning to the data, progressing the rounder domain as an example table 25 demonstrates three differing types of semantic relationships identified within the domain of rounder.

Table 25: Semantic relationships within the domain of rounder

(Cover Term) Rounder		
(Included Terms)	(Included Terms)	(Included Terms)
Sister/Charge Nurse	Brief caller	Smiling Person
Housekeeper	Single Question Asker	Eye Contacting Connector
Senior Nurse	Rushed Nurse	Chatty Nurse
Experienced Nurse	Introducer	Physical Contactor
Staff Nurse	End of Bed Stander	Helpful Nurse
Nursing assistant	Doorway Stander	Reassuring Nurse
	Sorter out	Caring Nurse
	Delegator	Knows patients
	Organiser	



The remaining cultural domains and their synthesised cover terms are presented in similar data analysis tables 26-28 (appendix 23).

5.6 Making a taxonomic analysis

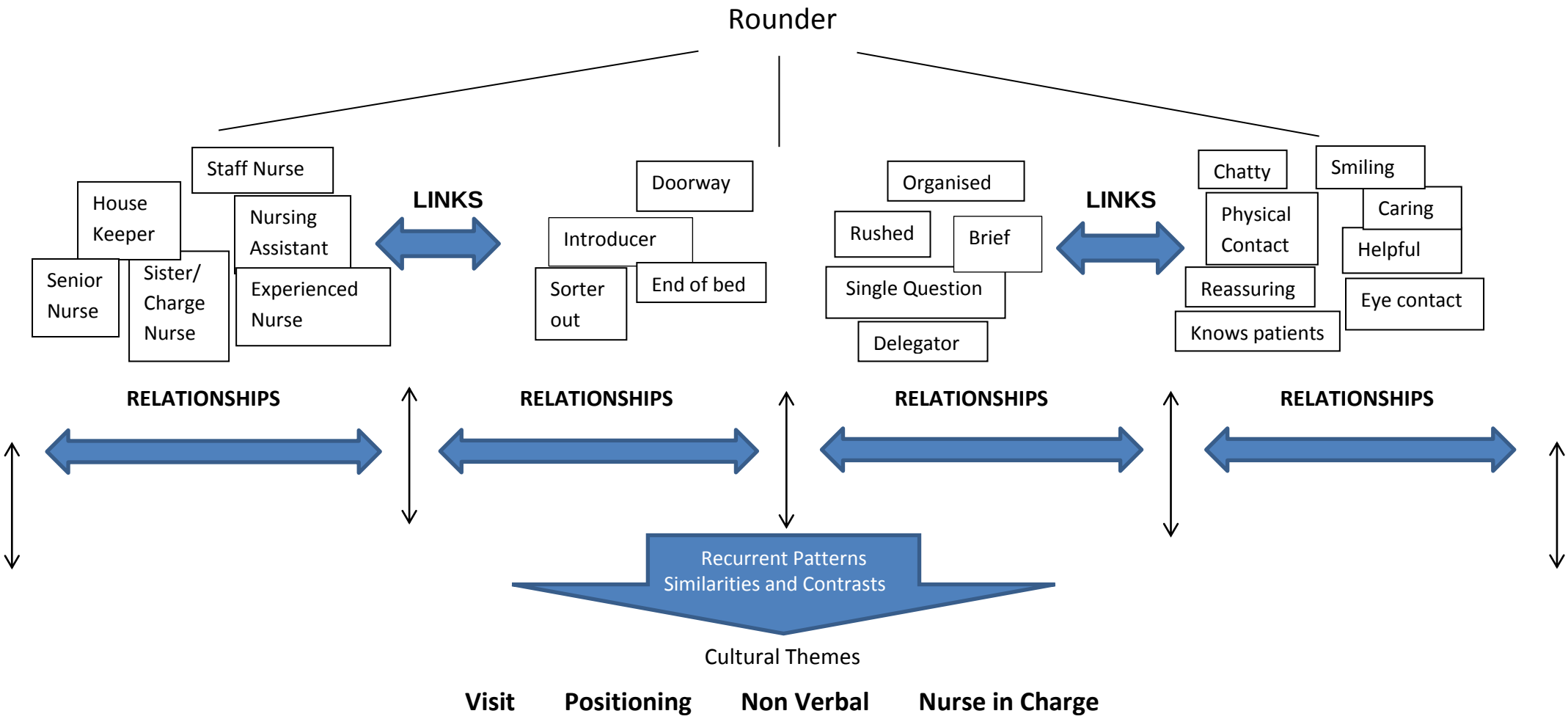
Taxonomic analysis promotes a more in depth search of the identified domains in order to uncover specific the relationships within the domain (Streubert and Carpenter 2011). Taxonomic analysis identified the link and similarities between actors and activities revealing subsets of relationships and how they related to the social situation of rounding on the ward. Figure 3 provides a diagrammatic representation that demonstrates the taxonomic analysis of the domain rounder. I organised the included terms of rounder to show sorts of rounder's, including actors and activities to link the two components together within the social situation. For example, a sort of rounder 'actor' can be identified within the team by their job title. A sort of rounder can conduct themselves their 'activity' in a certain way they can be brief, they can be organised and or they can be chatty. The process of linking activities with actor's flows through to the next process of identifying patterns of relationships within the data classified not just on similarities but also contrasts.

5.7 Making a component analysis

Making a taxonomic analysis uncovers patterns based on similarity, making a component analysis highlights contrast within the domains. Being able to categorise both similarity and contrast is an essential step in the identification of components or small units of cultural meaning (Spradley 1980). My identification of the similarities and contrasts came from revisiting and reviewing the diagrams developed from making a taxonomic analysis of the domains and seeking units of meaning, figure 3.

For example, similarities and contrasts evolved from the band or grade of nurse/experience, proficiency and conduct of the rounder. There was contrast within the grade of the rounder, however there were similarities within the proficiency of the rounder, the rounder could be brief in their role as a rounder, as a nursing assistant or a registered nurse. There was contrast within the conduct of the rounder in that they could be organised or rushed and similarities in that there was the use of non-verbal cues, such as eye contact and smiling. The analytical stages were repeated for all domains (figures 4-6, appendix 24).

Figure 3: Taxonomic and component analysis of the domain rounder



By making a component analysis, subsets of relationships emerged as components or units of meaning for each of the domains (table 28).

Table 29: Summary of component analysis units of meaning

Visits	Positioning	Non verbal	Nurse in Charge
Signalling	Reductionist	Documentation	Response
Non Clinical	Hands off	Team work	Tea round
Conversational	Consideration	Information	Feedback

5.9 Discovering cultural themes

Cultural themes are seen as the truths about beliefs and assertions, and it is important to find recurrent patterns whether tacit or explicit in order to discover cultural themes (Streubert and Carpenter 2011). Spradley (1980 p56) defines cultural themes as a *'recurrent principle, tacit or explicit which operate in the subsystems of a social situation*'. Examining the contrasts and similarities of the features of the component meanings of visits, positioning, non-verbal communication and nurse in charge, I identified that there was the recurrent pattern of presence in both tacit and explicit meaning recurrent throughout the cultural domain of rounder. The visit of the rounder had explicit links to their presence with the patient during the process of rounding. The tacit use of appearing rushed to prevent a prolonged patient visit also connected to the presence or being there with patients as part of rounding practice. Presence or being there were patterns of behaviour and knowledge that have been created as part of the social situation of the ward setting and the practice of rounding in that setting. Therefore, the cultural theme of presence was a new finding or truth to emerge from the data specific to rounding practice in the study setting.

The cultural themes did not emerge as single encompassing themes, but the complex social situation of the ward setting and practice featured a set of integrated themes. From the repeated process of making the domains, taxonomic and component analysis of the data four core cultural themes of Presence, Playing the routine, Actioning care and Engagement emerged as ways of understanding the culture of rounding practice in the study setting.

Table 29 illustrates a summary of the key components of meaning and examples of explicit and tacit meaning that depicts the cultural theme.

Table 30: Identification of four core cultural themes

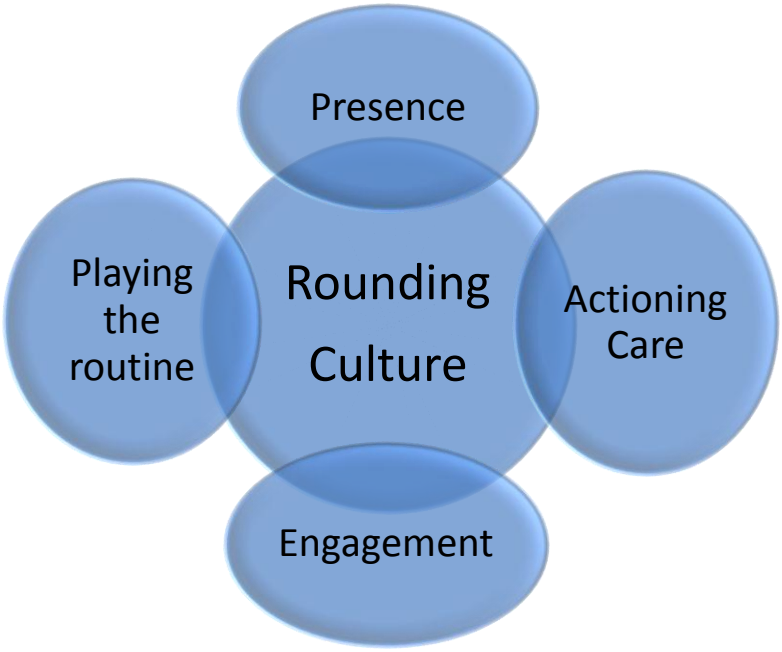
Components of meaning	Example of explicit and tacit meaning	Cultural theme
Visit Positioning Non verbal Nurse in Charge	• The visit of the rounder had explicit links to their presence with the patient during the process of rounding • The tacit use of appearing rushed to prevent a prolonged patient visit also connected to the presence or being there with patients as part of rounding practice	**Presence**
Signalling Reductionist Documentation Response	• The use of signalling had an explicit link to playing the routine • The tacit meaning of using signalling to manipulate patient response also connects to playing the routine	**Playing the routine**
Non clinical Clinical Hands off Team work Tea round	• The clinical intervention had explicit links to delivering care for patients during rounding process • The tacit process of promoting a non-clinical focus to rounding rather than assessing for patient care needs connects to the wider focus of the value and beliefs associated with the rounding process	**Actioning care**
Conversational Consideration Information Feedback	• The conversational nature of the rounder's approach is an explicit link to the rounder's engagement with the rounding process • The tacit consideration of the rounding process to make it as quick as possible is also a demonstration of the engagement with the rounding process	**Engagement**

In summary, examples of descriptive indexing and coding data are presented in tables 21-23, (appendix 22). The cultural domains and their synthesised cover terms are presented in tables in tables 26-28 (appendix 23) and taxonomic domains maps for the cultural themes can be located in figures 4-6 (appendix 24). In the remainder of this chapter each cultural theme is now interpreted and the key findings presented.

5.9 Cultural theme findings

Four core cultural themes, Presence, Playing the routine, Actioning care and Engagement are the focus of the study findings (figure 7). The cultural theme findings combine and construct the data from observations (Obs) coded with the identification number which links the staff (S) and patient (P) participant interviews with the corresponding observation period and nurse observer (table 18, earlier in the chapter).

Figure 7: Rounding culture



5.10 Presence

The culture ascribed to rounding practice in the study setting was revealed in the presence of the rounder with the patient. The units of meaning which built the cultural theme of presence from the data analysis were rounding visits, positioning of the rounder, non-verbal cues and nurse in charge rounds. Each of the units of meaning are examined in order to understand the experience of presence as part of rounding culture in the study setting.

The format of rounding practice involved an intentional process whereby all patients present on the ward, not asleep or otherwise occupied received a visit from the allocated rounder every two hours. The nurse in charge allocates the rounding times to staff at the beginning of the day. The allocation is additional to patient allocation. For the study setting, busy acute wards, the usual patient nurse allocation is one registered nurse and one nursing assistant per seven patients. The nurse in charge doesn't usually have a patient allocation, nor does the housekeeper. The allocated rounder could be a sister/charge nurse, staff nurse, nursing assistant or housekeeper and they should introduce themselves to the patient as part of the rounding process.

The participant observation field notes from the nurse observer's documents indicated the inclusive nature of the rounding visits, and the majority of ward patients received a rounding visit.

> *20 patients rounded, 7 away from bedside, 1 patient asleep (Obs 4)*
> *Number of patients seen 25, 3 absent (Obs 25)*
> *2 patients sleeping, 2 patients absent, 24 patients rounded (Obs 34)*

Patients recognised a regularity of rounding visits but did not appear to have an understanding of the process.

> *They come round every so often and ask you if you are all right and things like that (P 4)*
> *They are always popping in and out (P 15)*
> *They do it every 2 hours or something like that, but I don't really know the point of it (P 38)*

In terms of the amount of presence or quantity time taken to carry out rounding there was considerable variation plus there was variation within the differing staff groups that performed the rounding. The rounder's presence with the patients, the quickest time to complete the rounding for the ward was six minutes the longest 50 minutes with the majority of rounds observed ranging between ten to 30 minutes. This demonstrates that

the time taken with each patient at six minutes for a completed round, was extremely brief and the presence of the rounder with each patient usually lasts only one to two minutes at the most (table 31).

Table 31: Time taken for rounds

Time taken:	Number of rounds	Non-qualified Nursing Assistant Band 2	Non-qualified Housekeeper Band 2	Qualified Staff nurse Band 5	Qualified Nurse in charge Band 6
0-10 minutes	6	4	0	1	1
11-15 minutes	11	4	0	4	3
16-20 minutes	6	4	1	1	0
21-30 minutes	11	1	1	6	3
>30 minutes	4	2	0	1	1
Total	**38**	**15**	**2**	**13**	**8**

Linked to the amount of presence a rounder has with a patient is how the rounder displays their attendance to patients. There are clear differences in the observational data of how a rounder uses their position to display their presence to patients. Examples of the positioning were classified into four elements (table 32).

Some of the different positions were exhibited by the same rounder but to different patients during the rounding process, depending on their location on the ward. For example, observation 29 identified the rounder stood at the doorway of a side room and the middle of a ward bay but not at the end of an individual patient's bed or next to the patient. The observation data indicated the most common and preferred position for the rounder to carry out the rounding process was the end of the patient's bed. On these occasions the presence of the rounder excluded physical/touch contact with patients.

From a number of staff rounder interviews, the significance of the presence of the rounder was linked to the visibility of the rounder to the patient rather than a physical closeness.

We are just checking up on them to see if they are OK (S 23)

Yes, I think they are reassured by seeing us come around (S 30)

The patients are actually seeing us (S 36)

Table 32: Classified positioning of rounder's

Position	Observation	Staff role
End of the Bed	End of bed didn't enter side room (Obs 3) Stood at end of bed, didn't go into side rooms (Obs 6) Nursing assistant stood at end of bed, no physical contact (Obs 15) Rounder stood at the end of the bed, no physical contact (Obs 17) For all but two patients stood at the end of the bed (Obs 20) The nursing assistant stood at the end of the bed with a clipboard (Obs 21) Patients in bays were spoken to from the end of the bed (Obs 23)	Nursing Assistant Staff Nurse Nursing Assistant Staff Nurse Nursing Assistant Nursing Assistant Staff Nurse
Next to the patient	Stood next to the patient, physical contact when needed (Obs 5) When approaching the patients in the bays the charge nurse went up to each patient and spoke to them at their own level (Obs 22) Patients in side rooms were spoken to at the bedside (Obs 24) Knocked on the door of the side room, went into the side room and sat next to the patient (Obs 32)	Housekeeper Nurse in charge Staff Nurse Staff Nurse
Doorway of side rooms	Didn't enter into the side room asked if there is anything I can do from the doorway (Obs 2) Didn't walk into the side rooms (Obs 8) Stood at the door to ask patient if ok (Obs 11) Patients in side rooms asked the question from the door of the side rooms (Obs 29)	Nursing Assistant Nursing Assistant Nursing Assistant Nurse in charge
Middle of the bay	Walked along the middle of the 10 bed bay, nodding at patients and asking if they were OK (Obs 29) Swivelled round in the middle of the bay asking patients if they were OK (Obs 38)	Nurse in charge Staff Nurse

The importance of presence just as visibility rather than presence through physical proximity and touch is further illustrated in the rounding process for patients in side rooms. For the majority of patients in side rooms the presence of the rounder was displayed from the doorway and the rounder didn't enter into the room (table 32). The presence of the rounder at either the end of the bed or side room doorway does limit the interaction between the patient and rounder. Added to this is the relatively short time the rounder is

present with the patient the emerging impression from the data is that the presence of the rounder with the patient is brief, potentially one or two minutes only (table 31) and limited, stood at the end of the bed or in the door way with no physical contact (table 32).

However, the approach to displaying presence to the patients by a smaller number of rounders demonstrated a closer physical proximity to patients which included sitting next to the patient, moving to their level and having physical contact (table 32). This included the going into side rooms to have a closer proximity/physical touch presence with those patients in side rooms (table 32).

Although the observational field notes highlighted differences in the positioning of the rounder to display their presence to the patient, the majority of patients received their own if often brief individual visit from the rounder. For some patients the rounder didn't display individual presence, but positioned themselves in the middle of a bay to collectively round on the patients (table 32). These particular 'middle of the bay rounds' were observed to have been completed by qualified nurses, and when interviewed they clarified the reason was that they knew the patients and had performed rounding several times that day.

> *I know the patients really well and this is my third round of the day (S 29)*
> *The patients know me and I know the patients, I did the previous round (S 38)*

In the staff interviews the rationale of knowing the patients and the patients knowing who the nurses were was used as the reason for the rounder not introducing themselves to the patient, and understandably if you had been caring for the same patients all week there would be no need to introduce yourself.

> *I didn't introduce myself this round because it was half way through the day but once you've been round a few times they know who I am today (S 1)*
> *I didn't introduce myself because I did a previous rounding this morning (S 6)*
> *It goes out of my mind, most of the patients know who we are and we know who they are you don't think to introduce yourself (S 26)*

This could explain why there was variable practice in relation to the rounders introducing themselves to the patients as part of the rounding process, and that was observed and recorded. There was no consistent use of self-introduction to demonstrate their presence to the patient.

Introduced self to all new patients and family (Obs 7)
No introductions (Obs 9)
No introduction of self (Obs 16)
Introduced herself said her name (Obs 20)

As well as rounders highlighting the fact patients already knew who they were as a rationale for not introducing themselves, in the staff interviews it was also highlighted that the rounder thought that being too busy was a prohibitive factor in introducing themselves. Although time taken to say to a patient hello and my name can only take a few seconds. However for these rounders their presence with the patient had other competing priorities which potentially reduced their level of presence with the patient.

I didn't have time to introduce myself or say my name. I have several other things to do besides doing the rounding (S 16)
No I did not do that due to being very busy and having a few admissions to do as well as the rounding to do (S 31)

Patients also identified that nurses didn't always introduce themselves, for some, when the nurses did introduce themselves this was appreciated, potentially enhancing the presence of the rounder.

The nurse smiled and introduced herself. I thought that was lovely, it made me feel relaxed (P 11)
There are so many names and faces I forget who the nurses are so I am grateful when nurses say their name it's more human (P 38)

Although the rounder didn't consistently introduce themselves to the patients as part of the rounding process, there was a consistent use of non-verbal communication to indicate to patients the presence of the rounder. Smiling and eye contact were frequently observed irrespective of the physical positioning adopted by the rounder, the length time of the patient interaction, grade or experience of the rounder. This suggested the rounder felt it was important to make their presence known to the patient. The nurse observer data suggested an impression of a caring presence in their field notes, if often brief.

> *Rushed but smiling, did take the time to make eye contact with all the patients (Obs 8)*
> *Good eye contact, additional conversation, smiling appeared very caring and interactions of a good quality (Obs 19)*
> *Was smiling, good eye contact, she was polite and friendly had a lovely tone of voice when speaking to patients it did convey a caring and compassionate nature (Obs 21)*

The association with an impression of caring was also acknowledged within the data from some of the patients who felt the visits were reassuring, a good idea, they are looking after you. Other patients expanded their comments to cover patients who may not have visitors and the effect of rounding as an adjunct to their usual care.

> *Well I've only been here a couple of days and I have seen it happen a few times and the girls have been really nice and they feel like they are really concerned. Like if you had actually got any concerns they would really want to help (P 21)*
> *Oh yes it does reassure you, yes especially people who don't have anybody coming to see them and sometimes you have a little chat with them it's very, very good (P 28)*
> *Yes, I do because when the other nurses are tied up with other jobs and they are really busy sometimes, a nurse comes round to check you are OK, it is very nice, you feel cared for (P 32)*
> *Yeh, I think it does makes it seem the hospital is taking more care of you in between your doctors and nurse when they are taking your blood pressure and what not, they are monitoring you in a different form, so I think it is very useful that way (P 35)*

In terms of the overall observations no one staff group emerged as performing rounding more frequently than the other, there were slightly more registered nurse rounds (21) than non-registered staff (17) undertaking the rounding (table 18). One of the two housekeepers interviewed reflected that they did more rounding than the nurses but this didn't manifest during the period of the study. This may suggest that during the observed study period the usual rounding allocation was disregarded to reflect a better mix of staff performing rounding. However, it could also be an individual staff member's perception of the rounding allocation.

I do a lot of the rounding many of the nurses don't get involved (S 20)

Within the cultural theme of presence, the observation of practice generated evidence that exposed an important issue arising from the 'presence of the rounder' that was not highlighted in the staff or patient interview data. This was the significance of the nurse in charge performing the rounding. Within the rounding process implemented in the ward settings, there was an expectation that the nurse in charge of the shift should perform a round once, per shift. The nurse in charge was either a band 6, sister or charge nurse.

The presence of the nurse in charge when performing rounding was detailed through the data within the observer's field notes, eight rounds were performed by the nurse in charge. The nurse in charge rounds were often longer rounds (table 31), because they involved increased verbal communication with the patients, and the provision of information for both patients and relatives.

There was the tendency to introduce themselves to patients as the nurse in charge, they sat/stood near to the patient rather than performing rounding from the end of the bed (table 33). It was noticeable from the data that the nurse in charge who took the longest time to perform a round, asked open ended questions which resulted in a better response from patients. In response to not introducing themselves (Obs 29) the sister felt she knew the patients really well and it was her third round of the day.

Table 33: Nurse in charge presence

Code (Obs)	Time (mins)	Position	Introduction as nurse in charge	Observation
1	15	Stood next to patients in bays but didn't go into side rooms	Yes	Answered questions about observations and test
7	30	Stood next to patients not at the end of the bed	Yes	Helped patient who was coughing, found out about cardiac nurse review and cardiac tests
10	30	Stood next to patients	Yes	Sister's presence appears reassuring to most patients
13	15	Close to patients	Yes	Spoke to patient's about going home
14	50	Stood next to patients went into side rooms	Yes	Spent time with each patient, asked generally about the patient which appeared to elicit more response and open dialogue from patient All patients assessed for pain and analgesia offered
18	15	Stood near to patients, doorway for side rooms	Yes	Introduced self, asked question, assessed pain, did engage in conversation, most patients seemed to know what rounding was about
22	30	Went up to each patient and spoke to them at their own level	Yes	The charge nurse had a good sense of humour which the patients responded well to, the patients and relatives then asked more questions about their care, about what the doctors had said
29	10	Middle of bay, patient doorways	None	Removed x1 patient venflon

The emphasis on the presence of the nurse in charge potentially directs the focus of the data to examining further the implications of seniority or experience in relation to the presence of the rounder with the patient. However as with the grade of staff member as either a registered nurse or non-registered nurse the trait of seniority in a role was only

displayed through the nurse in charge role and not in the seniority or experience of the staff nurses, nursing assistants or housekeepers.

Table 31 and 32 demonstrate that there is no conclusive indication that experience and seniority are not prevalent feature of presence in terms of length of time taken to perform rounding or the position the rounder displayed to the patient, it may be the obvious issue that the nurse in charge is the nurse in charge and given the potentially brief interactions of the rounding process the stated introduction as the nurse in charge infers their experience, knowledge and seniority when visiting the patient at the bedside. However within the data and examined further in playing the routine is impression that rounding created additional work and was therefore a rushed process which could influence the key concept of presence. The pressure of work of the rounder's workload could influence the time they take to perform rounding and could therefore affect their presence with patients. What isn't clear from the data is if one particular staff group appeared more rushed due to a heavier workload, from the observation data it was recorded that six of the non-registered rounder's appeared rushed and eight of the registered rounder's appeared rushed.

In summary the cultural theme of presence forms part of the behaviour and values ascribed within the study setting to the everyday practice of rounding. Despite the often brief nature of the rounding intervention and the inconsistent lack of adherence to the process of introducing themselves, rounders appear to generate a sense of caring for patients through non-verbal cues, as experienced by patients, in their rounding presence.

5.11 Playing the routine

The term 'routine' encompasses the action of the rounding, the defined rounding practice associated to the particular study context. This includes the time of the rounding, the two-hour frequency of rounding, an introduction of the rounder to the patient and the use of the questions "Is there anything I can do for you?" and "Do you have any worries or concerns?" A record of the patient visit is documented on the rounding sheet an A3 size chart (appendix 2). Although not explicit in the rounding document as part of the rounding process the rounder is expected as part of their rounding process to check the patients call bell is within

their reach. The cultural theme of playing the routine identified itself through the behaviours and values the ward staff demonstrated when performing the practice of rounding. There appeared to be an accepted and adjusted rounding process which ward staff participated in, as part of the ward culture.

In the cultural theme of Presence the field notes attested to an inconsistent approach to the rounder introducing themselves to patients which some staff attributed to being busy. In playing the routine the rounder's appeared to signal to patients they were busy and patients appeared to adapt their response to this.

One of the most explicit examples of this was from the field note data of the nurse observers in that standing outside the doorway for patients in side rooms was a signal that the rounder didn't want to enter the room to have any further interaction with the patient. This approach was also apparent when the rounding process was carried out in bays.

> *The rounding appeared rushed by the nursing assistant, most patients I believe did not actually ask for anything because they were not invited to do so they were only asked are you okay to which they replied yes thank you or just yes. I got the impression the nursing assistant avoided engaging too much with patients as she was very busy (Obs 11)*
>
> *The patients in side rooms did not make any requests for assistance or engage in any conversation, I did wonder if this was because they were being addressed from the doorway which gave the impression the nurse was in a rush and also does not avail for much confidentiality if patients wanted to talk about worries and concerns (Obs 28)*
>
> *The nurse was busy, had to leave what she was doing to do the rounding this resulted in the nurse appearing distracted and disengaged in the process at times, no patients asked for anything (Obs 32)*

The potential use of signalling by the rounders to patients, to prevent patients asking for further assistance was not highlighted by the rounders as an overt tactic to lessen their obligations of rounding. From the patient perspective it was noted by two patients that

sometimes there was no consideration or reflection given to the patient interaction during the rounding process.

> *No it's just, hi can I do anything to help you, and when you say no they move on, pleasant when they approach, but that's it "Do you want anything?" really it's the same as the first question and they don't go into any depth about it all (P 30)*
> *I don't ask for any help, there's no time for the nurses to talk so it's not fair to put pressure and work on them by asking for extras (P 36)*

Playing the routine was further demonstrated in that some staff (noted in 8 out of the 38 rounding observations) amended and abridged the statement questions explicit in the rounding process. The actual questions used in the rounding process "is there anything I can do for you?" and "Have you any worries and fears?" was reduced in context and combined therefore the most frequent rounding question asked was "Are you ok?" or "Can I help you?" As well as this part of the playing routine the study site culture negated an explanation to the patients of the rounding process which was highlighted in the data from the field notes (noted in 9 observations) and patient interviews. A possible justification for this may have been that staff on the ward, were not fully aware or trained as to the purpose and process of rounding in order to be able to explain rounding practice to patients. From my own experience I know that no formal training in rounding practice takes place, staff had learnt rounding by watching other staff members and a reduced or combined question appeared to have become normal practice. However, rounding is an intentional process with a deliberate and planned structure aimed at achieving defined outcomes. The field notes highlighted this wasn't captured in everyday practice during the study period and that the rounding process seemed a simplistic single question process reduced in length and structure suggesting the value of the rounding process was not fully recognised by all the ward staff.

> *The question wasn't clear but some patients just answer yes but I am not sure they knew the question (Obs 3)*
> *Didn't explain what they were doing (Obs 4)*
> *Some patients appear not to know what "rounds" is about (Obs 12)*

Some patients did look confused when asked is there anything I can do for you, no explanation given about the purpose of the question or rounding (Obs 25)
Some patients in fact quite a lot of the patients looked puzzled when asked if they were ok, some relatives asked what was it all about, reply quite vague and didn't add impact or reason for rounding (Obs 30)

From the observational data there were five occasions when it was noted that patients appeared confused or didn't understand the question that was being asked as part of the rounding process and that no explanation of the rounding process was given to patients. The patient interview data also highlighted the use of an abridged rounding question and a lack of explanation about rounding, leading to a confused process which hindered the patient's response and limited the value of rounding to them.

I didn't know what it was about, if a series of questions had been added I would have been better informed, all the question asked was 'are you okay' and 'do you need anything', you need to know what is provided do you need help with the toilet, do you need help with this, do you need help with that (P 36)
I was just saying, I think you need to change your question, because it's too open ended so you could ask me that but I don't know what the options are so its I don't know whether I can ask you for painkillers for instance or kind of it's a set of list of things to be asked for, so the question may need to be clarified a bit more (P 38)

However from five different observations, all different registered nurses, there appeared to be an awareness of the purpose and process of rounding, with the registered nurses carrying out a more complete rounding process for the patients for that round. These rounds took between 15 to 25 minutes to complete but didn't fall into the category of rounds taking >30 minutes to complete. These rounds included checking the patients call bell was within reach (observed only on six different rounds), however patient call bells being out of reach (call bells out of reach observed on just one round seven time and a noted theme in eight observations) (table 34). These data revealed that this was an important part of the rounding process, ensuring patient call bells are in reach, was often overlooked, potentially not being seen as a key part of the rounding process (table 34).

Table 34: Call bell positioning observation

Call bell position	Observation	Rounder
Within patient reach	Call bells given to patients (Obs 6) Explained to the family what they were doing with the call bell and why they were doing it (Obs 7) Call bell moved for patient if needed (Obs 17) Staff nurse checked the immediate environment of the patients ensuring calls bells were in reach (Obs 24) Put buzzer on beds of sleeping patients (Obs 26) Offered patients buzzers (Obs 29)	Registered nurse = 4 Non-registered nurse = 2
Out of patient reach	Didn't seem to be aware that call bells should be in reach of the patient (Obs 4) No call bells checked (Obs 5) Didn't read the situation ie moving call bells 7 call bells observed to be out of reach, no attempt made to move them within the patients reach (Obs 20) Unfortunately some of the buzzers were out of reach of the patients, the nurse did not pick up on this (Obs 23) Call bells observed out of reach (Obs 27) Didn't see out of reach call bells (Obs 28) No check on patient buzzers (Obs 34) Didn't check buzzers (Obs 36)	Registered nurse = 4 Non-registered nurse = 4

It was difficult to ascertain from the data collected if the reductionist approach practiced by some of the staff related to lack of knowledge or emphasis of the rounding process and the importance of the patient's call bell. Or if there was an inclination to perform the rounding process as quickly as possible as it interrupted or was less important than other aspects of their work. Both observations 27, 28 related to registered nurses who appeared rushed during the rounding observation.

It was worth noting however, from the documentary findings (appendix 20; table 19) that call bell data (number of call bells ringing within one hour) were unfortunately inconsistently collected and therefore has a very limited value in terms of contributing to the study findings. What it does potentially demonstrate and highlight is that there was a difference between measuring an outcome of rounding as reducing number of call bells rung compared with actually observing rounding practice to see if the rounder is checking/positioning call bells within patients reach. The observational data revealed a potentially inconsistent picture in practice which questions the effectiveness of reduced call

bell usage as an outcome measure of rounding as from the observational data not every patient has their call bell within reach to use.

However, the importance of documenting the rounding process, emerged from the data, recorded on a large A3 chart (appendix 2). The chart was a daily chart consisting of tick and code boxes, the chart pertains to patient bed numbers and on the reserve side includes a space for writing free hand any variation to the stated rounding process, including documenting if patients have any worries or fears. The chart is not used within any ward handover process but is kept as evidence that rounding was completed.

The completion of the documentation (on review all 38 rounding observation had a coded entry against each patient and an initialled completion box on the rounding chart for the day and time of the observed round) suggests an importance was attached to the recording of the rounding process which is interesting as the same compliance wasn't observed in relation to following the rounding protocol for example checking the 4 Ps. This perhaps gives the indication that the culture of the study setting was that there was better compliance with the completion and the recording of rounding compared to practicing the correct process of rounding, as discussed already in the findings of the presence of rounder and discussed further in Actioning care theme.

The data from the participant observations presents a clear image of the recording of the rounding process.

> *End of bed, didn't enter side rooms, documentation completed (Obs 3)*
> *Documentation completed at the bedside (Obs 9)*
> *Documentation completed at the bedside there was no physical contact with the patients (Obs 13)*
> *He carried the clipboard and filled in the information on it after speaking to each patient (Obs 22)*
> *All documentation completed (Obs 33)*

The staff interviews didn't highlight the documentation of the rounding process as either a positive or negative experience for the rounder although no specific question about documentation was asked. The premise of the staff and patient interviews were that they were quick interviews that didn't interrupt patient care and therefore they were limited in their scope and range. The questions focused on activities and actions of the nurses/patients during rounding process and not the documentation (appendix 6 and 7). In fact there was no mention of documentation at all in any of the answers given by the ward staff in their interviews. The patients however did mention documentation but in relation to the clip board the documentation is placed on when the rounding is carried out. Patients associated rounding with the clip boards.

Erm these times they come with the boards (P 4)
Oh you mean the clip board club (P 29)
No she just had a clip board and she just asked me if I was okay (P 31)

Hence documentation and the clip board appear to be interwoven into the cultural theme of playing the routine; potentially linking in with the signalling of presence themes discussed previously, whereby rounder's signal their presence to round on patients by presenting with the clip board.

Whilst the data emphasised that rounders played the routine of the rounding process, it was also noted that some patients played the routine of rounding too. This indicated that some patients knew and understood the process of rounding, using this knowledge to choose to participate or not in the rounding process. From the observational data the rounders understood the patient meaning and acknowledged that some patients didn't require a rounding visit.

Patients seemed to know the question before it was asked (Obs 2)
Patients who had been there for longer seem to say 'no' as we walked to the bed (Obs 7)
Some of the patients appeared to be asleep as the support worker approached the bed to carry out rounding (Obs 15)

Indeed, one patient commented that they thought the rounding was repetitive and avoided engaging with the process.

> *I don't think asking someone every two hours if they are OK is right. It's from in the morning till night time, all the time. I usually wander off if I see them coming (P 31)*

The theme of patients playing the routine was also identified by staff who noted that some patients appeared to discourage the rounding interaction. Staff indicated that patients pretended to be asleep or on the phone in order to avoid a rounding visit. From one staff interview it was recognised that for the longer term patients the rounding process may be repetitive and the nurse tried to adapt her approach.

> *The patients see us coming round and some are suddenly asleep or on the phone but most of the time if patients don't want anything they say no thanks (S 24)*
> *Most patients seem to appreciate the rounding and a nurse visiting them, however I do think the rounding process is too rigid for the longer term ones especially if they are able to do things for themselves. We have to visit all the patients on the rounding but some patients don't want a visit they have been asked 'if there's anything I can do for you' loads of times. If the patients aren't pretending to be asleep then I try and make the visit more conversational but not everyone does this. You can see some people doing the rounding and all the patients are shaking their head. It does make the round quicker (S 33)*

It was interesting, as highlighted above that the patients also played the routine of rounding even to the extent of moving away from their bed space or feigning sleep (table 21; appendix 22). The focus of rounding is the patient interaction to the rounding question at their bedside. Patients who are able to play the routine realise if they are not at their bedside or appear to be sleeping the set structure of the rounding process means they are able to avoid the round. These patients appear to be one step ahead of the rounders and prepare their avoidance plan.

The cultural theme of playing the routine suggests that although the rounding process is an established part of the everyday ward practice for all patients irrespective of age and gender the process is exposed to modification to suit some of the staff and patients. The modification of the rounding process may indicate that rounding was not seen as essential to patient care and not fully valued. Rather sadly the correct completion of the documentation appears more important than performing rounding to the correct process, this makes rounding in the study setting potentially just a tick box exercise.

5.12 Cultural theme of Actioning care

The theme of Actioning care revealed the cultural value of the rounding process to care delivery, with rounding being promoted as a method of delivering care to patients. The units of meaning which built the cultural theme of Actioning care from the data analysis were rounding being non-clinical, rounding was a 'hands off' process, teamwork and tea rounds. An important part of the rounding process (but perhaps less explicit than asking the question; 'Is there anything I can do for you?' in the study setting rounding documentation) the rounder is supposed to check and action basic care needs (the 4 Ps) discussed earlier:

- if the patient is in pain
- whether the patient positioned correctly and comfortable in their bed or chair, delivering pressure relieving care
- if the patients call bell is in reach as well as personal possessions so their bed space environment is safe
- if the patient needs to go to the toilet or continence needs are met (falls prevention)

The aim of the 4 Ps is to manage patient's pain, to potentially deliver a better patient experience and prevent patient falls and pressure ulcers to increase patient safety. The rounding documentation used in the study setting does not require any compulsory accountable recording (as discussed in chapter 2) of the 4 Ps care delivery and does not prompt the rounder to ask specific 4 P questions. However, the documentation does

contain codes for 4 Ps actions to be recorded if they were carried out as part of the rounding for the patient (appendix 2). All patient requests are meant to be actioned at the time of the round.

The emergence of this cultural theme revealed that the ward staff didn't fully associate rounding with patient care delivery. The ward culture appeared to point to rounding being a process of generally checking on patients rather than an opportunity to action care. Rounding from the observations, staff and patient interviews came across as a 'hands off' process rather than 'hands on' care delivery. Part of this theme interlinks with the cultural theme of presence and the lack of physical contact with patients whilst staff were rounding however this element of 'hands off' rounding process on the ward adds a further dimension to describing practice. It also potentially questions the impact or significance of the rounding process to patient care delivery and the nurse sensitive outcomes that rounding is expected to positively affect, in particular falls and pressure ulcer prevention.

From the documentary data findings there is no identifiable reduction in the rates of patient falls or pressure ulcer prevalence which could suggest that rounding practice did not have any impact on reducing patient harm. From the observational data there was little evidence of patient's position being changed as part of the rounding process or patients being helped with toilet needs, possessions being close by in order to prevent patient falls. If there are no consistent actions within the rounding process to prevent these patient harms it is difficult to reduce rates of harm. However as identified in the literature review and methodology (chapters 3 and 4) falls and pressure ulcer prevention are multi factorial practices and it is difficult to isolate an individual intervention to make the causal link between a particular identified intervention and a reduction in these patient harms.

In terms of the patient satisfaction experience measures the documentary data does show some improvement in the patient satisfaction scores with pain management, one of the 4 Ps. However, assessing and managing patient's level of pain was not highlighted as a consistent practice within the observational/interview data. An alternative suggestion could be that the management of patient's pain is through a different care delivery method other than rounding practice namely the patient nurse allocation. So the nurse allocated to caring

for the patient for that shift manages the patient's pain requirements and pain management is not carried out via the rounding process.

The 'hands off' nature of the rounding process is further illustrated by the field notes of the observers whose findings demonstrated that for some of the rounds no actions or patient requests occurred, therefore no physical or clinical care needed to be delivered. In many instances the rounds involved verbal and non-verbal communication with patients with only a small number of actions required.

18 patients visited, no actions required (Obs 1)
One patient wanted to know about their discharge (Obs 14)
Only one patient wanted a urinal (Obs 17)
Two cups of tea asked for (Obs 26)

However the lack of care giving during the rounding process was also expressed through the patient and staff interviews.

No, I didn't want any help (P 14)
No the nurse didn't really do anything for me but I didn't need anything (P 18)
I said nowt cos nine times out of ten I don't (P 28)
Nope I didn't need anything (P 38)

I turned the air con off for a patient I got some towels for a patient (S 6)
Just made a cup of tea for the patient and contacted the nurse looking after the patient to answer a question (S 8)

Although the rounding process seemed strongly associated with 'hands off' care there was some evidence of clinical care delivery within rounding but these were observed to be more isolated episodes of action. However this potentially linked to the individual rounder having a greater adherence to the rounding process through asking the 4 Ps questions. The observational data highlighted four occasions when registered nurses actioned clinical care.

Helped a patient who was coughing (Obs 7)

All patients assessed for pain and analgesia offered (Obs 14)

One patient breathless, the rounder took the patients vital signs and reassured the patient (Obs 18)

Patient with chest pain, immediate intervention sought and actioned, excellent prompt response to the patient. Patient hadn't complained re chest pain until asked by the nurse rounding (Obs 25)

Interestingly from a staff interview a registered nurse highlighted the difference in staff grade, registered nurse compared to non-registered nurse as the rationale for rounding appearing to be a 'hands off' none clinical process. The staff nurse felt that:

I think it's better for the (registered) nurses to do the rounding, only because they can ask you questions like related to drugs and blood pressure which they did and I was able to look at them and discuss with the patient, I was able to check the patient's blood pressure and reassurance them. If that was a housekeeper or a nursing assistant they could get distracted because they couldn't follow up, it makes sense for the nurses to do the rounding, they are able to do things there and then or contact the right person in order to contact the patient or relatives question (S 31)

An interview with a sister also reflected the view point that the registered nurse rounds were more focused on clinical issues and care. This statement potentially links back to the previous discussion about presence and the importance of the nurse in charge round. The appreciation of the nurse in charge presence is linked to the nurse in charge round is perceived as being able to action more care issues and information about care issues for the patients.

As the nurse in charge I am asked a lot of questions about clinical care patients ask me about checking their dressings, their medication, what the doctor said on the ward round but I do make sure I check patients clinical care, I always check if patients need turning when I do the rounding, I check the and update the fluid balance charts as well (S 1)

A nursing assistant however suggested that it was the nursing assistants who delivered the care which comes out of the rounding process. The nursing assistants wear green uniforms and the staff nurses blue uniforms.

> *They know the ones in green are there to be able to get anything they need and stuff. The ones in blue are busy with medications and things so patients know that when we come round we are able to help with their needs if we needed to (S 36)*

The 'hands off' culture of rounding practice was not only demonstrated by the lack of care actions requested by patients but also by the identification of the concept which emphasised how rounding appeared to be actioning patient requests rather than a structured patient assessment process. From the question "Is there anything I can do for you?" rounding was more of a patient initiated request process rather than the rounder assessing patient needs related to the 4 Ps.

Elements of the presence of the rounder, time with patient, positioning, abridged rounding question and lack of 4 Ps assessment, as discussed previously would potentially reinforce the 'hands off' element of the rounding process in the study setting. The rounding process in the study setting because of the emphasis of the "Is there anything I can do?" question focuses mainly on a patient request basis to respond to care needs rather than the rounder's assessment of patient need through the 4 Ps assessment structure. This then results in a rounding process where it is generally only patient requests that are actioned (as discussed many patients don't request anything from the rounding process and as discussed some patients don't understand the rounding question) hence the 'hands off' culture is developed compared to actioning care which results from the 4 Ps assessment which would potentially lead to more 'hands on' care requirements for the patients.

The issue of a patient request process rather than a care delivery process is attended to in the observational data and both patient and staff interviews. In many of the patient interviews the patients describe being asked if they needed anything and the staff interviews focus on patient requests.

The observational data highlights when actions resulted from rounding the actions that were resulting from patient requests. There with only a few examples of care delivery resulting from rounder assessment rather than patient request. This accentuates a general 'hands off' behaviour being demonstrated by staff when performing rounding.

Only did what patients ask, didn't assess the situation ie moving bed tables closer, call bells within reach (Obs 8)
Patient wanted an extra blanket (Obs 18)
Patient requested bed to be made (Obs 25)
Patients who were unwell following a procedure had less interaction on the rounding, could have spent more time assessing and questioning (Obs 35)

I judge what I need to do by the answers they gave me when I asked them if they were okay (S 5)
The actions depend on what they want me to do (S 19)
I ascertain patient needs by speaking to them (S 27)

She just asked me if I was ok and was there anything they could do for me (P 6)
The nursing assistant just asks me how I am (P 11)
No they just ask me if there's anything I want (P 30)

Although the 'hands off' approach emerged from the data, there are examples of rounder assessment taking place but these illustrations were noted less within the data.

Patients all assessed for pain and analgesia (Obs 19)
I thought it was really nice that the rounding was individualised and that she has remembered to ask about pain and other assessment questions relevant to each patient, the nurse was looking out for things such as opportunities to update fluid balance chart's, empty catheters, she clearly had awareness of the bigger picture (Obs 23)

The identification in the study setting of the 'hands off' approach to rounding potentially suggests that rounding is not seen as central care delivery process based on patient assessment but rather an adjunct patient request service.

A further feature of the cultural theme Actioning care was significance attributed to the rounding process as part of team work within the study setting. In the previous section there was a discussion that highlighted that both registered staff and non-registered staff actioned patient's rounding needs. Within the data there was evidence to suggest that teamwork does exist as part of the rounding process but there was also evidence to suggest any actions resulting from rounding were left to the individual rounder to complete. As part of the rounding process any actions arising from the rounding interaction with the patients are meant to be performed at the time by the rounder rather than allocated to another staff member.

From the observational data there is no prevalent approach, both the carrying out of actions by the individual rounder was illustrated as was the allocation of actions to other staff members.

> *Rounder allocated some of the jobs to the support worker (Obs 14)*
> *Staff nurse, no one else helped (Obs 17)*
> *The charge nurse dealt with these request himself at the point of contact with the patient (Obs 22)*
> *The staff nurse dealt with all the requests as soon as the patients asked him this was mainly for information and refreshments (Obs 24)*
> *Sister allocated some jobs to the nursing assistant who was free (Obs 37)*

The rounding observations elicited good examples of team work but to balance this there were also instances of poor team work

> *Some nurses didn't seem to act on the jobs/actions asked by the nursing assistant (Obs 2)*

The staff nurse allocated to the bay helped the nursing assistant with the rounding (Obs 6)

Nursing assistant requested staff nurse to help her apply cream as she was not sure if it was prescribed (Obs 15)

There appeared to be a lack of teamwork amongst the staff when patients needed registered nurses for pain relief, the nurses would not assist the patients if they were not their own nurse and also seemed annoyed, frustrated at being interrupted from other tasks such as paperwork in order to assist patients I got the impression that some did not regards rounding as important, too busy to help with it (Obs 20)

When the patients requested refreshments, urine bottle or pain relief the nurse went off to get these herself and other staff also offered assistance (Obs 23)

Within the staff interview data there was an acknowledgement that nursing assistants needed to escalate some actions to registered nurses but this wasn't seem as a difficulty:

I was able to help the patient to the toilet but I asked the staff nurse about the prescription (S 9)

I asked the staff nurse for help as I wasn't sure about the patient request, the staff nurse helped me (S 15)

The patient interview data didn't explicitly link into the issue of teamwork however there was a degree of frustration in two patient's comments related to the issue of actioning not being completed or being delayed which could be an indication of a lack of team work.

Sometimes there are long delays if you asked for something, if one nurse cannot sort something out and so another nurse has to do it, it can take a long time (P 26)

Err sometimes it depends on who is doing it because sometimes you ask for something and you don't get it anyway (P 38)

The discussion on the findings related to the feature of team work depicted an indistinct practice in relation to rounding. There is observational and staff evidence to identify team work in association with the process of rounding, however patient interviews and

observations identify that team work practice is not consistently clear. The lack of importance of team work within rounding practice potentially points to a study setting culture where although rounding is practiced on a frequent day to day basis it is not viewed as essential team practice but more a peripheral activity which each individual rounder needs to completed rather than requiring support from the team.

The final consideration in the cultural theme Actioning care, relates to a feature about the type of care or actions which result from rounding. This feature has been discussed to an extent within dialogue of the findings from the 'hand off' approach to rounding and the issue of team work. The actions from the rounding process are however still worthy of individual discussion because of the illumination of the main actions resulting from the rounding process. Examples of the differing types of action observed, by staff band are highlighted in table 35. The table demonstrates a varying list of actions which have been categorised into clinical, toileting and hospitality actions, there doesn't appear to be any obvious link to action and band of nurse.

Table 35: Examples of differing types of actions observed

Clinical			Toileting			Hospitality		
Obs code	Band	Action	Obs code	Band	Action	Obs code	Band	Action
10	6	IV pump	6	5	Bedpan	14	6	Towel/razor
11	2	TED stocking check	9	2	Toilet	15	2	Phone
			12	2	Commode	16	2	Tea/drinks
14	6	Medications	17	5	Urinal	19	5	Pillow
15	2	Mouth care				26	2	Blanket
25	2	Dressing				31	5	Tissues
						33	5	Food

Within the observational data the prevalence of providing patients with refreshments and in particular cups of tea is highlighted as the most frequent action (seven out of 38 observations) this was a surprising finding.

Three patients wanted things, hot tea, call bell and back to bed (Obs 6)

Made coffee for a patient who had missed the 'tea round' (Obs 10)

Cup of tea for two patients (Obs 16)

Things asked for two cups of tea (Obs 26)
Seven patients wanted tea despite the tea trolley round being recently completed (Obs 33)
Patient wanted a drink (Obs 34)

The prevalence of hospitality type actions as part of the rounding process was noted in the staff interviews, including the potential need to take the tea trolley as part of the rounding process.

Some of them had brews and stuff but yes it's probably best if I take the tea trolley round as well rather than going back to the kitchen (S 26)
Fetching a drink, cups of tea, that kind of thing, possibly toileting (S 28)

Two patients described these actions as another level of care and comfort.

It's a small thing but my water jug never seems to be here when I have tablets to take, so I ask for a cup of tea, it's like they are really looking after you (P 29)
Yes, one of the young ladies who came round asked me a question, hello xxxx do you need anything, I did say yes I would like a cup of tea and she went out and made me a cup of tea and that was absolutely beautiful, it's that little bit extra, that little bit of help goes a long way for patient comfort (P 36)

Although not as predominant as the 'cup of tea' actions resulting from the rounding process other actions observed did have a hospitality type focus (table 35) rather than a clinical care focus although as discussed previously some clinical care was provided as an action from the rounding process. Further actions resulting from the rounding process related to patient requests with assistance for hygiene needs in particular male patients requested assistance with shaving.

From the observational data and the staff/patient interview data the minority of actions resulting from rounding were clinical actions. As discussed previously there were examples of the clinical assessment and resulting clinical actions due to rounder patient interaction

but considering the focus of the 4 Ps within the rounding process these were less prevalent. Again this potentially highlights that within the study setting rounding was not viewed as a clinical care delivery method by the staff. Within the process of rounding there did not appear to be a systematic assessment process within the structure of rounding and no consistent link to patient safety issues, particularly the safety aspect of preventing the avoidable harms of falls and pressure ulcers. The generality of the 'Is there anything I can do for you?' and 'do you have any worries or fears?' questions which were often then paraphrased to 'are you ok' moves the rounding process away from a clinical focus that results in clinical actions to a process which answers patients requests for cups of tea. The consequential culture within the study setting potentially views rounding practice as a glorified tea round.

5.13 Cultural theme of Engagement

The final cultural theme identified from the ethnographic analysis of the data is engagement, exploring how staff and patients engaged in the rounding process. The themes of Presence, Playing the routine and Actioning care, overlap and have Engagement aspects embedded for example concerning the position of rounder to being 'hands off' that influence the level of engagement between staff and patients. The level of engagement both staff and patients have with the rounding process has the potential to influence patient and staff satisfaction/experience. The components of meaning that built the cultural theme of engagement were the conversational aspect of rounding, the consideration given to rounding practice, the link to rounding and patient information and patient feedback.

One of the main issues that the data drew attention to was how the ward staff engaged in the process of rounding from the importance placed on rounding and how rounding was completed as a series of tasks almost in isolation from the main care delivery method.

The rounding process on the ward was carried out two hourly by an allocated staff member, this was usually a different staff member each round. The allocation of staff to a round took place at the beginning of each day, at the start of the early shift. This would be a different

allocation to the nurse and nursing assistant allocation for the group of patients they were caring that each shift. However there were times when the allocation for rounding hadn't taken place (eight out of 38 occasions), and there appeared to be no volunteers to do the rounding, or rounding allocation was a secondary consideration. This was an important issue as the nurses/nursing assistant allocated to those patients wouldn't have performed the rounding in the absence of an allocated rounder, rounding was not considered essential to patient care.

> *No rounding completed since 8.30 (time was 13.30) no staff allocated to rounding (Obs 6)*
> *Rounding allocated to nursing assistant but had gone on her break at the time of the rounding (Obs 8)*
> *Rounding started late registered nurse keen to complete her tasks with patients first (Obs 28)*
> *No one allocated to do the rounding so the sisters did the round (Obs 29)*

Indeed nurse observers commented on these eight occasions they felt it was their arrival on the ward that prompted a round to start or take place. The nurse observers also noted that during these occasions there were no emergency or urgent situations on the wards which would have focused staff priorities differently.

Rounding often was seen as a separate consideration of work outside of the nurse patient allocation, the manner staff engaged with the actions resulting from rounding was interesting. The approach to the actions appeared to be a task related duty which required very little follow up or feedback to the patients allocated nurse. Contributing to this may be that actions resulting from rounding were considered mainly non clinical issues however given one of the questions in the rounding process to patients is 'do you have any worries or fears?' the link to the allocated nurse does seem important. The lack of consideration could suggest a degree of insignificance was attached to rounding because resulting patient responses were seen as inconsequential requiring very little documentation or feedback. Rounding was seen as a tick box of questions and actions which required very little engagement or commitment from the staff allocated to perform the rounding. This was

emphasised in the interaction of the rounder who stood at the end of the patient's bed or didn't go into side rooms (table 30).

For all but 2 of the patients stood at the end of the bed (Obs 20)
Patients in side rooms rounding question done from the door (Obs 25)

From the viewpoint of the nurse observer this did prevent or stifle opportunity for patient discussion or disclosure about any worries or fears they may have as there was often a lack of any privacy between the patient and rounder.

Staff nurse did ask the worries or fears question but the whole bay could hear the nurse patient interaction, the nurse was standing at the end of the bed (Obs 21)
Worries and fears question was delivered in a matter of fact way as the nursing assistant stood with the clip board in front of her (Obs 27)
Patients were asked are you ok do you have any worries or fears. I felt the question was asked without meaning to them (Obs 35)

For many patients the worries and fears question wasn't asked as a separate rounding question but wrapped up with the 'is there anything I can do for you' question to make 'are you ok' which wouldn't necessarily mean patients would talk about their worries or fears.

There were only two observed instances when patients did want to talk about their worries or fears and the different approach of the two rounder's perhaps highlights the need that staff should be at an appropriate level of staff to perform rounding or in particular ask the worries and fears question;

Patient said they were concerned about their test results, the sister was able to reassure the patient, she sat next to the patient and explained what the tests results may show, then went back to the patient after looking up the test results and talking to the doctors (Obs 14)
Patient voiced a lot of worries and concerns the rounder appeared uncomfortable and out of her depth because they were medical problems this may have come across

as a lack of sympathy as the rounder appeared to have no engagement with the patient when the patient was quite upset (Obs 20)

It was noted that for some of the rounds (ten out of 38) the worries and fears question was not directly asked as part of the rounding process. Also from the observations of rounding the process within the study setting patients were not usually provided with the space or time to speak about their worries or fears (table 31 and table 32). It appeared that patient contribution in terms of discussing their worries or fears was negated through asking abridged rounding questions (eight observations) or due to a degree of patient confusion related to the rounding question (five out of 38 observations) or by asking in a manner which marginalises the patient contribution. Within the study setting it could suggest staff do not appear to consider this part of the rounding process as a particular dimension of compassionate care. The staff did not seem engaged in the exploration and interpretation of patients feelings as part of the rounding culture in the study setting.

Rounding appeared to be practiced on a more superficial information giving level where patients engage in the opportunity to seek information from nurses but related to providing housekeeping issues, updates on care/treatment or checking on information previously given. However this did appear to be valued by the patients. Asking for information was noted as a fairly frequent action of rounding if patients didn't require any physical intervention from a rounding visit.

Patient wanted to know about their discharge (Obs 13)
The patients asked him for information (Obs 24)
Patients wanted the simplest of things information re discharge (Obs 25)
Explained to patients about being nil by mouth (Obs 34)

I don't usually need anything as I can get up and do things but it's useful to ask about what's happening, I wanted to know when my doctors were coming round (P 5)
No I didn't need any help… but I did ask about my test results (P 14)

The nurses are busy so when they come round I can ask them when I am going home, I am keen to go home so I do ask them when they come round, I am going home today (P 19)

From the staff point of view, often when asked if they had engaged in any activities from rounding, information giving was not seen as engagement with patients or an act or activity associated with rounding as compared to providing tea, toileting or any clinical care.

I wasn't asked for anything on this round, a patient asked for information about their discharge (S 1)
No nothing on this rounding, the patient asked me for information about when he was going down for his procedure (S 27)

The difference between the patient and staff emphasis on patient engagement with information giving as part of the rounding process is of significance. Patients appear to value the opportunity to engage staff in questions about their care more than the staff. These questions the patients ask don't appear to relate in particular to the worries and fears question but from more of a need to know what is happening. Most of the staff within the study setting appeared not to value this regular communication aspect of rounding negating its importance to patients except perhaps as discussed earlier, the nurse in charge round perceived information giving to be important part of their rounding process. The requirement for information from patients potentially illustrates that there may be a lack of communication in respect of information giving from the ward staff and that the rounding process affords additional opportunity for patients to meet their information needs but currently the rounding process only partially meets this need.

A further dimension of the engagement within the rounding process that appears to be valued particularly by patients is the use of banter and jokes within the rounding process. This would suggest for some patients they welcome the conversational, chatty communication aspect of rounding as a way to engage with the ward staff. Indeed rounding for patients offered a degree of social interaction value which is not recognised formally in the rounding process.

Some nurses have a joke it shows they know you (P 14)

Its good when they come round you can have a laugh and joke with them, it makes the day better (P 24)

I like talking about everyday things not just hospital stuff (P 26)

The appreciation of a conversational, chatty style to rounding potentially fits with the patients appreciating a brief regular presence of the ward staff which is informal compared to a formal protocol led assessment. It may be that the construction of engagement with patients during the rounding process, from the patient's viewpoint, needs only to be brief and informal to convey engagement, caring and consideration. This aspect of rounding is also recognised by two staff and was also highlighted from observation

I always feel that rounding goes very well because its communication with the patients (S 8)

I like to feel I show a genuine interest in patients as you learn more about their concerns (S 23)

For many observed instances of rounding the nurse observers noted that patients appeared to appreciate the rounding visit even if it was brief as long as the rounder smiled and added some other brief conversation.

Caring, friendly, smiling, good verbal and non-verbal skills, added general conversation (Obs 3)

The nurse engaged in general conversation and used humour which the patients appreciated (Obs 25)

In terms of the patient satisfaction as a patient experience measure the documentary data does show some improvement in the patient scores for communication and the overall satisfaction rating. As discussed previously this may be related to the increased number of patients surveyed and it is difficult to attribute this perceived improvement to rounding practice. The observational and interview data highlighted the lack of focus within the rounding process on asking if patients 'have any worries or fears' hence there is no

correlation between observed practice in the study setting and any improvement in communication scores.

It was observed and come through in two interviews that staff enjoyed the conversational, chatty aspect of the rounding process and that some staff commented how patients thanked them for their help during rounding.

The patients seem really appreciative (S 17)
Patients say thank you for your help (S 25)
Many of the patients said thank you to the nurse (Obs 17)
Patients said thanks for asking (Obs 30)

Some patients engaged in the rounding process as a way to acknowledge the nurses contribution to their care and their gratitude to them. This could potentially enable the ward staff to feel the process of rounding was valued by the patients and that their role in rounding was important to patients.

The one measure from the documentary findings which may link to patient and staff engagement with rounding practice is the slight increase in the overall patient satisfaction score. Again it would be difficult to prove a causal link and the potentially large numbers of variables affect the overall patient satisfaction score but the observational and interview data did suggest patients valued the process of rounding and hence this may affect the overall patient satisfaction score. However this could not be substantiated until a direct link between patient satisfaction and rounding was identified.

As a cultural theme Engagement highlights how the rounding interaction is constructed, within the study setting there is a degree of task and routine applied to the rounding process. Staff commitment with the process appears not to consider and even to preclude the rounding process from their main systems of care delivery and team work. However the nuances of the rounding interaction potentially emphasise the important aspects of rounding practice which patients appear to value. These are the role of the rounder as an information giver and the informal conversational style of the rounding process.

5.14 Summary

The findings from the merged data strands of observation, patient and staff interviews combined to provide a rich multi dimension illustration of the truths and beliefs of rounding practice in the study setting. The key findings present new knowledge about the process of rounding in the study setting which have been discovered through an applied research process. The discovery of the four key cultural themes (presence, playing the routine, actioning care and engagement) has been constructed through the examination and discussion of the units of meaning (table 29) that form the subsets of relationships in complex social situations.

The findings are important as they offer insights into a nursing practice that has not previously been examined in terms of a naturalist paradigm and therefore this knowledge can add to the vibrancy of the discourse related to the practice of rounding.

It has been difficult to interpret any substantial findings from the historical documentary data. The documentary data findings have not been able to directly attribute variations in the highlighted outcome measures to rounding practice in the study setting. The main problem is that isolating variables which may affect the link between rounding practice and set outcomes is very challenging in a clinical setting. A summary of the study key findings are captured in table 36.

Table 36: Key findings

Presence
• Patient contact is minimal and usually carried out from the end of the bed or side room door way
• Nurse in charge round 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 it was introduced, the 4 Ps are not part of the rounding process
• Rounding practice does not appear to influence rates of falls, pressure ulcer prevalence or patient satisfaction
• Rounding is not seen as integral to delivering patient care
• Rounding is a glorified tea round
Engagement
• Patient value brief regular visits from staff
• Patients see rounding as caring
• Social element to rounding

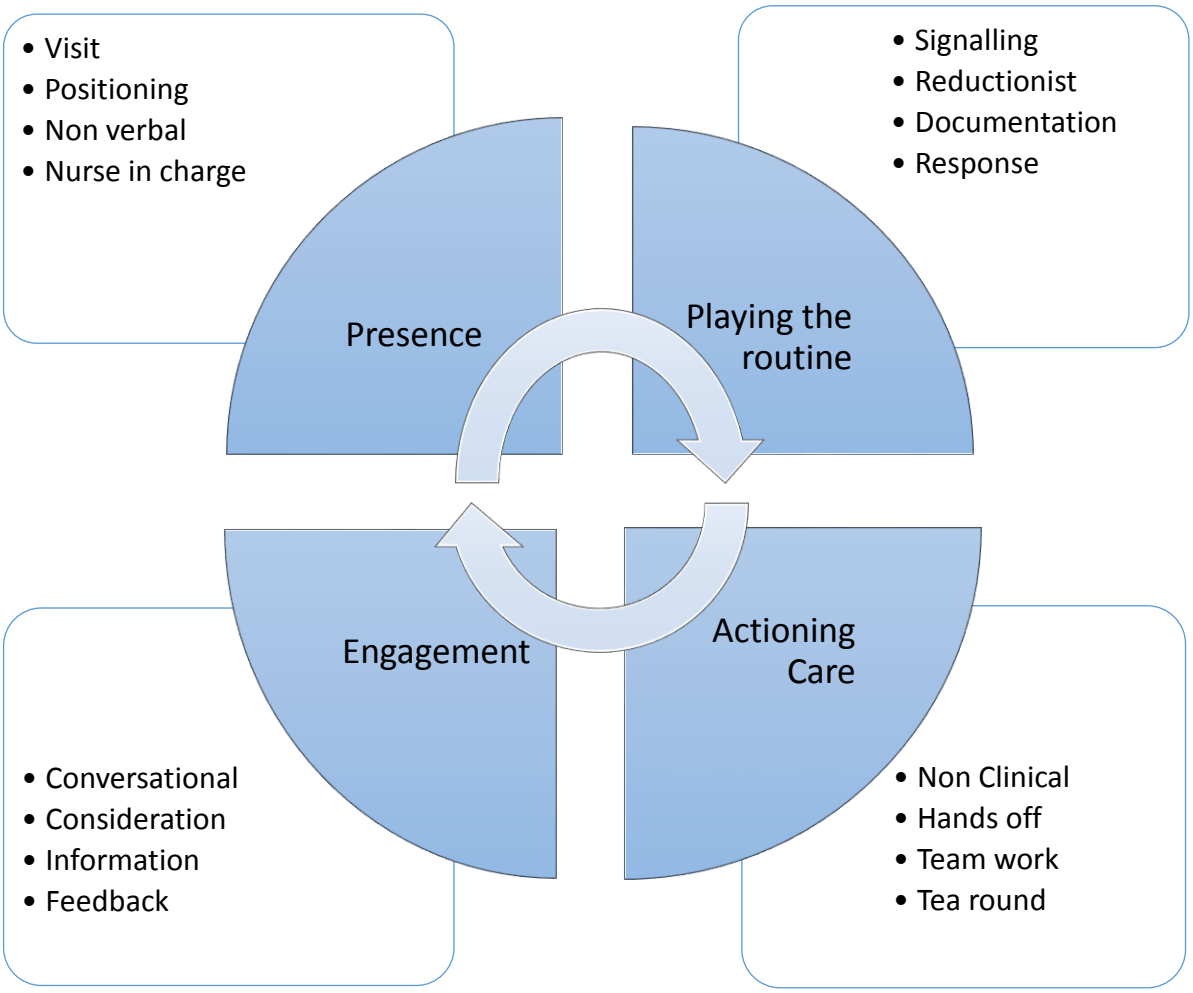
Now that new knowledge about the practice of rounding has been exposed this new learning can be contextualised in terms of the current evidence base about rounding practice to synthesise a greater appreciation of rounding and its potential benefits to nursing and patient care. The findings will be discussed in the next chapter.

Chapter Six: Rounding knowledge and new cultural insights

6.1 Introduction

The findings chapter presented evidence of new knowledge discovered by this in-depth study of rounding practice culture. Four key cultural themes were exposed each with four key sub-themes (figure 8) and these form the focus of this discussion chapter.

Figure 8: Cultural themes and sub-themes



This chapter discusses the findings of the study in the context of current literature and generates deeper insights and learning about rounding practice, extrapolating potential

benefits to patient care. The parallels with current literature are examined but more importantly the contrasting and deeper explanatory evidence exposed by this qualitative study challenges the meaning of rounding to nursing care and patients. The cultural themes and sub themes interconnect to form the complex reality of day to day practice. The strength of my study methodology and analysis process was to expose the nuances of the practice setting and draw out for discussion the potential gaps in practice which limit our present understanding of rounding practice. The existing evidence and indeed these study findings articulate potential patient benefit through defined outcomes. However, the discussion of the findings generates debate as to the meaningful relationship of rounding practice to clinical nursing care and also uncovers new knowledge regarding the social impact of rounding for patients within this study setting.

6.2 Presence

The cultural theme of presence was built on the foundations of four component constituents:

- Receiving a rounding visit
- Positioning of the rounder
- Non-verbal communication
- The role of the nurse in charge

Each of these constituent elements have been previously exposed within the literature (Meade et al. 2006; Bourgault et al. 2008; Sobaski et al. 2008; Tea et al. 2008; Woodward 2009; D'Alessio et al. 2010). However, this in-depth study highlighted a divergent and modified rounding practice is actually observed in 'real life' where the presence of the rounder to the patient can at times be limited.

The majority of published studies on rounding have been conducted from a quantitative perspective, the limitation of which is the lack of detailed findings relating to the presence of the rounder. In contrast studies from the deductive paradigm (Neville et al. 2012;

Rondinelli et al. 2012) indirectly addressed the issue of presence through staff/patient questionnaires and interviews; not using 'real life' data gathered from direct observation of the rounder patient relationship and presence. Other studies note the observation of rounding but provide limited evidence of a structured observational methodology (Blakley et al. 2011; Sherrod et al. 2012; Tucker et al. 2012; Brosey and March 2015). Apart from my study, Deitrick et al. (2012) Harrington et al. (2013) and the pilot study of Goldsack et al. (2015) were the only studies that directly monitored the rounding process in practice enabling a structured focused observation of how staff were performing rounding. The rounding visit, the position of the rounder, non-verbal communication, and the role of the nurse in-charge are cultural concepts that warrant further explication and discussion.

6.2.1 Receiving a rounding visit

The study found an important part of the presence of the rounder was that a patient actually received a rounding visit. Rounding, according to Sobaski et al. (2008 p332);

> *'…is the planned action of nursing staff visiting each patient on a predetermined schedule.'*

The study findings indicated an inclusive process whereby the majority of the patients, in a busy acute ward setting, received a rounding visit, and patients recognised the regularity of the visits. Staff compliance with the practice of rounding was observed to be high and rounders were physically present with patients, on a regular basis. However, in many studies the compliance with rounding practice was not directly observed but measured through the completion of documentation or rounding logs (Meade et al. 2006; Sobaski et al. 2008; Krepper et al. 2012; Tucker et al. 2012). The exception is the study by Goldsack et al. (2015) which abet for a short period directly observed high compliance rates with documentation completion. Meade et al. (2006) on one hand suggested a high compliance with rounding through the completion of documentation, but then discarded data from units where documentation was poorly completed, maintaining there were still high levels of nurse presence. Tucker et al. (2012) reported lower compliance rates with documentation and suggested nurse presence was lower. Similar to Meade et al. (2006), although it is unclear, is whether this was related to documentation compliance rather than

compliance with the rounding process, as interview data reinforced that documentation was burdensome. Walker et al (2015) identified from direct staff feedback data that compliance rates with documentation were low as there was little time available to complete the documentation. Deitrick et al. (2012) and Fabry (2015) highlighted that nurses were present with patients during rounding and compliance with the process was high, but that documentation didn't provide a contemporaneous record of nursing presence with the patient as the rounding documentation was completed at the end of a shift. Observing direct compliance of nurse presence with the patient during the rounding process, then confirming this through patient and staff interviews provided an enhanced methodology for identifying the extent of the nurses' physical presence within the rounding process. The study setting revealed a culture to promote regular patient visits, the basic premise of rounding practice. In contrast Walker et al. (2015) highlighted that nurses felt they had a presence with patients during their usual care delivery processes and rounding presence with patients wasn't required.

Only one previous study (Harrington et al. 2013) has examined the amount of time the nurse was present with a patient. My study demonstrated that the presence of the nurse could vary, from being brief, sometimes with ward rounding's performed in ten minutes, or longer than 30 minutes (table 31). In contrast Harrington et al. (2013) exposed generally shorter rounding times of five to ten minutes, although the context of the study was unclear, the number of beds within the ward setting of the study was not identified. The process of rounding was incorporated within the primary nurse patient allocation, the nurse allocated to care for the patient performed the rounding compared to this study where the rounding allocation was in addition to the nurse patient allocation. The variety of time taken with a patient, particularly less than one minute raised questions whether the such a short presence could be either clinically or otherwise meaningful for the patient. Current rounding literature links the physical presence of the rounder to a patients enhanced perception of nursing care (Meade et al. 2006; Sobaski et al. 2008; D'Alessio et al. 2012; Neville et al. 2012). Interestingly, Rondinelli et al. (2012) found that an unintended outcome of their study was also patient's perceptions of being cared for. In the UK anecdotal evidence from Hutchings et al. (2013) suggests that even from brief rounding visits patients were reassured that nurses are caring for them.

My study evidence directly observed the presence of nurses to patients and confirms existing literature that rounding visits take place and there is a presence of the nurse with patients. This study identified, in terms of patient experience, that the patient's themselves did recognise the regularity/presence of a rounding visit, even if this was a brief visit.

> *They come round every so often and ask you if you are all right and things like that (P 4)*
> *They are always popping in and out (P 15)*
> *They do it every 2 hours or something like that, but I don't really know the point of it (P 38)*

There wasn't, however always an understanding of the rounding process from the patient's perspective. Through the direct examination of the nurse patient process of rounding both staff and patients were able to identify the presence attached to a rounding visit even if it was brief.

> *We are just checking up on them to see if they are OK (S 23)*
> *Yes, I think they are reassured by seeing us come around (S 30)*
> *The patients are actually seeing us (S 36)*

The premise that most patients receive a visit is only one component feature of the cultural theme Presence a further component of presence which the study revealed was the importance of positioning as part of the rounder's presence, indeed the position of a rounder could directly influence the length of time or presence of a rounding visit.

6.2.2 Position of a rounder

The positioning of the rounder when performing a rounding visit to a patient has received scant attention in the literature, reflecting the lack of direct observation of rounding in practice. An additional reason may be because many US studies took place in hospitals where most patients are nursed in side rooms and the rounding protocol directs the rounder to enter the patient's room although without direct observation it is unclear if this actually occurs in practice (Meade et al. 2006; Studer Group 2007; Weisgram and Raymond

2008; Olrich et al. 2012; Rondinelli et al. 2012). The findings from this study exposed a culture of rounding practice which meant that the presence of the rounder's visit to the patient was identified through the visible positioning of the rounder, rather than a physical touch closeness. The rounder either stood at the end of the patient's bed, doorway of a side room or in some cases the middle of a bay (table 32). For the majority of the rounding observed the position of the rounder was at a distance, reducing physical proximity to the patient, reinforced within both staff and patient interviews. The implications of this lack of physical proximity positioning to the patient indicated that the patient assessment in terms of the 4 Ps was potentially limited, and sensitive conversation difficult for patients to share across a ward, thus potentially rendering a rounding visit of little value to those with unmet needs. The extreme illustration of this practice was the positioning of the rounder in the middle of a patient bay to do their round. At this level the patient doesn't have an individual visit so it was interesting to note if in terms of enhanced patient's perceptions of care if rounding practice as a brief visit at a doorway or end of the bed, was sufficient for their needs. In addition, the distance of the rounder suggested a lack of time, potentially encouraging patients not to engage in the process (discussed in more detail later). However, it was observed that even with a distant position some patients indicated issues (such as a need for information, a drink, or use of a commode) which then required closer physical proximity of the rounder. Therefore, the distance of the rounder, although potentially restrictive, was not an issue for some patients. However one of the nurse observers commented that the distant positioning didn't provide much confidentiality if patients wanted to talk about their worries or concerns. The literature indicates that presence is linked to a patient's enhanced perception of care (Sobaski et al. 2008; D'Alessio et al. 2012). The removed and varied position of the different rounders has not been identified in other studies prior to my examination of positioning so the link between rounder position and the patient experience of being cared for has not been understood. My study suggests that no matter where the rounder stood their presence was understood by patients to be caring and that similar to Rondinelli et al. (2012) the lack of physical proximity did not appear to influence this perception of enhanced care or being cared for.

An important part of rounding protocols is the introduction of the rounder to the patient (Meade et al. 2006). However, within the study setting the introduction of the rounder to

the patient was not an established practice, nor did it seem sensible to continue to introduce yourself to people who knew you and you came in contact with regularly. Collectively the nurses indicated they knew the patients and the patients knew them so an introduction wasn't required. This practice did not reflect the protocol of the study setting or other study rounding protocols where introducing yourself was considered essential (Meade et al. 2006; Studer Group 2007; Weisgram and Raymond 2008; Olrich et al. 2012; Rondinelli et al. 2012; Harrington et al. 2013). It was interesting to note that none of these studies raised the issue of rounder's not introducing themselves. This may be because in 'real life' people don't introduce themselves to people they know each time. However, because these studies didn't observe rounding processes it was assumed that rounding takes place as per protocol which I would strongly question is a false assumption underpinning current evidence. However the short pilot study by Goldsack et al. (2015) is able to offer a degree of substantiation to compliance with the elements of a rounding protocol, their observation of rounding revealed a high compliance with staff greeting patients but other elements of the protocol were completed less frequently. Fabry (2015) also surprisingly concluded that compliance with the greeting element of the rounding protocol was high despite some controversy with the use of protocols or scripts.

The ethnographic study by Deitrick et al. (2012) observed rounding being performed in practice. However, the study didn't address the issue of adherence or performance of the detailed elements of the rounding protocol but was limited to focusing only on the entry of the rounder into the patient's room and hourly signature of the rounding log. Other studies that concurred that rounding logs weren't completed were not sensitive enough to identify which aspects of the rounding protocols may or may not have been completed (Blakley et al. 2011; Kessler et al. 2012; Tucker et al. 2012; Harrington et al. 2013; Walker et al. 2015; Toole et al 2016). Whereas, my rounding study revealed the authentic detail of rounding in the practice setting, played as real life and not unseen by the observer.

This was an important finding as the new details of the rounder patient relationship during the rounding process highlighted a reality of rounding practice that was contrasted with much of the current literature, as well as the protocol for rounding practice developed within the hospital. Staff in the study setting linked the visibility of themselves to the

patients as part of rounding rather than physical touch closeness. It would appear that the rounding process in practice had been adapted and modified in terms of the rounding process documented in the literature and indeed to the rounding practice initially implemented within the study setting. This modification and adaptation is not through lack of compliance with the process, most patients are receiving a rounding visit but it is through adapting the rounder positioning during the visit. It is also interesting to note the positioning perhaps reflects more of the positioning of a medical ward round where an end of the bed position is adopted as part of practice rather than close physical proximity to the patient.

The distant position of the rounder, suggested a lack of time to perform the round, and staff interviews reinforced that rounding at times detracted already busy nurses from a heavy workload. A way of managing this pressure was to perform the round quickly at a distance. Current evidence pays some attention to staffing levels when examining rounding, and the impact on the quality of rounding practice poor staffing levels may have (Meade et al. 2006; Sobaski et al. 2008; Halm 2009; Woodward 2009; Harrington et al. 2013). However, there are no conclusions offered in terms of whether staffing levels affect better or poorer rounding practice and/or if there was an influence on patient satisfaction, although it is acknowledged further work is needed to examine potential links (Sobaski et al. 2008; Harrington et al. 2013). Snelling (2013) supposes an either or scenario of rounding working better when there are good staffing levels or rounding could produce more beneficial effects where staffing levels are poorer. From my study a patient interview offered the view that rounding for them was beneficial if the nurses were busy.

> *Yes, I do because when the other nurses are tied up with other jobs and they are really busy sometimes, a nurse comes round to check you are OK, it is very nice, you feel cared for (P 32)*

However, being too busy was seen by the nursing teams as one of the prohibitive factors to performing rounding in this study setting. Often the reality of rounding practice was that visits were being performed from doorways/end of beds instead of next to patients to save time. This reality of rounding practice is far removed from the ideals of some authors who

proposed that rounding saved time and therefore gave nurses more or free time (Meade et al. 2006; Culley 2008; Blakley et al. 2011). Walker et al. (2015) and Toole et al. (2016) acknowledge the impact of time constraints on the ability to perform rounding. This is also an emerging theme although not scientifically proven from the UK studies that time constraints can affect the ability of staff to perform rounding (Crossfield and Pitt 2012; Dix et al 2012; Lowe and Hodgson 2012; Dewing and Lynes O'Meara 2013; Kenny and Norton 2015).

6.2.3 Non verbal communication

An important part of presence, highlighted by this study, was the use of non-verbal communication. This has not been identified in previous studies. From my findings rounders may not have been physically close to patients or introduced themselves consistently, but the use of non-verbal communication was regularly observed and used to promote the presence of the rounder to the patient. The observational methodology of the study exposed the use of non-verbal communication through smiling, eye contact and demonstrated there was an emotional awareness or presence between the rounder and the patient. This happened even if verbal communication was limited and the rounder was not in close physical proximity to the patient. Non-verbal communication was often used to promote the presence of the rounder and visibility to the patient, but is not listed as an expected action in the study site's rounding protocol.

Woodward et al. (2009) provided the only protocol for rounding practice which specifically emphasised eye contact and the personable demeanour of the rounder. Although, Bourgault et al. (2008) in addition to patient assessment, scripted that the rounder convey a friendly attitude through positive verbal communication and body language. Other studies encouraged less specific face to face time with the patient and the importance of the rounder to demonstrate an individual connection and attentiveness with the patients (Meade et al. 2006; Sobaski et al. 2008). In this study, through non-verbal communication rounding practice, and the regular visits of a rounder, conveyed a sense of caring, positively identified by the patients and nurse observers *(rushed but smiling, time to make eye contact obs 8; smiling appeared very caring, interactions of a good quality, obs 19)*. The culture of

the acute ward setting meant that even though rounding practice was often rushed, brief individual patient encounters had a caring value attributed to it.

The observational methodology of the study enabled this important finding to be discovered and then triangulated by the patient's voice.

> *The nurse smiled and introduced herself, I thought that was lovely, it made me feel relaxed (P 11)*

Much of the existing literature on rounding does not provide the detail of the rounder patient interaction at a focused clinical level. The rounder patient interaction, often theorised in many papers, has been measured through third party patient satisfaction surveys, which do not sufficiently capture or isolate the 'real life' rounding interaction (Meade et al. 2006; Sobaski et al. 2008; Tea et al. 2008; Gardner et al. 2009; Woodward 2009; D'Alessio et al. 2010; Blakley et al. 2011; Neville et al. 2012). Indeed, Snelling (2013) argues that patient satisfaction is a poor indictor of evaluating the patient experience, and this was confirmed through the documentary data (table 19) that it was difficult to identify a definitive link between rounding and patient satisfaction as a measure of patient experience. However, examining the social and cultural mechanisms governing behaviour (the constructionist perspective) provided evidence of the value patients placed on non-verbal communication; such as smiling and eye contact, conveying caring as a feature of the rounding culture. It was perhaps that rounding practice showed the presence of the rounder to the patients, the patient feels they are being regularly checked and acknowledged even though this can be brief, this action in itself conveys attention and caring to some patients.

> *Well I've only been here a couple of days and I have seen it happen a few times and the girls have been really nice and they feel like they are really concerned. Like if you had actually got any concerns they would really want to help (P 21)*
> *Oh yes it does reassure you, yes especially people who don't have anybody coming to see them and sometimes you have a little chat with them it's very, very good (P 28)*

Yeh, I think it does makes it seem the hospital is taking more care of you in between your doctors and nurse when they are taking your blood pressure and what not, they are monitoring you in a different form, so I think it is very useful that way (P 35)

This practice of rounding was different to that described by Meade et al. (2006), which details a set process relying on physical close patient proximity, touch and a listed patient question schedule. Although with the Meade et al. (2006) and similar replicated studies there was no observed evidence, other than completed documentation, that rounding in practice was actually being delivered as per the process, whereas in my study the regular patient visit appeared to be the essence of rounding. The focus of the study methodology on the ethnographic observation of the rounder and patient interaction, in particular the descriptive matrix (appendix 3) enabled the frequency of visits, the position and non-verbal communication to be exposed and closer scrutiny compared to existing studies. My own reflexivity, experience and the collaboration of the nurse observers generated a grounded data collection tool which provided a unique and rich vein of data for the study.

6.2.4 Role of nurse in-charge

The presence of the nurse in charge undertaking rounding once a day emerged as a significant influence on rounding practice. At the study hospital the nurse in charge round had been initiated as part of the hospital wide introduction of rounding in April 2012. For each shift/part of the day the nurse in charge was to complete a patient round, particularly during visiting times, this was not necessarily the ward manager although it could be if they were also in charge of the ward. The nurse in charge round could be undertaken by a band 6 sister/charge nurse or a more senior band 5 (for this study all the nurse in charge rounds were undertaken by a band 6 sister/charge nurse). The rationale for this was to provide patients and relatives with an opportunity to address specific concerns which they felt a more senior nurse needed to deal with. The observational data, the staff interviews and the patient interviews all highlighted the nurse in charge round to be an important component of daily rounding practice. The nurse in charge rounds were usually longer, more verbal communication and more information given than on the non-nurse in charge rounds (table 33). Significantly, on most occasions the nurse in charge introduced themselves as the nurse in charge plus tended to sit/sat nearer to the patient than the end of the bed. The

presence of the nurse in charge as part of the rounding process appeared to benefit the patients as they are able to ask questions and seek information which other staff when rounding, particularly non-qualified staff, were perhaps not able to provide. The nurse in charge was the focal point for information during the shift, for example attended the doctors rounds, spoke with bed managers and discharge coordinators. This was an important finding from the study as the current literature does not appear to focus on the role of the nurse in charge as a significant factor in the experience of the rounding process.

The research evidence has examined who performs rounding in terms of registered nurses and or non-registered nurses (Bourgault et al. 2008; Gardner et al. 2009; Sobaski et al. 2009; Dietrick et al. 2012; Neville et al. 2012; Sherrod et al. 2012; Forde-Johnson 2014; Fabry 2015) and this is discussed further in the teamwork section. However, only Woodward (2009), examined rounding being performed by senior nurses as a comparator to other staff within the ward setting. The rationale for the nurse in charge performing rounding meant that activity would not detract time away from the primary nurse patient allocation workload if they had to perform rounding in addition to their patient allocation (Woodward 2009). This was a different approach from the study setting where registered nurses caring for an allocated patient group and allocated rounding duties along with the nursing assistants, housekeepers and nurse in charge, although both study settings were acute wards. In the Woodward (2009) study the nurse in charge rounding provided an experienced nurse to supply specialised knowledge and assessment skills to the rounding process. The charge nurse completed the rounding two hourly throughout a twelve-hour shift compared to the nurse in charge rounding once per shift in the study setting. Other studies within the literature acknowledged a link between senior nurses and rounding however this was related to checking the compliance of rounding practice and leadership of the implementation process rather than considering the value of the nurse in charge round (Culley 2008; Tea et al. 2008; Blakely et al. 2011; Deitrick et al. 2012; Kessler et al. 2012; Olrich et al. 2012; Rondinell et al. 2012; Walker et al. 2015; Toole et al. 2016). My study builds on the work of Woodward (2009) by providing new insights into the nurse in charge role and describing its merit as a constituent feature of the rounding process within this particular culture of the acute ward study setting.

6.3 Playing the Routine

The second cultural theme of playing the routine was built on the foundations of four component constituents:

- Signalling
- Reductionist
- Documentation
- Patient response

The identification of the cultural theme of playing the routine may be a some what controversial finding that originated from this study. The four component constituents which underpin the cultural theme exposed a rounding process which contrasted significantly with the documented protocols within the literature (Meade et al. 2006; Bourgault et al. 2008; Murphy et al. 2008; Tea et al. 2008; Sobaski et al. 2009; D'Alessio et al. 2010; Kessler et al. 2012; Tucker et al. 2012; Brosey and March 2015; Goldsack et al. 2015). The examination of the playing the routine culture revealed a divergent and modified rounding experience, an adaptation of rounding practice which raised questions as to the importance of rounding to nursing practice in the study setting. The discussion of the cultural theme of presence has already highlighted a minimalist process which heavily relied on non-verbal communication to intimate the attendance of the rounder to the patient. Playing the routine uncovered a rounding experience which re-inforced a minimalist process, including signalling to patient's that rounders' were busy, and reducing the rounding questions to short closed questions. Through the in-depth examination of the rounding culture it appeared completing the rounding documentation was seen as an important part of the rounding process. Some patients even adapted and adopted strategies to avoid rounding which could suggest the rounding process potentially lacked the flexibility to meet individual patient need.

6.3.1 Signalling

There could be some extenuating factors within the study setting that have contributed to this finding, to begin with the hospital rounding sheet (appendix 2) didn't explicitly emphasise the requirement of 4 Ps assessment process. There was an intensity of staff education when rounding was implemented about the assessment requirement but there has been little subsequent staff education about rounding to reinforce this element. The importance of staff education to the sustainment of rounding is recognised in the literature as a significant component of effective implementation (Fabry 2015; Walker et al. 2015; Toole et al. 2016).

From my study findings the rounding experience observed would not be recognisable as structured rounding protocols cited previously if it wasn't for the regularity and perhaps sadly the focus on documentation observed within the study setting. Of course with the deductive paradigm prevalent within the current literature it was difficult to say if this was a wider observed reality of rounding practice at a clinical level, but it was an important new finding from this study. Some studies, as previously discussed, do report that adherence to the process of rounding protocols was problematic suggesting that rounding practice is not strictly adhered to (Blakely et al. 2011; Kessler et al. 2012; Tucker et al. 2012; Harrington et al. 2013; Walker et al. 2015; Toole et al. 2016). However, no studies highlighted a practice similar to what was observed within this study setting where it appeared that the rounders signalled to patients that they are too busy to engage with the rounding process. Indeed, by standing at a distance or outside the patient room the impact of patient requirements that could result from a rounding visit, were reduced or contained. A rounding visit had taken place, the rounder had been present to the patient however, by the rounder's signal to the patient it resulted in no care as in the 4 Ps had been delivered but communication with the patient had been minimal. This was exposed from patient interviews.

> *No it's just, hi can I do anything to help you, and when you say no they move on, pleasant when they approach, but that's it "Do you want anything?" really it's the same as the first question and they don't go into any depth about it all (P 30)*
> *I don't ask for any help, there's no time for the nurses to talk so it's not fair to put pressure and work on them by asking for extras (P 36)*

This contrasts sharply with the purpose of rounding as postulated by Sobaski et al. (2008 p333):

> *'With a scheduled rounding protocol, the nursing staff has a reason to enter a patient room on a regular basis. This will help form a connection with the patient, facilitating a relationship between patient and nursing staff, which leads to more open communication of the patient's needs.'*

By constructing the detail of the patient rounder encounter my study was able to expose the experience of an adaptive practice of rounding not previously reported within the literature.

6.3.2 Reductionist

A further constituent of playing the routine uncovered was that the clearly articulated question which was part of the rounding script "is there anything else I can do for you? was reduced to "are you ok?" or "can I help you?" (noted in eight out of 38 rounding observations). The additional question used within the study setting "Have you any worries or fears?" was also covered by the use adapted phrases, so even the two rounding questions were reduced to one, then minimised further. Both of the adapted phrases could affect patient response as there was a high degree of generalisation within the questions "are you ok?" or "can I help you?" which could potentially lead to patients not knowing how to specifically respond to the questions except with a generalised answer which was often either just yes or no. In addition, an explanation of the rounding process from the rounder to the patient was absent (noted in nine out of 38 rounding observations) and patients were confused by the rounding process (noted five out of 38 rounding observations). There was scant literature to compare and contrast these study findings other than the previously discussed lack of adherence to completing rounding logs or documentation. Harrington et al. (2013) reported rounding process taking between five or ten minutes which may provide evidence to suggest that rounding practice in their study was also a reduced process. In contrast Goldsack et al. (2015) observed high compliance rates with some elements of their rounding protocol and the majority of staff (77%) surveyed by Fabry (2015) agreed that rounding was consistently performed.

The adherence to the 4 Ps was an essential part of the rounding process (chapter 3). Halm (2009) makes the point that if the 4 Ps are not intentionally addressed then there will be no difference to the outcomes related to care attributed to the 4 Ps (reduced patient falls, reduced pressure ulcer prevalence, reduced call bell usage for toileting/hygiene needs and improved pain management). Examining the rounding process within the study setting revealed that the 4 Ps were not routinely addressed as part of rounding, in the study setting rounding was a reduced process with the 4 Ps assessment largely absent from practice, reflected in patients' comments.

> *I didn't know what it was about, if a series of questions had been added I would have been better informed, all the question asked was 'are you okay' and 'do you need anything', you need to know what is provided do you need help with the toilet, do you need help with this, do you need help with that (P 36)*
> *I was just saying, I think you need to change your question, because it's too open ended so you could ask me that but I don't know what the options are so its I don't know whether I can ask you for painkillers for instance or kind of it's a set of list of things to be asked for, so the question may need to be clarified a bit more (P 38)*

This highlights the importance of knowing the deeper detail of the nurse patient interaction during the rounding process and how this needs to be described and understood. The literature and even the hospital protocol for rounding detail a process which is not the reality or truth of the experience in the study setting. Potentially the expectations on the outcomes of the rounding process were unachievable because the rounding process practised does not address patient care in a method that would affect those outcomes. It may be that for some studies that reported inconclusive results from measuring rounding outcomes (Culley 2008; Ford 2010; Olrich et al. 2012 Sherrod et al. 2012; Tucker et al. 2012) there was not sufficient attention paid to the consistency and detail of the rounder and patient interaction to ensure the rounding process practiced actually addressed the outcomes that the study was measuring. There may be more reductionism and more adaptation of the approach to rounding process being practiced than is realised in many practice settings.

A well-documented aim and outcome of rounding was to reduce call bell usage but also for patients to have their call bell at hand should they require them to summon assistance (Meade et al. 2006; Studer Group 2007; Torres 2007; Culley 2008; Halm 2009; Ford 2010; Berg et al. 2011; Kessler et al. 2012; Kreppler et al. 2012; Olrich et al. 2012; Harrington et al. 2013). However, from this study there was an inconsistency within the rounding process regarding call bell prominence (table 32). The experience of the study setting was that the scripted protocols '*to make sure the call bell is within patient reach'* (Meade et al. 2006 p60) was further reduced. This finding suggested that within the study setting the association between rounding practice and call bell usage was less explicit than in the literature. The reason for this could that the rounding process within the study setting did not routinely direct the rounder to the importance of call bell positioning or that sometimes the detail of the rounding process was discarded due to the requirement to complete the rounding as quickly as possible, due to the rounder being busy with other duties.

Similarly, Sobaski et al. (2008); Walker et al. (2015) and Toole et al. (2016) all identified that time constraints could prevent rounder's from fully completing all aspects of the rounding process. However realistically checking a patient's call bell was within their reach was not a time consuming undertaking. It could be performed from a doorway or the end of a patient's bed without a great deal of conversation between the rounder and patient. Call bell usage was not consistently recognised within rounding process of the study setting due to staff not knowing its importance to the rounding process. The findings of this could potentially highlight a gap in staff understanding and experience related to the aims and outcomes of rounding leading to a reduced process. Indeed, Tucker et al. (2012) proposed a lack of clarity around the purpose of rounding that could affect the performance of the process. Additionally concerns were raised that there were knowledge gaps in the description of common structures and processes related to rounding practice (Deitrick et al. 2012; Rondinelli et al 2012 and Fabry 2015). A further consideration would be that staff adapt the process of rounding to meet the individual needs of the patients. Both Tucker et al. (2012) and Fabry (2015) highlighted staff in their study questioned the relevancy of a rounding intervention when asking a mobile self-caring patient if they required toileting each hour. However, the observational data from my study setting, including the short time

taken to complete rounds and the patient voice (patient 36 and 38 p153) would not support this proposition.

> *I didn't know what it was about, if a series of questions had been added I would have been better informed, all the question asked was 'are you okay' and 'do you need anything' (P 36)*
> *I was just saying, I think you need to change your question, because it's too open ended, I don't know whether I can ask you for painkillers for instance or kind of it's a set of list of things to be asked for, so the question may need to be clarified a bit more (P 38)*

The lack of adherence to the rounding process or reduced approach appeared more prevalent to identifying a lack of adherence to process, rather than decisions being on individual patients need.

6.3.3 Documentation

Also important for this study was the finding that documentation was an integral part of the rounding experience in the study setting and how this contributed to the culture of rounding practice for both patients and staff. Compliance with documentation completion was high, whereas studies within the literature highlighted it to be a challenge requiring the documentation of rounding or rounding logs to be checked to ensure compliance (Meade et al. 2006; D'Alessio et al 2012; Sherrod et al. 2012; Tucker et al. 2012; Harrington et al. 2013). The contrasting high compliance with documentation completion from this study could be multi-factorial. One factor could be that within my study setting rounding practice was being observed as part of practice and therefore the observation of the rounder by the nurse observers may have encouraged or promoted completion of contemporaneous documentation. A secondary factor could be related to the rounding documentation itself and how it defined rounding practice. Deitrick et al. (2012) noted that few staff members signed the individual hourly rounding logs as they exited patient's rooms. In my study setting rounding documentation was not an individual sheet or white board kept with the patient/in their room which appeared to be the practice within other studies (Meade et al. 2006; Studer Group 2007; Ford 2012; Toole et al. 2016) but a document which recorded the

rounding visits to all the patients on the ward made more distinct by being fastened to a large clip board. This was carried with the rounder as they did the rounding and was seen as an important part of the rounding process not only for staff but patients even recognised it as part of the experience.

Erm these times they come with the boards (P 4)
Oh you mean the clip board club (P 29)
No she just had a clip board and she just asked me if I was okay (P 31)

It appeared that the documentation gave a visible routine and ritual to the process of rounding and also perhaps an importance that wasn't recognised through the way staff performed rounding. The staff may not have assessed the 4 Ps or even spent any time with the patient but to the reality of the patients and themselves they had checked the patient and importantly this was documented. The rounding document potentially gave both the staff and patients reassurance, perhaps false reassurance, they were being cared for. In the study setting staff didn't highlight that documentation was problematic whereas in contrast documentation in other studies was perceived by staff as burdensome and a barrier to individualising or customising patient care (Halm 2009; Deitrick et al. 2012; Neville et al. 2012; Tucker et al. 2012; Fabry 2015; Walker et al. 2015; Toole et al. 2016). This maybe because the documentation not only was a record of the rounding procedure being performed but also required a documented accountability of each stage of the particular rounding protocol. Therefore a further factor in the apparent success of the study setting documentation compliance could have been due to the simplicity of the documentation which required less in terms of accountability of practice. It required only a tick to denote a rounding visit had taken place rather than the documentation of each stage of a rounding protocol which could include assessment of the 4 Ps (Meade et al. 2006). It could be argued for the study setting that as the rounding documentation was not patient specific, it moved the rounding process further away from patient individuality and promoted a tick box mentality. However, what is potentially apparent is that for rounding practice there needs to be a balance found between the burden of documentation and the requirement to individualise the rounding process for patients.

6.3.4 Patient response

This study also introduces an important new experience of rounding which is not exposed in the current evidence; that patients may also play the routine of rounding practice. Through the in-depth observation of the rounding process at a clinical level it was identified that patients themselves may decide not to be part of the rounding process. This was through behaviours such as feigning sleep or purposely wandering off which ensured the patient was unavailable for the rounding visit.

Patient feedback from the UK study of Dewing and Lynes O'Meara (2014) reported some patient discontent with the repetitiveness of rounding practice. Within the reviewed literature there is some comparison as it is documented that staff had concerns about the rounding process being perhaps onerous or even oppressive for patients as structured rounding protocols didn't fit all patients' needs (Neville et al. 2012; Rondinelli et al. 2012, Tucker et al. 2012; Fabry 2015; Toole et al. 2016). However, few studies gathered data from the rounder patient interaction, or considered it as part of their study framework and therefore were not able to recognise this phenomenon. Within the study setting this subtle decline to participate in rounding by the patients wasn't evident for all patients but the behaviours were frequent enough for the nurse observers, staff and a patient to highlight this feature of the rounding culture. It appeared that not all patients wished to receive a rounding visit but there was no flexibility within the process for not performing a rounding visits to these people, so they had to use subtle strategies to avoid the process. This would suggest that the rounding experience isn't suitable for all patients at all times and that there should be more adaptation, accommodation and rounder autonomy to suit patient need without losing the perceived benefits of the rounding process. Both Tucker et al. (2012) and Walker et al. (2015) would concur that the standardised practice of rounding prohibits tailored nursing interventions based on clinical judgement for individual patients. Of significance to this discussion is the conclusion of Harrington et al. (2013) who found that rounding practice didn't meet the needs of patients with cognitive impairment. A limitation of this study was the exclusion criteria included patients who were unable to provide informed consent, patients with communication difficulties not associated to a language barrier.

6.4 Actioning care

Actioning care is the third cultural theme identified within the finding of the study, this cultural theme is probably the most illuminating in terms of the modified and divergent experience of rounding practice in the study setting contrasting with the current literature. Within the narrative there are already connections between the components sub themes and identified cultural themes. The distinction for actioning care is that through the use of the descriptive matrix (appendix 3) this cultural theme focuses on the activity associated with rounding rather than the delivery. The cultural theme of actioning care was built on the foundations of four component constituents:

- Non clinical
- Hands off
- Team work
- Tea round

6.4.1 Non clinical

The original study finding's uncovered a reality of rounding experience which did not consistently promote patient assessment or clinical care activity. Table 35, offered a summary of actions observed during rounding, identifying hospitality actions featured as much as clinical actions. In contrast, the literature was consistent in its description of the assessment and interventions related to the 4 Ps process (Meade et al. 2006; Sobaski et al. 2008; Weisgram and Raymonds 2008; Halm 2009; Ford 2010). Some authors documented how rounding linked into clinical care activity outside of the 4 Ps process to include nutrition, clinical observations and within maternity, baby and breast feeding care (Bourgault et al. 2008; Berg et al. 2011; D'Alessio et al. 2012). Within the study setting rounding was experienced as a separate process to the main patient care activity and the system of nurse patient allocation. A contributory factor may be that there were no explicit prompts to guide rounder's to assess the 4 Ps. There was also a perceived lack of time to perform clinical actions or it may be because the intended outcomes of the rounding process did not focus on meeting patient pain needs, preventing falls or pressure ulcers.

Therefore, staff cannot see the link between rounding practice as a care intervention and the beneficial patient outcomes. This compares to the findings that highlighted a lack of clarity from staff both about the purpose of rounding and how rounding could affect patient outcomes (Deitrick et al. 2012; Tucker et al. 2012; Fabry 2015; Toole et al. 2016). This was a particularly surprising finding from Tucker et al. (2012) as their rounding process focused on falls reduction so potentially the outcome was very clear. Over time rounding may have become reduced in process due to time constraints and the assessment and care activity part of the process or experience has been lost. This may especially be the situation if staff think the patient's needs of pain management, falls and pressure prevention are part of their patient allocation workload. These activities would then be subject to the individual autonomy of the nurse to determine frequency/level of care and not be limited by the rounding process. Neville et al. (2012) and Walker et al. (2015) attest to staff stating that patient need should be met through individual assessment rather than a scripted protocol. It may even be a self-fulfilling scenario in the study setting that both staff and patients only see the reality of rounding practice mainly addressing non clinical needs (cup of tea, information or a less formal social chat) and therefore both parties experience rounding as a non clinical process; highlighted from observational, staff and patient interviews data. Although it must be noted that my study exposed examples of individual staff performing clinical interventions as part of the rounding process, but these were less prevalent.

The study was able to capture an inconsistency within individual rounder's practice. It could be that different staff have difference experiences of rounding from other care settings where the process is different. Or it could be the rounder's reaction to the immediate presentation of the patient at the time of the rounding, for example if the patient appeared to be physically in discomfort the rounder would review pain management and positioning. The literature doesn't offer any conclusive support for any of these suppositions however the literature does concur that an individual's practice of rounding can vary and the effort required to embed a consistent practice is significant (Meade et al. 2006; Studer Group 2007; Bourgault et al. 2008; Culley 2008; Tea et al. 2008; Blakely et al. 2011; Deitrick et al. 2011; Neville et al. 2012; Rondinelli et al. 2012; Sherrod et al. 2012; Fabry 2015; Goldsack et al. 2015; Walker et al 2015; Toole et al. 2016).

6.4.2 Hands off

A related concept to the non clinical aspect of rounding which the study has exposed, is the hands off approach to rounding within the study setting. The in-depth findings highlighted that many patient rounds resulted in only a few interventions or patient requests and these were mainly non clinical. It appeared that rounding practice responded mainly to patient requests (which were few) potentially linking into a modified form of rounding. Generally, no actions by the rounders influenced the patient safety outcomes associated with rounding, reduced falls and reduced pressure ulcers, because no interventions occurred on the rounds to impact on the patients care in relation to the outcomes, no hands on care was performed.

It was interesting to note that rounders only appeared to action patient requests, whereas rounding is described as a purposeful pro-active process promoting hands on care interventions (Meade et al. 2006; Studer Group 2007; Woodward 2009). The only part of the experiennce which seemed purposeful and proactive in my study was the regularity of performing the rounding. The impression of the individual interactions between the rounder and patient often appeared more reactive. The hands off approach to rounding practice was a new finding from this study which had not been highlighted in the literature, albeit the suggestion by Meade et al. (2006) that rounding could meet patients the housekeeping type needs as well as clinical care issues. A strength of this study has been the forsenic examination of the patient rounder interaction rather than a focus on the clinical outcomes proliferated in the literature previously. The hands off approach to rounding illustrated the considerable gap exposed when seeking a causal link to the clinical outcomes of falls reduction and pressure ulcer prevalence if no hands on care interventions are performed during rounding. The approach of this study has again exposed the day to day realities of the rounding experience which differ from the perceived view of how rounding was being/is being performed. This was particularly worrying for myself as a senior nurse responsible for ensuring the implementation and application of rounding practice across wards and departments within the hospital.

6.4.3 Team work

The staff interview data provided deep insights into the reasons why the rounding experience within the study setting is a non clinical, hands off process. The staff interview data uncovers the potential friction between which staff group carried out the rounding and how this can affect the patient interventions during the round. Registered nurses highlighted how support staff (nursing assistants and housekeepers) could not perform patient assessment and interventions required to the same level. A registered nurse would be able to assess patients for pain and provide intervention in the form of medication if required, whereas the housekeeper would not be able to perform this function during a round.

Interview data from the nursing assistants demonstrates an awareness of their limitations and the requirement to escalate to registered nurses.

> *I was able to help the patient to the toilet but I asked the staff nurse about the prescription (S 9)*
>
> *I asked the staff nurse for help as I wasn't sure about the patient request, the staff nurse helped me (S 15)*

The balance of the rounding practice during the study suggested equableness between registered and non registered ward staff, this means that approximately half of the time rounding was performed by non registered nurses. Therefore, the potential to fully assess and meet patient's needs is limited. However, the observational data does not support this particular distinction of a registered nurses performing a more clinical round, from data it appeared that registered nurses could be as non clinical and hands off in their approach to rounding as non registered ward staff as evidence in the time taken to perform rounds (table 31) position of the rounder (table 32) and the actions associated with rounding (table 35). There was also a debate in the data dialogue between the registered and non registered staff in terms of the ward housekeeping staff and some nursing assistants emphasising that they did more of the rounding and more responding to patient requests than the registered nurses. The literature supports a multi staff approach to rounding reporting both registered and non registered ward staff performing rounding, however there is caution in that the delegation of interventions from rounding within the team

context need to be robust (Bourgault et al. 2008; Gardner et al. 2009; Sobaski et al. 2009; Deitrick et al. 2012); Sherrod et al. 2012). Fabry (2015) provides the greatest context in the literature in terms of experience, grade and education of staff participating in rounding found that non registered staff had the higher agreement that rounding was consistently practiced which may attest to themselves performing rounding more frequently.

Potentially working to the scripted protocols as devised by Meade et al. (2006) may direct non registered ward staff to pro-actively assess and intervene with some of the aspects of the 4 Ps without the requirement for registered nurses to assist or support their actions all the time. Linked to the teamwork aspect of rounding was the initial work by Meade et al. (2006) which based the development of their rounding protocol on the premise that much of the patients call bell usage was based on housekeeping or hospitality type requirements rather than interventions specifically requiring a registered nurse. In the study setting this maybe why the non registered ward staff perceived they performed the preponderance of the rounding.

What does appear from the study setting is that patients reported there can be a lack of team work which can delay actions patients requested from rounding taking place in a timely manner.

> *Sometimes there are long delays if you asked for something, if one nurse cannot sort something out and so another nurse has to do it, it can take a long time (P 26)*
> *Err sometimes it depends on who is doing it because sometimes you ask for something and you don't get it anyway (P 38)*

Deitrick et al. (2012) and Rondinelli et al. (2012) agreed that a lack of teamwork impeded the process of rounding and issues about the delegation of rounding need to be addressed to ensure a robust rounding process. An important part of why rounding was devised was timely response to patient requests, however within the study setting patients sometimes experienced inconsistent rather than timely responses (Meade et al. 2006). The study revealed that the random allocation of registered nurses compared to non registered ward staff to perform rounding, other than the set rounds by the nurse in charge, combined with

the lack of a scripted protocol produced an arbitrary approach to teamwork which then prevented a structured rounder patient interaction and intervention. This reflected a culture in the study setting where the rounding process was not seen as important or a core strand of ward staff's perception of teamwork.

In contrast the quantitative studies promoted rounding as being a core element of ward teamwork and a care intervention method (Meade et al. 2006; Studer Group 2007; Bourgault et al. 2008; Culley 2008; Sobaski et al. 2009; Kessler et al. 2012). However, my findings concur with studies that have examined rounding in an inductive paradigm and have suggested that rounding was not the formidable care intervention method it was first proposed to be (Blakley et al. 2011; Deitrick et al. 2012; Neville et al. 2012; Walker et al. 2015).

6.4.4 Tea round

Perhaps the most telling observation within the study setting is the startling finding that the most prevalent experience from the rounding observed were the numerous patients requesting drinks, in particular cups of tea.

This was not an explicit component of rounding described within the current literature apart from the acknowledgement by Meade et al. (2006) who found that most patient call bell requests had a housekeeping or hospitality focus. It could be potentially encouraging if this finding of rounding practice being related to cups of tea was in anyway linked to particular fluid balance or hydration intervention however this is not the case. What this data identified was that patients needed more access to drinks than the catering schedule for the ward allowed. It would also suggest that without direction for patients about what the rounding process involves, patients experience rounding as a procedure by which you can request additional drinks.

> *It's a small thing but my water jug never seems to be here when I have tablets to take, so I ask for a cup of tea, it's like they are really looking after you (P 29)*
> *Yes, one of the young ladies who came round asked me a question, hello Michael do you need anything, I did say yes I would like a cup of tea and she went out and made*

me a cup of tea and that was absolutely beautiful, it's that little bit extra, that little bit of help goes a long way for patient comfort (P 36)

It also seemed within the study setting that ward staff practices do not contradict this position. It maybe that this small service increases patient satisfaction with their overall hospital stay, however this practice of rounding is a long way from the ideals promoted in the literature (by Meade et al. 2006; Studer Group 2007; Tea et al. 2008; Woodward 2009; Kessler et al. 2012). The culture prevalent within the study setting has mainly reduced the 12-point protocol (Meade et al. 2006) to a tea round, so much so that a member of the ward team thought that it would be useful to take the tea trolley with the rounder when rounding was performed. It maybe appear flippant to discuss rounding in terms of a tea round but small actions can be important in terms of patient perceptions of caring, as patients' articulated above. In comparison the importance of face to face time, response to call bells and anticipation of requests is emphasised as being seen by patients as an indication of caring compared to clinical competence (Gardner et al. 2009; Halm 2009; Sobaski et al. 2009). The finding also resonated that senior observation of the rounding process and staff education was important to ensure the rounding process was performed correctly, on a day to day basis (Neville et al. 2012; Fabry 2015; Toole et al. 2016). In addition, it is essential when the rounding process is first implemented the process is monitored in order to ensure the required outcomes are achieved and that staff are engaged with the process (Fabry 2015; Goldsack et al. 2015; Walker et al. 2015; Toole 2016). Fabry (2015) and Goldsack et al. (2015) promote the role of unit level staff champions to improve rounding processes through education and support for ward teams. In the UK, Hutchings et al. (2013) described a link nurse role that ensured training and oversight of the quality of the rounding process. A further challenge to performing the rounding process is staff workload, which if not recognised and reviewed can provide a barrier to the effective performance of the rounding process (Tucker et al. 2012; Walker et al. 2015; Toole et al. 2016). Within the study setting this appeared to have happened over the two years since rounding implementation, a modified and divergent experience had evolved, with the study results providing evidence to suggest a timely focus for reviewing rounding practice.

6.5 Engagement

The cultural theme of Engagement was defined by four main constituent components:

- Consideration
- Patient information
- Conversational
- Patient feedback

Isolating distinct and separate practice within the settings of the wards was difficult as beliefs and values attached to the practice of rounding were complex and multifactorial therefore as with the previous discussions there was a degree of overlap and merging with the other identified cultural themes.

6.5.1 Consideration

The consideration given to the practice of rounding within the study setting was nominal at times this was demonstrated through several differing rituals:

- Gaps in allocation of staff members to do the rounding
- Lack of staff volunteering to do rounding when there had been no allocation
- Separation of rounding from main care delivery processes

The significance attached to rounding practice by staff was reflected within the literature with respect to compliance and staff satisfaction with rounding practice. The qualitative studies identified staff drawing attention to their concerns regarding the value of rounding practice to nursing care (Deitrick et al. 2011; Neville et al. 2012; Tucker et al. 2012; Harrington et al. 2013; Forde-Johnson 2014; Walker et al. 2015). In contrast the quantitative studies proposed a tentative link between rounding reducing nursing workload, improving communication and teamwork (Meade et al. 2006; Studer Group 2007; Bourgault et al. 2008; Culley 2008; Sobaski et al. 2008; Gardner et al. 2009; Brosey and March 2015). The evidence within this particular study setting suggested none of the benefits proposed

were apparent otherwise rounding practice may have been given more consideration. Snelling (2013) proposed that there was only a slim chance of nurses leaving more important work to perform rounding, this study confirmed this actually does happen in practice, rounds were often started late and there were instances of nurses wanting to finish their allocated patient's care requirements before commencing rounding. Additionally the tension between the nurses allocated patient workload and their rounding allocation could be the reason why the rounding process was rushed. Neville et al. (2012); Harrington et al. (2013) and Walker et al. (2015) provide some corroboration in that staff reported frustration when their allocated patient's care conflicted with the requirements to perform rounding. This is an important finding from the study which is at odds with one of the main perceived benefits of rounding practice, increased staff satisfaction.

The perspective that nominal consideration and importance was given to rounding practice in the study setting was further emphasised by the performance or presentation of the actions resulting from rounding interventions. There were only a few actions resulting from rounding interactions with patients. Teamwork to complete actions was inconsistent and there was little feedback or follow up of the rounding action to ensure a link back to the key method of care delivery, patient allocation. This meant that the staff member performing the rounding did not routinely feedback to the nurse allocated to care for that patient, even if certain interventions had been performed for the patient. The experience of lack of consideration for rounding practice maybe due to the prevalence of non clinical housekeeping type interventions the resulting actions from rounding that were seen as too inconsequential to feedback to the allocated nurse. However, part of the rounding practice in the study setting was specifically devised to determine if patients had any worries or fears. This was potentially a very important part of patient's psychological care, asking patients, if they have any worries or fears, opens up the opportunity for patients to speak about concerns which impact on their well-being. As discussed previously this question was introduced as part of an initiative responding to the national in patient survey. From the findings it was clear that the question "Have you any worries or fears?" was interpreted differently by different members of staff who were performing the rounding. The question was often combined with the question "Is there anything I can do for you?" to rounder asking "Are you ok?" and the delivery of the question could prevent the patient having the

best opportunity to reply. The only literature specifically to mention worries and fears is Crossfield and Pitt (2012 p21). Disappointingly this was a generalised reference to improved patient feedback data due to rounding practice *'being able to allay worries and fears'* rather than a specific examination at the clinical interface of the delivery of the worries and fears question to patients and the patients capacity to respond.

The literature does dedicate some attention to psychological care but this is more in terms of regularity of the attentive episodes of rounding (Meade et al. 2006). Woodward (2009) discusses the patient's psychological effect of the uncertainty of when help may next arrive rather than rounding providing the opportunity for patients to discuss their worries and fears. My in-depth study was able to highlight potential problems with the 'worries and fears' component of the rounding process. The problems relate to the culture of rounding in the study setting often being a brief intervention (table 31) therefore consideration was not provided to the time, space or approach required to address the complexity that the worries and fears question may elicit from the patient response. Inconsistent consideration was given by staff who were performing the rounding by ensuring if they were asking the worries and fears question were they appropriately trained to deal with the patient response. Demonstrated by these patient comments of the sister and the housekeeper:

> *Patient said they were concerned about their test results, the sister was able to reassure the patient, she sat next to the patient and explained what the tests results may show, then went back to the patient after looking up the test results and talking to the doctors (Obs 14)*
> *Patient voiced a lot of worries and concerns the housekeeper appeared uncomfortable and out of her depth because they were medical problems this may have come across as a lack of sympathy as the housekeepers appeared to have no engagement with the patient when the patient was quite upset (Obs 20)*

However, it may be that patients recognise they have the opportunity to discuss their worries and fears during the rounding process even if they didn't wish to discuss their worries or fears. The patient feedback data (appendix 20, table 19) has the specific question "Did you find somebody on the hospital staff to talk to about your worries and fears?" had

increased in its overall satisfaction score during the study period. The same result was shown in many of the other studies which focused on patient satisfaction surveys as a method of evaluating rounding practice. However, it remains difficult to isolate this improvement to rounding practice as other variables such as specialist nurse input and communication from the medical team which could influence the patient's response to the overarching satisfaction question.

6.5.2 Patient information

A counterpoint to the worries and fears question was that information giving was prominent as one of the more frequent requests on the rounding visits. This was a useful finding from the study as this was not emphasised in the literature to the same degree more than likely because rounding was not formally observed in practice as part of their study methodology (Deitrick et al. 2012; Blakely et al. 2012; Neville et al. 2012; Harrington et al. 2013). Several studies have examined the rationale for call bell use but information giving has not highlighted as a specific need (Meade et al. 2006; Studer Group 2007; Tea et al. 2008; Weisgram and Raymond 2008; Woodward 2009). Some researchers have collected data on the number, times and type of request when patients used call bells (Weisgram and Raymond 2008; Ford 2010) and others focused on patients using call bells as the patients were not sure when help for them would arrive again (Woodward 2009). Harrington et al. (2013) indicated that one patient used their call bell for a medical enquiry compared to over 30 patients using their call bell for toileting purposes during the one morning of call bell data collection within their study. Within this setting the study uncovered an unmet patient need which rounding practice can facilitate. In the UK Dewing and Lynes O'Meara (2013) anecdotally highlighted how patients viewed rounding a positive experience because rounding afforded the opportunity for the patient to be kept informed of what was happening.

It would seem the patient's requirements for information about their hospital stay, their treatments, test results, medications and discharge plans are higher requirements than nursing and medical teams are delivering through their usual information giving methods but rounding meets this need for patients. It was interesting to note that rounding was not fully recognised by staff as a good opportunity to provide information for patients even

though staff highlighted that patients had asked them for information. However, the rounding experience was providing a way to supplement current patient information requirements, this also could link into the importance of the nurse in charge round as previously discussed. Patients' were seeking further information from the nurse in charge because they were perceived to hold most of the ward information.

6.5.3 Patient feedback

Another finding identified through the staff interviews was that rounders' experienced patient feedback as part of the rounding interaction, ranging from people saying thank you to being very appreciative.

Patient feedback on the actual process of rounding does not appear to be systematically addressed within the current literature and is often more anecdotal when highlighted (Kessler et al. 2012; Rondinelli et al. 2012). Both of these studies used continuous patient feedback to adapt their rounding processes. They found an unintended outcome of the study was that patient feedback positively influenced the nurses' perception of the effectiveness of rounding. It could be that if the positive patient feedback was utilised in the correct way it could positively influence the staff perceptions or considerations of rounding. It was interesting to note on deeper examination of the staff patient interaction during the rounding process, it was the more engaged staff who received more thanks and appreciation from the patients. This type of interaction has not been studied in the literature the proliferation of deductive methodologies focussing on the cause and effect of measuring rounding practice have impeded a more meaningful understanding of rounding to be generated. The rounder patient interaction aspect of rounding is still not well researched and perhaps disappointing for a practice that received national roll out.

Reduced complaints and better patient feedback are emphasised within the anecdotal evidence from the UK literature, unfortunately little conclusive scientific evidence has been presented to demonstrate rounding affected either outcome (Crossfield and Pitt 2012; Dix et al. 2012; Hutchings 2012; Lowe and Hodgeson 2012; Braide 2013; Dewing and Lynes O'Meara 2013). Crossfield and Pitt (2012) identified improvement from patient feedback in relation to being able to placate worries and fears, a topic which requires further robust

exploration. Dix (2012) reported an increase in positive responses from patients comments cards and Briade (2012) a decrease in complaints. The combined results from the UK work do appear appealing in terms of improved patient feedback however they are six small scale reports and their findings have to be treated with great caution.

6.5.4 Conversational

Patients used the opportunity of rounding to engage in banter and jokes with staff as well as saying thank you. However, this finding may further emphasise that within the study setting that rounding was not experienced as a completely clinical process by patients. The detail of the data does uncover the idea that patients valued a conversational style of interaction during rounding rather than just the clinical care, making rounding part of the everydayness of passing time whilst in hospital, adding to their sense of satisfaction with their care and hospital stay. It may be that patients' feel these interactions make them feel more of a person rather than a patient and increased their satisfaction with care, although as previously highlighted not all patients welcomed rounding visits.

The conversational or social aspect of rounding did not appear to be addressed within the literature. The focus of rounding protocols was on the delivery of meeting patients physical and comfort needs with communication being structured through set questions (Meade et al. 2006). Little attention has been paid to the everydayness of conversation and even jokes, the social interaction of a cup of tea and chat. The poignancy of which is illustrated in a UK study which described how patients joked about the set routine of the rounding question itself (Dewing and Lynes O'Meara 2013).

6.6 Summary

The originality of chosen methodology of ethnography has provided an explicit and tacit examination of the patient staff interface during rounding. This has drawn out new knowledge of the cultural themes and sub themes that provide an understanding of the day to day rounding experience. In the discussion chapter a comprehensive discourse related the nuances of rounding practice has been debated. Crucially the discussion of new finding in comparison and contrast to the existing literature has developed an experience of

rounding and its constituent features which could potentially be used as a model to review and further examine rounding practice (figure 8).

The current literature is dominated by deductive studies measuring what are considered to be the main outcomes of the rounding process (Meade et al. 2006; Studer Group 2007; Culley 2008; Krepper et al. 2012; Olrich et al. 2012). Importantly the key new knowledge about rounding practice that this study has identified moves away from the causality evidence of the deductive paradigm to understand the relationship between the nurse and the patient in the rounding process. In contrast to the prevailing view, this relationship can be brief and even unspoken however it can influence a patient's perception of caring. The study emphasises the gaps within the current UK literature as little scientific rigour has been applied to any existing study of rounding practice despite rounding being adopted whole scale across the NHS and beneficial outcomes being reported in the literature (Crossfield and Pitt 2012; Dix 2012; Braide 2013; Hutchings et al. 2013).

The discussion illuminates a new understanding of the relationship and interactions between staff and patients during the rounding process. The discussion demonstrates how the culture or day to day realities of the rounding process negate the potency of rounding as a nursing intervention with a potentially negligible impact on patient experience and care. Rounding in the study setting is a mainly hands off non clinical process. This is in sharp contrast to the current literature both deductive and naturalistic which emphasises rounding as a clinical care delivery process (Murphy et al. 2008; Sobaski et al. 2008; Ford 2010; Blakley et al. 2011; Harrington et al. 2013). From this presupposition the study further identifies that as a nursing intervention rounding does not have the impact on the patient outcomes that have previously been promoted in the literature because rounding doesn't deliver clinical care.

The discussion also emphasises that rounding practice and the culture of rounding practice within the study setting does have challenges attached to its every day practice. These challenges can make the process of rounding appear adapted, routine and ritualistic and therefore the value of the process can be lost to both patients and staff. Several studies would concur that the implementation and embedding of rounding practice is difficult

(Deitrick et al. 2012; Neville et al. 2012; Rondinelli et al. 2012; Tucker et al. 2012; Walker et al. 2015; Toole et al. 2016). However this study has been able to contribute to the detailed understanding of the constraints and adaptations which occur in everyday practice rounding which devalue and nullify the experience for both patients and staff. The new knowledge isolated from this study promotes the value attached to rounding as an information giving process or perhaps unfortunately an additional drinks round which is a move away from the ideals of improving patient safety unless attention is paid to defining the specific outcomes required from rounding practice and the practice of rounding is observed as a day to day reality. Table 37 highlights the new knowledge and original contribution of the study.

Table 37: Summary of new knowledge and original contribution

	Key discussion points
1	New knowledge This study is the first NHS examination of the rounding process which reveals the practice of rounding in its day to day reality
2	New knowledge Rounding may have an impact on patient experience and care but it is much more limited than the current literature emphasises
3	New knowledge Rounding is not a method of care delivery and seen as potentially inconsequential compared to the main patient care delivery method of patient allocation
4	Original contribution Forsaking the deductive paradigm and engaging with a ethnographic methodological approach has been crucial to describing the culture of rounding in the study setting
5	Original contribution The study has identified specific new knowledge about the rounding process by its detailed examination of the process of rounding rather than focusing on the measurement of flawed outcomes
6	Original contribution The development of the descriptive matrix (appendix 3) and the reflexivity of the researcher contributed to the uncovering the social situation of rounding practice for patients and staff
7	New knowledge The cultural themes and the constituent features extracted by the study provide new knowledge concerning what is important within the rounding process
8	Original contribution The cultural themes and the constituent features provide a model for reviewing and further examining rounding practice (figure 8)

Chapter Seven: conclusion and recommendations for practice

7.1 Introduction

The final chapter of the thesis concentrates on encapsulating the learning from the research study. The conclusion will focus on three main themes firstly, an evaluation of how well the application of methodology has enabled the four study objectives and the overall study aim to be achieved. Secondly how the aims and objectives of the study have contributed to developing the recommendations for nursing practice related to rounding. The final consideration is a summary of my journey through the research process.

7.2 Evaluation of study methodology

The first objective of the study was to 'to understand the patient and nurse experience of rounding' based on an interpretivist theoretical perspective that meanings are constructed by individuals as they engaged in the rounding process (Crotty 1998). The discussion chapters highlighted that the study has been able to meet this objective by not only describing but crucially understanding the impact of rounding on patient experience and care through a structured and scientific examination of the rounding process. The study has uncovered a rich detail in the 'every dayness' of rounding in the study setting. The constructionist methodological approach of this study meant that an alternative view on the impact of rounding practice to patient care and experience can be proposed. The existing literature has highlighted the impact of the rounding process to be a powerful nursing intervention in influencing patient care and experience (Meade et al. 2006; Studer Group 2007; Sobaski et al. 2008; Olrich et al. 2012). The understanding of the rounding process extracted in the study setting provides an alternative cultural view of frontline practice where the impact of rounding is more under stated and imperceptible.

The second objective of the study was to identify the component features of rounding practice. As discussed the strength of the study was the ethnographic methodology which allowed the capture of data from seeing, listening and talking about rounding as well as my

own reflexivity, encapsulated within a descriptive matrix (Spradley 1980). The participant observation of the rounding process and particularly using the descriptive matrix (appendix 3) captured a richness of data due to direct involvement with the rounding process. This enabled the component features of rounding within the study setting to be identified and the study objective to be achieved. The component features of rounding are captured within the identified cultural themes and sub themes (figure 8) again these features differ from much of the existing literature identifying component features of a more social than clinical practice, a brief visibility to patients with minor consideration given to rounding practice by the ward teams.

However a limitation with the study is that the data capture has focused on the participant observation of rounding practice compared to the capture of patient and staff interview data. The interviews of the patients who were rounded on and the interviews with staff who performed rounding was also expected to provide rich data in terms of feedback from those directly involved in rounding to add to the participant observational data. However the pre-defined questions of the interviews and the short allocated interview times (planned in order to minimise disruption staff and patients) potentially precluded the same rich data capture as the participant observation. Therefore in terms of staff and patient feedback about the rounding process further investigation is required to isolate more informative feedback specific to the rounding process. Better interview data capture within this study may have resulted from fewer but more in depth less structured and longer patient and staff interviews (Manias and Street 2001; Hill 2003). This would have enabled the interview process to further explore in detail the patients and staffs beliefs and truths about the process of rounding.

The studies third objective was to collate situational documentary evidence from patient care and experience metrics to describe the influence of rounding practice, this was achieved and demonstrated in appendix 20, table 19. It was also somewhat disappointing that on analysis the documentary data didn't provide any useful links to promote the impact of rounding on patient care and experience, suggesting particularly in terms of patient safety metrics rounding is not an influential intervention. It also potentially triangulates the findings of the study that rounding is a non-clinical practice.

Robson (2011) does caution the use of data records but for my study this is particularly poignant given the emphasis of the existing literature and also the initial stance of the research student in wanting to provide and prove that causal relationship between rounding and identified patient outcomes.

The choice to set the study within the naturalistic paradigm potentially excluded the investigation of direct and stated outcomes to measure the impact of rounding however the inclusion of the documentary data perhaps provided for scant data analysis and therefore a weakened contribution to the study findings. The study results may have been stronger if differing documentary data were to have been included within the study. This could have been the analysis of the nursing notes to identify how care was delivered in terms of the 4 Ps compared the rounding documentation. A stronger link to outcomes may have also been described if the participant observation had focused on observing rounding practice associated with an identified outcome. For example the participant observation could have focused on describing rounding care related just to falls prevention to extract a link between falls prevention rounding care and a reduction in patient falls. However the focus on a specific outcome of rounding was the approach of Tucker et al. (2012) who failed to find conclusive evidence to link rounding and reduced falls rates.

The study also had a limited focus in terms of describing the leadership of the rounding process. As discussed the study has importantly identified that a component feature of rounding practice was the role of the nurse in charge process and also the influence of teamwork. However these two findings cannot be directly linked to the importance of ward leadership, in terms of the ward manager's and matron's influence on the ward staffs approach/adoption of rounding practice, its sustainability and barriers to its effectiveness. This could be a consideration for further study as potentially the cultural constituents of rounding identified by this study, particularly the issues of playing the routine and engagement, potential barriers to effective implementation, could be influenced by ward manager and matron leadership. The potential for role modelling of the nurse in charge rounds could impact on the culture of the rounding process within a particular setting if supported by strong ward leadership. Effective leadership could demonstrate best rounding practice for staff new to a ward or to nursing assistants or staff in non clinical roles

(housekeeper role). An investigation in to the leadership of the rounding process, particularly through the naturalistic paradigm could add to understanding the context and interpreting the meaning of the nurse in charge round.

Although the evaluation of the study has highlighted specific issues which a modified study design could have potentially captured these criteria could possibly form the foundation for the future study of rounding practice.

The final objective of the study was to add to the theory of nursing knowledge related to rounding practice by understanding the patient experience and nursing care. With standing the critique of its design the study has been able to meet this final objective. The study has provided new knowledge regarding the practice of rounding which is encapsulated in recommendations for nursing practice. The new knowledge is particularly important for UK nursing practice where there is an identified evidence gap.

The overall aim of the study was to describe the process of rounding as a method of delivering nursing/patient care by exploring the culture of the social situation of the ward setting. By meeting the study objectives the study has been able to achieve its overall aim. The unique and purposeful application of the chosen ethnographic research methodology has provided a rich or thick description of the cultural context of rounding and how care may or may not be delivered. The aim of the exploring culture through a robust methodological framework was to negate problems which could question the validity and reliability of the study findings (Crotty 1998; Creswell 2007; Mason 2010; Streubert and Carpenter 2011). A poor research methodology would have potentially would have prevented the study from meeting its aims. However despite some limitations in the study design an original contribution and new knowledge about the practice of the rounding process has been uncovered.

7.3 Recommendations for practice

The aim and objectives of the study have contributed to developing the recommendations for nursing practice related to rounding by exposing a culture of rounding practice which is

different from the process documented in much of the existing literature. The practice also differs from the practice that was initially thought to exist in the organisation of the study setting. The recommendations for practice resulting from this study are different to those that I first thought would be the practice recommendations. Initially I felt the recommendations would be about encouraging further adoption of rounding into practice as rounding was a nursing intervention which impacted positively on patient experience and care. Following the research journey and the review of the study results the recommendations for practice follow a differing path. Although I feel that I fall short of stating that rounding is not a recommended practice I would advise caution and review of rounding practices.

From the four study objectives, understanding of the culture of rounding practice, identifying component features of rounding, collating patient experience and safety data plus understanding patient and staff experience the study has been able to develop new knowledge about rounding practice that is encapsulated with in the descriptive matrix (appendix 3) and in the model of cultural themes and sub themes (figure 8). As the initial recommendation from the study I would champion the use of these two instruments for assessing, developing and evaluating rounding practice.

The rounding model devised by this study provides a new tool to reveal two of the basic elements of rounding presence and engagement are a starting point for understanding the relationship between the rounder and the patient. Then the processes of actioning care and rounding routine can be examined to link rounding practice into care delivery. Previous literature has focused more the actions of care 4 Ps and the protocols of rounding rather than the presence and engagement of rounding. The application of the model framework will potentially expose gaps and barriers in rounding practice unless of course the practice of rounding is completely thorough.

Recommendation – use of the descriptive matrix to assess practice

Recommendation – application of the rounding model to expose potential gaps in the delivery of rounding

Recommendation – examination of the presence and engagement within the rounder patient relationship

Recommendation – examination of the actioning care and routine of rounding practice

My study would also recommend that individual healthcare settings need to identify what they believe rounding practice will achieve. I feel that this study has highlighted that many of the initial outcomes of rounding in terms of patient care and experience are at best uncertain therefore the outcomes of rounding practice need to be made explicit to both staff and patients. Unless outcomes are explicit the practice of rounding loses it focus and drifts into an inconsequential task orientated process in which documentation completion is more important than impacting on patient care and experience. It maybe for many healthcare setting the distinction between rounding being a method of providing for staff presence and engagement to patients rather than delivering the care associated with the 4 Ps needs to be identified. However in other healthcare setting if falls prevention is the most important outcome of rounding then falls prevention measures are the main concentration of the regular rounding visits and actioning care through falls prevention interventions is the focus of the rounding process.

Recommendation – application of the rounding model to define the outcomes of rounding practice

Recommendation – revise the expectations of rounding practice influencing patient safety (falls, pressure ulcers, use of call bells)

Recommendation – patient satisfaction with rounding processes requires direct patient feedback

Recommendation – staff satisfaction with rounding processes requires direct staff feedback

Recommendation – the process and work allocation of rounding needs to be explored in relation to patient allocation

One of the most important recommendations for practice is that further examination of the rounding process is required particularly within the UK healthcare setting. Rounding is practiced widely within the NHS its adoption into practice has been recommended by the government and senior nurses within the UK as a means of improving patient care. There

has been little rigours scientific examination of the practice within the UK practice setting. At first nursing practice in the UK was expected to accept the US evidence base and it was only latterly to the UK wide implementation the authenticity of the evidence base was questioned. It would be interesting to identify how many other professions would accept a government led recommendation to introduce a new practice developed in another countries healthcare system without their own UK evidence first determining the benefit of the practice. It maybe that UK nursing was in reaction mode to the Francis report and the urgency of introducing a potentially potent intervention to improving care was too appealing to wait for further evidence of the effectiveness of rounding. It may also be that evaluating rounding in the practice setting is too difficult a proposition. This study has identified how difficult it is to identify and isolate casual links between rounding practice and recognised outcomes in the complex setting of the ward environment. Therefore the acceptance of the US literature may have been an easier option than devising a UK evidence base. Although what is now emerging from UK healthcare are more reports of rounding practice particularly about rounding being implemented in practice therefore this may develop into more robust scientific study.

Recommendation – the study findings require wider discussion and debate in order to promote a UK rounding evidence base

Recommendation – the transference of practice from other healthcare settings require robust and scientific evaluation within the UK setting before whole scale implementation

A recommendation of this study is that the research methodology used to investigate rounding needs careful consideration. Potentially in the UK we do not understand enough about the constituent features of rounding, we do not have understand the patient and staff perspective of rounding practice even before we begin to review outcomes therefore further study of the practice is required. As with this study the recommendation is that UK practice needs to investigate and understand the rounder patient relationship as the first step to providing a UK evidence base. In order to do this the practice setting and the academic setting need to work in close cooperation to ensure the practice of rounding is fully understood and its benefits fully revealed.

Recommendation – before examining the outcomes of rounding practice the constituents and constructs of the rounding process need to be understood to find the true value of the practice (for example the role of the nurse in charge, patient information giving)

Rounding is a high profile nursing intervention which was implemented in the UK potentially without a fully considered regard for its effectiveness. Transferability from another healthcare setting was assumed, the recommendations from this study is that nothing can be assumed about rounding practice. The results of the implementation from this study setting depict a patient and staff experience which is not recognisable from the depicted US rounding practice therefore much about rounding practice has been potentially lost in the translation of day to day frontline NHS practice.

7.4 Research student's journey through the research process

The final part of the conclusion to the thesis is the reflection of my own journey through the study process. The journey has been considerable in terms of my view on the practice of rounding. As discussed previously I was a proponent of the process and started this journey wanting to prove the effectiveness of rounding on patient care and experience. The reason for starting the research journey was to cross the divide between the practice world and the academic world in order to be ensured as a nursing leader nursing interventions with a focus on the fundamentals of care were fully examined and their benefits acknowledged. However this journey was not straight forward, both as a nursing leader and research student. Through the processes involved in rigorous scientific investigation of rounding I have re-evaluated my appreciation of rounding practice both as a nursing leader and research student. This journey has been so eventful that I have now developed almost an opposing view of rounding practice. The realities of understanding the culture of rounding practice in the study setting have led me to a more cautious and considered opinion of the practice. As a nursing leader this has ultimately been an instructive and reproving experience to see a nursing practice which was seen as beneficial to both patients and staff being adapted and almost reduced to an inconsequential aspect of ward culture. The journey has emphasised the importance of nursing practice is not to focus on outcomes of care but to be able to understand what happens in the cultural setting of a ward day to day,

to be able to identify the truths and realities of practice, the relationships between staff and patients. It is essential to understand what is important and what isn't important. The research process has made me as a nursing leader a more contemplative practitioner now that they have been able to understand through the research process how gaps in theory and practice actually exist. Contentiously, if this gap exists for rounding practice does the gap exist for other fundamental elements of nursing care. For myself as the research student it has highlighted that nurse leaders need to do more to investigate through observation and feedback what happens during care delivery. Equally the observation needs to be structured and the feedback needs to be more than satisfaction surveys. Additionally the research process has led me as a nursing leader to pay more attention to being able to explicitly define and measure outcomes through processes other than recording numbers, for example of falls or numbers of pressure ulcers. Conversely academic research is a complex process which requires a focused commitment from myself as the research student and within the practice setting it can be difficult to achieve the level of application required for an academic study. Hence as a nursing leader often the more viable option is to examine nursing practice through more simplistic tools and techniques rather than research methodology.

My journey as a research student can also be illustrated through the embracing of ethnographic methodology as the framework for the study. Initially I wanted to assume the importance of making the casual links to rounding practice with beneficial patient care and experience in an NHS acute healthcare setting. The development of the research student's knowledge regarding qualitative methodology and the richness of data collection from ethnographic methods has been transforming in terms of a methodology to examine nursing practice. Even given time constraints, far too often nursing leaders do not take the time to see, to listen and to talk about nursing practice with ward staff in order to understand front line clinical practice. Ethnography provides a framework to promote this detailed level of investigation of clinical practice. The ethnographic methodology needs to be adopted further within nursing practice and especially in the investigation of the everyday fundamentals of nursing practice. Too often in nursing (and rounding is a good example) outcomes are sought before consideration is given to fully being able to understand what is happening in practice. Through undertaken high level research I have

changed my view as a nurse leader. As a nurse leader I now understand the importance in promoting the value of different approaches to investigating care and in particular the vibrancy of ethnographic methods to nursing practice. It is a professional responsibility of a nurse leader to understand the practice setting however as the research student, I have now recognised the tools that I often used to examine practice can be restrictive in their effectiveness and therefore can prevent the true picture of practice from being developed.

The remaining influence on my journey has been the reminder that although a senior nursing leader as a research student they are a novice, who has had much to learn and experience through the research journey. The journey has been personally invigorating as it has been about trying to improve patient care from a bottom up rather than top down approach, the process has involved myself as a nurse leader exposing being exposed to my team as a novice and engaging the team through vision and commitment rather than line management. This is an important lesson learnt as a research student which I can further translate into the practice of the nurse leader. Working at the clinical level with identified teams can bring the benefit of sharing learning about the tacit practices of ward teams, how this can influence their care delivery and patient experience.

For myself, as the research student studying the practice of rounding through ethnographic methodology has developed not only new knowledge about the practice of rounding but also a new awareness of myself and how I can transfer this experience to improving my function as a nurse leader.

References

Barker K (2012) Hourly ward rounds: we need to communicate not inspect. British Journal of Midwifery 20 (2) p150

Bates J (2011) Round again. Nursing Standard 25 (26) p27

Bartley A (2011) The Hospital Pathway Project: Making it happen: Intentional Rounding. The King's Fund Point of Care and The Health Foundation, UK

Bassett N (2002) Nursing has always had comfort rounds. British Journal of Nursing 11 (9) p603

Berg K, Sailors C, Reimer R, O'Brien Y and Ward-Smith P (2011) Hourly rounding with a purpose. Iowa Nurse Reporter 24 (3) p12-14

Blaikie N (2009) Designing Social Research: the Logical Anticipation. 2nd Ed Polity Press, Cambridge, UK

Blakley D, Kroth M and Gregson J (2011) The impact of nurse rounding on patient satisfaction in a medical surgical unit. Medsurg Nursing 20 (6) p327-332

Bourgault A, King M, Hart P, Campbell M, Swantz S and Lou M (2008) The circle of excellence: does rounding by nursing associates boost patient satisfaction. Nursing Management 39 (11) p18-24

Braide M (2013) The effects of intentional rounding on essential care. Nursing Times 109 (20) p16-18

Brettle A (2008) How to do a literature search. www.lifeforce-centre.co.uk/downloads/level4-yr1/session3/literature-search/

10/4/13

Brewer J (2000) Ethnography. Open University Press, Maidenhead, UK

Brewer J, Shoulders A and Emmons K (2010) Mind your mommies! Our Hospital's story of hourly rounding on the obstetric patient. Journal of Obstetric, Gynaecological and Neonatal Nursing 39 Supplement 1 p49-50

Brosey L and March K (2015) Effectiveness of structured hourly nurse rounding on patient satisfaction and clinical outcomes. Journal of Nursing Care Quarterly 30 (2) p153-159

Burden B (1998) Privacy or help? The use of curtain positioning strategies within the maternity ward environment as a means of achieving and maintaining privacy, or as a form of signalling to peers and professionals in an attempt to seek information and support. Journal of Advanced Nursing 27 p15-23

Burke K (2011) Improvements evident thanks to new two-hourly rounds. Nursing Standard 26 (3) p32

Care Quality Commission (2011) Dignity and Nutrition Inspection Programme: National Overview. Care Quality Commission, Newcastle on Tyne, UK

Care Quality Commission (2012) State of care report.
www.cqc.org.uk/content/cqc-launch-state-of-care-report-2012
1/1/13

Castledine G (2002) Patient comfort rounds: A new initiative in nursing. British Journal of Nursing 11 (9) p603

Castledine G, Grainger M and Close A (2005) Clinical nursing rounds part 3: Patient comfort rounds. British Journal of Nursing 14 (17) p28-30

Cresswell J (2007) Qualitative inquiry and research design. Sage Publications, London, UK

Crossfield S and Pitt C (2012) Introducing care rounds using rapid spread. Nursing Times 108 (38) p20-21

Crotty M (1998) The Foundations of Social Research Meaning and Perspective in the Research Process. Sage Publications, London, UK

Culley T (2008) Reduce call light frequency with hourly rounds. Nurse Management 39(3) p50-52

Curley C, McEachern J and Speroff T (1998) A firm trial of interdisciplinary rounds on the inpatient medical wards: an intervention designed using continuous quality improvement. Medical Care 36 (8 Supplement) p4-12

D'Alessio E, Magsalin M, Neville K and Patten C (2010) Enhancing nursing's presence. Nursing Management 41 (12) p16-18

Dean E (2012) Regular ward checks raise standards of care. Nursing Management 19 (2) p12-16

Deitrick L, Baker K, Paxton H, Flores M and Swavely D (2012) Hourly Rounding: Challenges with Implementation of an Evidence-Based Process. Journal of Nursing Care Quality 27 (1) p13-19

Department of Health (2001) The Essence of Care. TSO, London, UK

Department of Health (2011a) Harm Free Care.
www.dh.gov.uk/en/healthcare/qualityandproductivity/QIPPworkstream
4/12/2012

Department of Health (2011b) Governance arrangements for Research Ethics Committees (GAfREC). www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/ 5/8/13

Department of Health (2012a) A commitment to quality – Salford Royal NHS Foundation Trust welcomes the Prime Minister. www.dh.gov.uk/2012/01/31/a-commitment-to-quality-2/ 4/2/2012

Department of Health (2012b) Nursing and Quality Care Forum. www.dh.gov.uk/2012/01/01/pm-announces-new-focus-on-quality-and-nursing-care/ 1/6/2012

Department of Health (2012c) Top nurses announce new strategy to build a culture of compassionate care across NHS (6 C's). www.dh.gov.uk/2012/12/04/top-nurses-announce-new-strategy-to-build-culture-of-compassionate-care-across-NHS/ 4/12/2012

Department of Health (2013a) Patients first and foremost. TSO, London, UK

Department of Health (2013b) NHS Friends and Family Test. TSO, London, UK

Dewing J and Lynes O'Meara B (2013) Introducing intentional rounding: a pilot project. Nursing Standard 28 (6) p37-44

Dix G (2012) Engaging staff with intentional rounding. Nursing Times 108 (3) p14-16

Dixon – Woods M, Leslie M, Bion J and Tarrant C (2012) An Ethnographic Study of Infection Data. The Milbank Quarterly 90 (3) p548-591

Driscoll P (2011) Introduction to primary research: observations, survey and Interviews. p153 In Lowe C and Zemliansky P Writing Spaces; Reading on Writing Vol 2, Parlor Press, San Francisco, US

Duffin (2010) Hourly ward rounds improve care and reduce staff stress. Nursing Management 17 (7) p6-7

Dutton R, Cooper C, Jones A, Leone S, Krammer M and Scalea T (2003) Daily multidisciplinary rounds shorten length of stay for trauma patients. Journal of Trauma Nursing 55 (5) p913-919

Fabry D (2015) Hourly rounding: perspectives and perceptions of the frontline nursing staff. Journal of Nursing Management 23 p200-210

Fitzsimmons B, Bartley A and Cornwall J (2011) Intentional rounding: its role in supporting essential care. Nursing Times 107 (27) p18-21

Ford B (2010) Hourly rounding: a strategy to improve patient satisfaction scores. Medsurg Nursing 19 (3) p188-191

Forde-Johnston C (2014) Intentional rounding a review of the literature. Nursing Standard 28 (32) p37-42

Francis Report (2013) Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 Volume 1 and 2. House of Commons, TSO, London, UK

Gardner G, Woolett K, Daly N and Richardson B (2009) Measuring the effect of patient comfort round on practice environment and patient satisfaction; A pilot study. International Journal of Nursing Practice 15 p287-293

Gillen (2012) It is about being highly visible to your patients at least every hour. Nursing Standard 26 (51) p12-13

Goldsack J, Bergey M, Mascioli S and Cunningham J (2015) Hourly rounding and patient falls: what factors boost success? Nursing 2015 45 (2) p25-30

Guba E and Lincoln Y (2004) Competing paradigms in qualitative research: Theories and Issues. In Hesse – Biber S and Leavy P (Eds) Approaches to qualitative research: A reader on theory and practice. Oxford University Press, New York, US

Halm M, Gagner S, Goering M, Sabo J, Smith M and Zaccagnini M (2003) Interdisciplinary rounds impact on patients, families and staff. Clinical Nurse Specialist 17 (3) p133-42

Halm M (2009) Hourly rounds what does the evidence indicate? American Journal of Critical Care Nursing 18 p581-584

Hammersley M and Atkinson P (2007) Ethnography: Principles in Practice. 3rd Ed Routledge, New York, US

Harrington A, Bradley S, Jeffers L, Linedale E, Kelman S and Killington G (2013) The implementation of intentional rounding using participatory action research. International Journal of Nursing Practice 19 p523-529

Hart C (1998) Doing a literature review: releasing the social science research imagination. Sage, London, UK

Hatch C (2002) Nursing has always has comfort rounds. British Journal of Nursing 11 (9) p603

HCPRDU (2002) HCPRDU evaluation tool.
www.usir.salford.ac.uk/13070
1/2/14

Health and Social Care Information Centre (2013) NHS Safety Thermometer: Patient Harms and Harm Free Care.
www.hscic.gov.uk
1/2/14

Healthcare Commission (2007) Investigation into Maidstone and Tunbridge Wells NHS Trust. HMSO, London, UK

Health Service Management Centre (2011) Time to care. Responding to concerns about poor care.
www.birmingham.ac.uk/time-to-care-final-reportpdf.
1/12/12

Henderson V (1997) Basic principles of nursing care. 2nd Eds International Council of Nurses, Geneva, Switzerland

Hicks D (2015) Can rounding reduce patient falls in acute care? An integrative literature review. Medsurg Nursing 24 (1) p51-55

Hill K (2003) The sound of silence – nurses' non-verbal interaction within the ward round. Nursing in Critical Care 8 (6) p231-239

Hunt J (2012) Intentional rounding belies evidence based practice. Nursing Standard 26 (23) p26

Hutchings M (2012) Caring around the clock: rounding in practice. Nursing Times 108 (49) p12-14

Hutchings M, Ward P and Bloodworth K (2013) Care around the clock: a new approach to intentional rounding. Nursing Management 20 (5) p24-30

Keats J (2002) Patient comfort rounds are an excellent idea. British Journal of Nursing 11 (8) p530

Kenny R and Norton C (2015) Staff and patient views on intentional rounding. Nursing Times 111 (42) p16-19

Kessler B, Claude-Gutekunst M, Donchez A, Dries R and Snyder M (2012) The merry-go-round of patient rounding: ensure your patients get the brass ring. Medsurg Nursing 21 (4) p240-245

Kim H (1993) Identifying alternative linkages among Philosophy, theory and methods in nursing science. Journal of Advanced Nursing 18 p793-800

Krepper R, Vallejo B, Smith C, Lindy C, Fullmer C, Messimer S, Xing Y and Myers K (2012) Evaluation of a standardised hourly rounding process (SHaRP). Journal for Quality Healthcare 36 (2) p62-69

Krippendorff, K. (2004) Content analysis: An introduction to its methodology. Thousand Oaks: Sage, CA, US

Leighty J (2007) Hourly rounding dims call lights: a nationwide study sparks protocol to improve nursing efficiency and patient satisfaction. Nursing Spectrum 18 (25) p8-9

Levenson R (2013) A Report on the Implementation of Intentional Rounding at Demonstrator Sites for The Nursing and Care Quality Commission www.6cs.england.nhs.uk/dl/cv-content/81294

Lowe L and Hodgson G (2012) Hourly rounding in a high dependency unit. Nursing Standard 27 (8) p35-40

Lowenberg J (1993) Interpretive research methodology: Broadening the dialogue. Advances in Nursing Science 16 (2) p57-69

Lucas B, Adjoto E and Ahmed R (2010) Report on – proactive patient rounding: developing nursing practice to improve the quality of patient care. Whipps Cross University Hospital Trust, London, UK

Lyons S, Brunero S and Lamont S (2015) A return to nursing rounds – person centred or a task too far? Australian Nursing and Midwifery Journal 22 (9) p30-33

Manias E and Street A (2001) Nurse – doctor interactions during critical care ward rounds. Journal of Clinical Nursing 10 p442-450

Manthey M (2002) The practice of primary nursing. Creative Healthcare Management, Minneapolis, US

Marquis B and Huston C (2009) Leadership role and management functions in nursing: theory and application. 6th Ed Lippincoott Williams and Wilkinson, Philadelphia, US

Mason J (2002) Qualitative Researching. 2nd Ed Sage Publications, London, UK

Mason M (2012) More than a check list. Nursing Standard 26 (20) p20

McCartney P (2009) Hourly Rounds: An evidence based practice. American Journal of Maternal Child Nursing 34 (5) p327

McDonagh V (2013) Sustaining pressure ulcer prevention in practice. Nursing Times 109 (15) p12-16

Meade C, Bursell A and Ketelsen L (2006) Effects of nursing rounds on patient's call light use, satisfaction and safety. American Journal of Nursing 106 (9) p58-70

Miller L and Limbaugh C (2008) Applying evidence to develop a medical oncology fall prevention programme. Clinical Journal of Oncology 12 (1) p158-160

Mitchell M, Lavenberg J, Trotta R and Umscheid C (2014) Hourly rounding to improve nurse responsiveness. The Journal of Nursing Administration 44 (9) p462-473

Mid Staffordshire NHS Foundation Trust Inquiry (2010) The Robert Francis Inquiry into Mid Staffordshire NHS Foundation Trust. TSO, London, UK

Moran J (2011) Improving care on mental health wards with hourly nurse rounds. Nursing Management 18 (1) p22-26

Mower-Wade D and Pirrung J (2010) Advanced practice nursing making a difference; Implementation of a formal rounding process. Journal of Trauma Nursing 17 (2) p69-71

Murphy T, Labonte P, Klock M and Houser L (2008) Falls prevention for elders in acute care: an evidence based nursing practice initiative Critical Care Nursing Quarterly 31 (1) p33-39

National Institute for Health and Clinical Excellence (2012) Patient experience in the adult NHS services: improving the experience of care for people using adult NHS services: patient experience in generic terms. Clinical guidance, methods, evidence and recommendations. National Institute for Health and Clinical Excellence, London, UK

National Institute for Health and Clinical Excellence (2014) Safe staffing for nursing in adult inpatient wards in acute hospitals. Safe staffing guideline.
www.nice.org.uk/sg1
1/8/2014

National Nursing Research Unit (2012) Intentional Rounding: What is the evidence?
www.kcl.ac.uk/nursing/research/nnru/index.aspx
1/6/2012

National Patient Safety Association (2008) Supporting the NHS in Wales to save 1000 lives.
www.npsa.uk/corporate/news
1/6/2012

Negus J (2010) Regular checks cut falls rates. Nursing Standard 25 (6) p8

NHS Institute (2007) Safer Care.
www.institute.nhs.uk/safer-care/
1/6/12

NHS Institute (2008) The Productive Ward.
www.institue.nhs.uk/the-productive-ward.html
1/6/12

NHS Institute (2009) High Impact Actions (HIA)
www.institute.nhs.uk/high-impact-actions/
1/6/12

Neville K, Lake K, LeMunyon D, Paul D and Whitmore K (2012) Nurses' perceptions of Patient Rounding. Journal of Nursing Administration 42 (2) p83-88

Olrich T, Kalman M and Nigolian C (2012) Hourly rounding: a replication study. MedSurg Nursing Jan – Feb 21 (1) p23-6

Orlando I (1993) A nursing process theory. In Vol 12 of Notes on nursing theories, Sage, London, UK

Orr N, Tranum K and Kupperschmidt (2008) Hourly rounding for positive patient and staff outcomes: fairy tale or success story. Oklahoma Nurse 51 (4) p11

Parahoo K (2014) Nursing Research, principles, process and issues. 3rd Edition Palgrave Macmillan, London, UK

Parliamentary and Health Service Ombudsman (2011) Care and Compassion? Report of the HSO on ten investigations into NHS care of older people.TSO, London

Paterson J and Zderad L (2008) Humanistic Nursing.

www.gutenberg.org/files/25020/25020-8.txt
1/8/14

Patients Association (2010) Listen to Patients, Speak up for Change. Patients Association, London, UK

Picker Institute (2008) Inpatient Survey.
www.nhssurvey.org
1/12/12

Quigley P, Halm B, Collazo S, Gibson W, Janzen S, Powell-Cope G, Rice F, Sarduy I, Tyndall K and White S (2009) Reducing serious injury from falls in two veteran's hospital medical-surgical units. Journal of Quality Care 24 (1) p33-41

Robson C (2011) Real World Research. 3rd Edition Blackwell Scientific Oxford, London, UK

Rondinelli J, Ecker M, Crawford C, Seelinger C and Omery A (2012) Hourly rounding implementation: a multisite description of structure, processes and outcomes. Journal of Nursing Administration 42 (6) p326-332

Roper N, Logan N and Tierney A (2000) The Roper, Logan and Tierney Model of Nursing. Churchill Livingstone, Edinburgh, UK
Roy C (1981) Theory construction in nursing: an adaptation model. Prentice Hall, New Jersey, US

Salch B, NUSir H, Al Zubadi N, Al Shloul S and Salach U (2011) The nursing rounds system: effects of patient's call light use, bed sores, falls and satisfaction level. International Journal of Nursing Practice 17 p299-303

Savage J (2000) Ethnography and health care. British Medical Journal 321, 2nd December p1400-1402.

Savage J and Scott C (2005) Patients' nutritional care in hospital: An ethnographic study of nurses' role and patient experience. NHS estates
www.npsa.nhs.uk
14/4/2014

Schneider Z, Whitehead D and Elliott D (2007) Nursing and midwifery research. 3rd Edition Mosby Elsevier, Sydney, Australia

Scott M (2002) Patient comfort rounds are an excellent idea. British Journal of Nursing 11 (8) p530

Sheedy S (1989) Responding to patients: the unit hostess. Journal of Nursing Administration 19 (4) p31-33

Sherrod B, Brown R, Vroom J and Sullivan D (2012) Round with purpose. Nursing Management 43 (1) p33-38

Silverman D (2013) Doing Qualitative Research. 4th Edition Sage, London, UK

Snelling P (2013) Ethical and professional concerns in research: intentional rounding in the United Kingdom. Nursing Ethics p1-13

Sobaski T, Abraham M, Fillmore R, McFall D and Davidhizar R (2008) The effects of routine rounding by nursing staff on patient satisfaction on a cardiac telemetry unit. The Health Care Manager 27 (4) p332-337

Sorrell J and Redmond G (1995) Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies. Journal of Advanced Nursing 21 p1117-1122

Spradley J (1980) Participant Observation, Wadsworth, Belmont, US

Sterman E, Guauker S and Krieger J (2003) Continuing education: a comprehensive approach to improving caner pain management and patient satisfaction. Oncology Nurses Forum 30 (5) p857-864

Stoddart K, Cicco-Moore R, Grant F, Niven B and Paterson H (2014) Care and comfort rounds: improving standards. Nursing Management 20 (9) p18-23

Streubert H and Carpenter D (2011) Qualitative Research in Nursing. Wolters Kluwer, Philadelphia. US

Studer Group (2007) Best Practice: Sacred Heart Hospital, Pensecola Florida. Hourly Rounding Supplement. Studer Group, US

Tea C, Ellison M and Feghill F (2008) Proactive patient rounding to increase customer service and satisfaction on an orthopaedic unit. Orthopaedic Nursing 27 (4) p233-240

Toole N, Meluskey T and Hall N (2016) A systematic review: barriers to hourly rounding. Journal of Nursing Management 24 p283-290

Tucker S, Bieber P, Attlesey-Pries M, Olsen M and Dierkhising (2012) Outcomes and challenges in implementing hourly rounds to reduce falls in Orthopedic Units. Worldviews on Evidence Based Nursing 9 (11) p18-29

Ulanimo V and Ligotti N (2011) Patient satisfaction and patient safety: outcomes of purposeful rounding. Topics in Patient Safety 11 (4) p4

Walker K, Duff J and Fitzgerald K (2015) 'Rounding' for better patient care: an evaluation of an improvement intervention implementation. International Journal of Nursing Practice 21 p207-213

Watson J (1999) Nursing: Human Science and Human Care: a theory of nursing. Jones and Barrlett, London, UK

Waszynski C (2012) More rounding means better fall compliance. Same Day Surgery 26 (3) p30-31

Weisgram B and Raymond S (2008) Using evidence based nursing rounds to improve patient outcomes. Medsurg Nursing 17 (6) p429-430

West D (2012) Intentional rounds should be done every hour, says forum lead. Nursing Times 108 (18) p3

Wood D (2008) Rounding cuts call light use.
www.nursezone.com/nursing-news-events/more-news/Rounding-cuts- call-light-Use_28644.aspx
1/6/2012

Woodward J (2009) Effects of Rounding on Patient Satisfaction and Patient Safety on a Medical – Surgical Unit. Clinical Nurse Specialist 23 (40) p200-206

Appendix 1

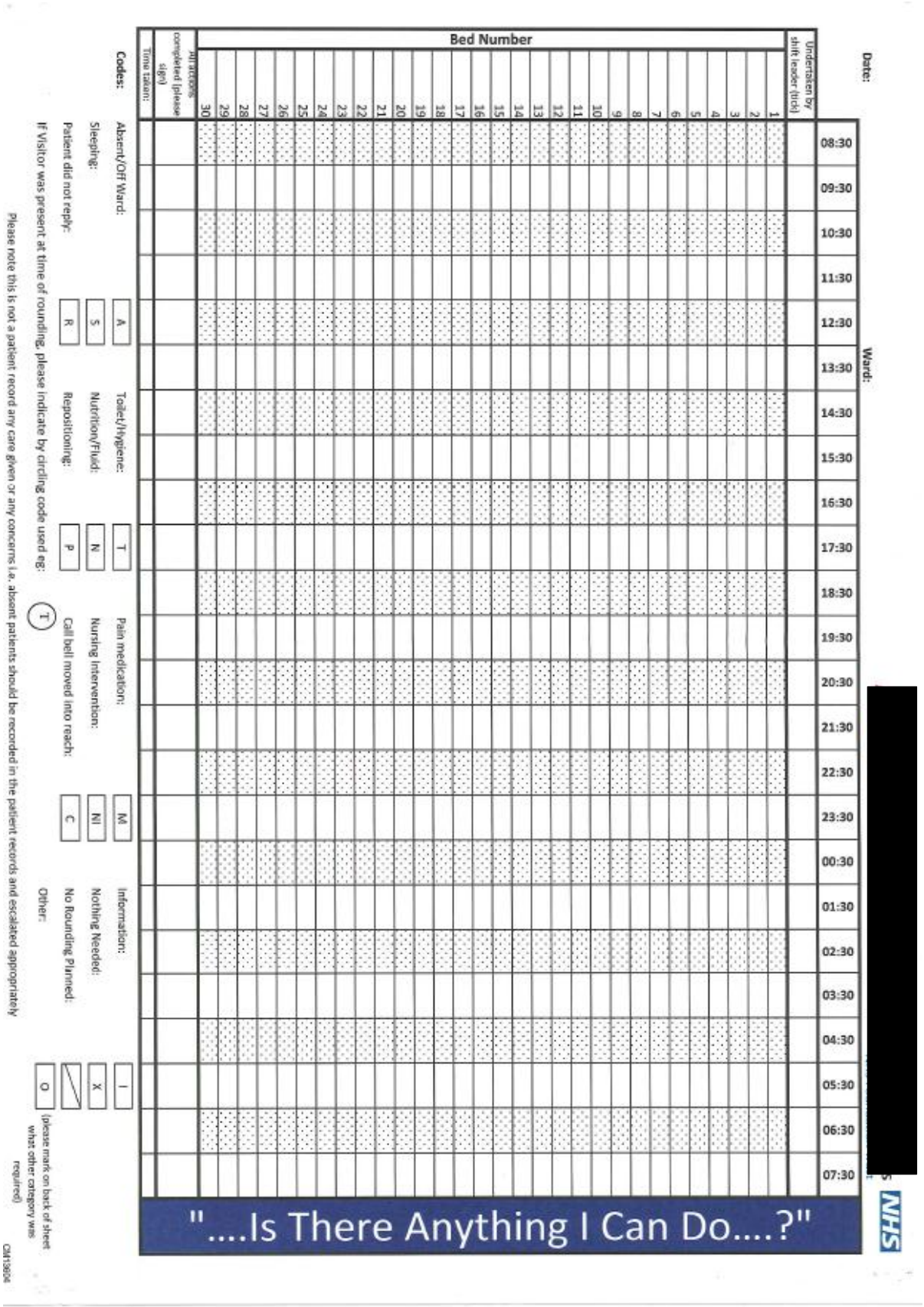
Research Training and Development

September 2010 to September 2014

September 2010	Doctoral Foundation Module
February 2011	Research Methods Module
	Critical Leadership Module
September 2011	Professions and Practice Module
February 2012	Researcher Practitioner Module
April 2013	Introduction to Endnote x5 (Library)
	Trust Re-launch of Patient Focused Rounding (Central Manchester Foundation Trust)
June 2013	Directors of Nursing Workshop, The 6 C's (NHS England)
	Application for Post Qualification Learning Funding (Central Manchester Foundation Trust)
September 2013	Workshop presentation Nursing and Midwifery Conference, The Art and Science of Nursing (Central Manchester Foundation Trust)
November 2013	University of Salford, College of Health and Social Care, Research Ethics, Ethical approval submission
December 2013	National Research Ethics Service, Application presentation for approval to Greater Manchester West Committee
January 2014	Introduction to Good Clinical Practice Certificate (GCP)
February 2014	Manchester Heart Centre, Royal Manchester Infirmary (Central Manchester Foundation Trust) Research Meeting, presentation of research project for approval

April 2014	Facilitated workshop for nurse participant observers/interviewers
	Research and Development application submission (Central Manchester Foundation Trust)
September 2014	Workshop presentation Nursing and Midwifery Conference, Let's get Personal about Rounding (Central Manchester Foundation Trust)
March 2015	Conference presentation RCN Education Forum, National conference and Exhibition, Patient rounding the biggest tick box exercise in nursing today (East Midlands Conference Centre, Nottingham)
June 2015	Publication, Continuing Professional Development article, Effects of rounding on patient care, Nursing Standard 29, 42 p51 – 58

Appendix 2: Rounding chart



....Is There Anything I Can Do....?	
Arabic	كيف استطيع مساعدتك؟
Polish	Czy jest coś co mogę zrobić, aby pomóc?
Romanian	Vă pot ajuta cu ceva?
Simplified Chinese	这有什么我可以帮忙的吗？
Urdu	کیا کچھ ایسا ہے جس میں ہم اپکی مدد کر سکتے ہوں؟
Bengali	এমন কিছু আছে কি ংসাহায্য করতে পারি?
Somali	Miyey jiraan waxkasta aan kuu sameeyn karo inaan ku caawiyo?

If you require a different language please use Big Word or book a translator

....Have you any worries or concerns...?				
	worries & concerns? Y/N	Time asked	Relative Present Y/N	Response to Worries and Concerns Question.....
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

Tally of responses to worries and concerns question that fit within current themes:	info re discharges	info re care mgt	other

Appendix 3

Descriptive Matrix – Rounding Process

Features of Social Situations – Spradley 1980 p82,

	Feature	Rounding Feature – Overall process Examples	Rounding Feature – Individual process Examples
1	Space – physical place	Layout of the ward, bays, side rooms, boundaries of bed spaces	Closeness to patient Position by bed/chair Entering privacy curtains Ability to discuss worries and fears question in a bay
2	Actor – people involved	Nurse/HCSW/Housekeeper/Student Nurse Patient/Relative Number of staff participating in the round Team work	Seniority/Experience Additional assistance required eg if none RN round and medication required
3	Activity – set of related acts	Documentation/charting	Introduction Talking to patient Carry out activities requested by patient Carry out interventions related to assessment **Closing question** – is there anything more I can do for you **Inform about next round**

4	Object – physical objects present	**Personal possessions (P assessment)** call bell, drinks/food, mobility aids, footwear, hygiene materials, medication	Organisation of objects within bed space area, closeness to patient, importance to patient Assessment of the safety of the environment due to objects/positioning
5	Act – single actions undertaken	Number of acts Verbal interaction, physical interventions, environmental interaction	Task approach/completion Complexity of what was done for individual patients
6	Event – set of related activities people carry out	**4 P assessment** **Pain** **Position** (comfort/change of position), **Personal Hygiene** (toilet requirements) **Possession** (see objects) Patient safety (falls prevention)	Promptness of response Degree of responsiveness Prioritisation
7	Time/Timing – sequencing that takes place overtime	Time taken to complete round Sequence of rounding	Length of individual interactions
8	Goal – things people are trying to accomplish	Patient comfortable, pain free, questions answered Patient need met – patient feels that there is no more that is required from the rounding nurse Reduced call bell usage	Individuality to each patient, not task **Presence (5th P)** Accessibility/availability Engagement Opportunity to express

			needs Safe bed space environment Call bell with patient
9	Feeling – emotions felt expressed	Perfunctuary/Habitual Enthusiasm Smile, use of humour Physical touch, eye contact	Appropriate expression of caring for each individual

Appendix 4

Nursing and Midwifery Conference

Art and Science of Nursing

[redacted] 2013

Workshop: Patient Rounding

Review of Descriptive Matrix: Rounding Process

Workshop attendance

- 3 workshops, 50 minutes in length, approx. 30 participants in each workshop
- Participants had various roles within the acute and community setting both qualified nurses and unqualified Health Care Support Workers, it also included Dental Nurses
- At the end of the workshop participants were asked for verbal comments on the Descriptive Matrix to gather opinion about its usefulness as a tool to observe the process of rounding in practice

General comments on the matrix

A show of hands for each workshop session gave a majority of participants who felt the matrix covered the components required for the rounding process

Specific verbal comments on the matrix

- The Matrix covers basic nursing which is good, rounding helps to look at the basics, modern nursing more paper work and technology rounding re addresses this balance
- Good no additional comments this covers what rounding should be
- Need to observe how physical space used to discuss worries and fears
- Observe if tasks passed onto other staff eg Registered Nurses administering analgesia
- Ensure the environment is assessed
- Need to see if patients see rounding is just another task
- Is prioritisation observed
- Need to check if call bells with patient
- Need to ask staff if they have had training in rounding
- Observe if it is explained to patients why they are being asked the rounding questions and that someone will return

Appendix 5

Field Note Record

Field Note Record Rounding Project			
Ward:	**Observer:**	**Date:**	
Rounding started:	**Rounding finished:**	**Rounder ID:**	**Title:**
Patient interview ID:	**Staff interview ID:**		

Raw Date/What I saw	What I thought/Interpretation

Raw Data/What I saw	What I thought/Interpretation

Appendix 6

Version 1: 8 11 13

Interview Guide – Patients

Patient Interviews

Patient interviews will be based on what is observed/not observed during the observation of the rounding process

The observation will be based on the Descriptive Matrix which will guide the observer to the component parts of the rounding process

From the observation the interviewer will be able to explore if the patients care needs were met at the time of the rounding and how this impacts on their hospital experience of nursing care

Example Questions

Did the nurse introduce themselves and explain what they were doing?

Did the nurse ask a series of questions to see if you had any needs?

Was the nurse able to perform any actions / activities which helped you?

Did the presence / visit of the nurse helpful / reassuring?

Did the nurse say they would come back to see you and if so when?

Appendix 7

Version 1: 8 11 13

Interview Guide – Staff

Staff Interviews

Staff interviews will be based on what is observed/not observed during the observation of the rounding process

The observation will be based on the Descriptive Matrix which will guide the observer to the component parts of the rounding process

From the observations the interviewer will be able to explore if the staff feel they have met the patient's care needs at the time of the rounding process and how this impacts on their patient care delivery

Example Questions

Were you able to introduce yourself to the patients and explain what they were doing?

How did you ascertain if the patients had any needs?

Did you perform any actions / activities for the patients?

Do you think your presence / visit to the patients was helpful / reassuring?

Did you say you would come back to see the patient and if so when?

Appendix 8

Rounding Research

Nurse Participant Observer/Interviewers Training Workshop – Agenda

Date: 6/4/14

Time: 12.30 to 14.00

Venue: Ward 36 Seminar Room

Facilitator: [redacted] Principle Investigator

Agenda

- Overview of the research project – rationale, design and methodology
- Descriptive matrix
- Consent, ethics and practice
- Participant Observation – participation and field note records
- Interviews – patients and staff
- Information file
- Timetable of observation
- Use of digital recorders

Appendix 9

Rounding Research – May 2014

Nurse Observer/Interviewer Information Pack

Contents

- Programme for nurse observer training
- Powerpoint presentation – rounding research
- Participant Observation – double entry record keeping information sheet
- Ethnographic paper Burden 1998
- Observation record
- Descriptive matrix
- Interview structure/questions
- May calendar
- Rounding sheet ward 1+2
- **Confidential patient and staff ID (Separate circulation)**

Appendix 10

Version: 1: 1.10.13

Date:

Participant Identification Number for this study:

Invitation Letter – Patient

Study Title: Patient Rounding: a study of the impact on patient experience and care

Dear participant,

My name is [redacted] and work as Head of Nursing at [redacted] Trust. I am currently doing a Professional Doctorate Study at University [redacted]. I am conducting a research study into an aspect of patient care in an NHS hospital, as part of the requirements of my PhD programme, and I would like to invite you to participate. The study is to find out about a process called patient rounding and to see if this impacts on the patient experience and care during their hospital stay.

I am inviting you whilst you are a patient with us on the [redacted] ward to take part in my research study. Attached is an information sheet explaining the research study and what it would involve from a patient's perspective.

Please read it carefully and telephone me if you have any questions (see below). If you are happy to be involved please can you sign the consent form that the [redacted] pre admission nurse has at the end of your visit to the pre admission clinic.

With kind regards,

[redacted]

Appendix 11

Participant Identification Number:

PARTICIPANT INFORMATION SHEET - PATIENT

Project Title:

Patient Rounding: a study of the impact on patient experience and care

Dear Participant

You are invited to take part in a research study. Before you decide you may wish to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information, please contact [redacted] (contact details below).

Purpose of the research study

Nurses regularly checking on patients when they are in hospital and this practice called 'rounding' has been introduced into many hospitals throughout the UK, in the past few years. Rounding is now part of the usual ward routine, undertaken either hourly or on a two hourly basis, by the ward nurses. However we don't know if such nursing care practice is useful to patients and if so in what way. We want to do some research to understand how the practice of rounding, in this hospital may impact on patient experience and patient care. The research is based on seeing, listening and talking about rounding with patients and staff. It is hoped the findings of this study will be valuable information to help nurses develop their practice to meet the needs of the patients.

Why have I been invited?

You have been chosen because you will spend time on wards 3 and 4 where the study into rounding will take place, where we will be observing nursing care and we would be interested to understand your views of rounding.

Do I have to take part?

No, your participation is entirely voluntary. It is up to you to decide whether or not to take part. If you choose not to take part you can dispose of the study information and we will not contact you again.

What will I have to do if I choose to take part?

There are two ways you can be involved within the research study. The first is to give your consent and agree to a nurse who will be observing rounding on the ward to be able to observe your care, only during rounding, whilst you are an in-patient on the ward. The observation will not be intrusive and the nurse will be stood away from the bedside, in a quiet location on the ward, so as not to interfere with nursing care. The second way is that we will be selecting a number of patients and asking them to take part in one short interview after a nurse round. You could agree to take part in an interview which should not take longer than 15 minutes asking you about your experience of nurse rounding. The interview will take place in a private room or at your bedside if you do not wish to move from your bedside area. The interviews will be audio recorded and the audio tapes of the interviews will be transcribed and then deleted.

Will I get paid for my involvement?

Taking part in the study is voluntary there is no payment or expenses available to people who participate.

What are the side effects of the study when taking part?

There are no known side effects.

What are the possible benefits of taking part?

There are no benefits to you as an individual taking part in the study, but your responses may help patients and nurses develop their practice in the future..

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time without any effects on you or your in-patient care. If you decide after giving consent for your care to be observed that you do not want to be involved, any observation recorded about you will be removed. If you decide after the interview that you no longer want your information to be involved then you can contact the researcher. She will have a master list of all the assigned numbers of the patient's participant information sheets (see top of this sheet). This number will then identify all the information within the study pertaining to you. The lead researcher can then remove all the information from you that is included in the study. Your information can be removed, if requested, up to the point of the final report being produced.

What if there is a problem?

If you have a problem with the research at any time you can report this to the researcher (contact details below). If the problem you have relates to the way in which the research is being undertaken then you can report this to the researcher's supervisor: Professor [redacted] **Email:** [redacted] **or Telephone:** [redacted] or the Research Office, on telephone [redacted]

If you feel you cannot contact the above person an independent advocate to contact is Mr [redacted] who is a Clinical Effectiveness/Governance Manager at the Trust, E mail: [redacted] Telephone [redacted]

Will my taking part in this study be kept confidential?

Yes. All information which is collected about you during the course of the research will be kept strictly confidential, the information you provide through your interview will be anonymous using a unique code. This information will be kept safe on a password protected computer, accessed only by the researcher and the research supervisor. Any audio taped interviews will be transcribed and then deleted. The information will only be used for the research and will not be shared with anyone outside the research group which

consists of me, a team of 4 research nurses, my supervisors and Trust's Research Office Managers.

What will happen with the results of the study?

Results will be published in scientific journals or presented at conferences. When the findings of the study are reported the opinions and perspectives of patient interviews will be discussed as a group with the identity of individual people being anonymous. If you would like further information about the results of the study you can contact the researcher, details below, in June 2015 when the study will be completed.

Who has reviewed the study?

This study has been reviewed by the Trust's Research & Innovation Division and the University [redacted] Ethics Committee as well as the National Research Ethics Committee

Who has paid for this research?

There are no specific costs related to this research.

Further information and contact details

[redacted]

Appendix 12

Date :Participant Identification Number :

CONSENT FORM FOR RESEARCH STUDY

(for observation and interviews)

Title of Project**: Patient Rounding: a study of the impact of rounding on patient experience and care**

Name of Researcher: [redacted]

	Please initial to confirm
I confirm that I have read and understand the information sheet dated 16.1.14 (v2) for the above study.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	
I understand that relevant sections of data collected during the study, may be looked at by responsible individuals, from regulatory authorities or from the NHS Trust.	
I understand that if I require further support because of an issue(s) related to the research I have an independent advocate to contact.	
I give permission for the information's to be accessed by the academic supervisor and hospital research committee members.	
I understand that if the research nurse when observing rounding saw unprofessional practice, the research nurse would inform the Ward Matron	
I agree to the use of audio recording the interview and the use of anonymised direct quotes	
I agree to take part in the above research study	

Appendix 13

Participant Identification Number for this study:

Invitation Letter – Staff

Study Title: Patient Rounding: a study of the impact on patient experience and care

Dear participant,

My name is [redacted] and I work as [redacted] at [redacted] Trust. I am currently doing a Professional Doctorate Study at University [redacted]. I am conducting a research study into an aspect of patient care in an NHS hospital, as part of the requirements of my PhD programme, and I would like to invite you to participate. The study is to find out about a process called patient rounding and to see if this impacts on the patient experience and care during their hospital stay.

I am inviting you as a member of staff on the cardiac ward to take part in my research study. Attached is an information sheet explaining the research study and what it would involve from a member of staff's perspective.

Please read it carefully and telephone me if you have any questions (see below). If you are happy to be involved please can you sign the consent form that I distributed at the end of the information giving sessions.

With kind regards,

[redacted]

Appendix 14

Participant Identification Number:

PARTICIPANT INFORMATION SHEET - STAFF

Project Title:

Patient rounding a study of the impact on patient experience and care

You are invited to take part in a research study. Before you decide you may wish to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information, contact [redacted] (details below).

Purpose of the research study

The practice of rounding in hospitals is a process for nurses regularly checking on patients and this practice has been introduced into nursing care across many hospitals in the country in the past few years. Rounding is now part of the usual ward routine, undertaken either hourly or on a two hourly basis, by the ward nurses. However we don't know if such nursing care practice is useful to patients and if so in what way. We want to do some research to understand how the practice of rounding, in this hospital may impact on staff workload, patient experience and patient care. The research is based on seeing, listening and talking about rounding with patients and staff. It is hoped the findings of this study will be valuable information to help inform nurses develop their practice to meet the needs of the patients.

Why have I been invited?

You have been chosen because you are part of the ward team and work on wards 3 and 4 where the study into rounding will take place, where we will be observing nursing care and we would be interested to understand your views of rounding.

Do I have to take part?

No, your participation is entirely voluntary. It is up to you to decide whether or not to take part. If you choose not to take part you can dispose of the study information and we will not contact you again.

What will I have to do if I choose to take part?

There are two ways you can be involved within the research study. The first is to give your consent and agree to be observed by a nurse researcher when you are carrying out the process of rounding for patients. The observation will not be intrusive and the nurse will be stood away from the bedside, in a quiet location on the ward, so as not to interfere with nursing care. The second way is that we will be selecting a number of staff and asking them to take part in one short interview after a nurse round. You could agree to take part in an interview which should not take longer than 15 minutes asking you about your experience of delivering rounding to patients on the ward. The interviews will take place in a private room. The interviews will be audio recorded and the audio tapes will be transcribed and deleted.

Will I get paid for my involvement?

Taking part in the study is voluntary there is no payment or expenses available to people who participate.

What are the side effects of the study when taking part?

There are no known side effects.

What are the possible benefits of taking part?

There are no benefits to you as an individual taking part in the study, but your responses may help nurses develop and create an evidence base for their practice in the future. The results of this study will help to understand the process of rounding and how it can impact on the patient experience and patient care.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time without any effects on you as nurse.
If you decide during the observation process or after the interview that you no longer want your information to be included then you can contact the lead researcher. She will have a master list which has all the assigned numbers of the staff member's participant information sheets (see top of this sheet). This number will identify all the information within the study pertaining to you. The lead researcher can then remove all the information from you that is included in the study. Data can be removed if requested, up to the point of the final report being produced.

What if there is a problem?

If you have a problem with the research at any time you can report this to the researcher (contact details below). If the problem you have relates to the way in which the research is being undertaken then you can report this to the researcher's supervisor: Professor [redacted] Email: [redacted] or Telephone: [redacted] or the Research Office, on telephone [redacted]

If you feel you cannot contact the above person an independent advocate to contact is Mr [redacted] who is a Clinical Effectiveness/Governance Manager at the Trust, E mail: [redacted] Telephone [redacted]

If the researchers see any poor practice during their observation of rounding the researchers will need to disclose this information to the Ward Matron.

Will my taking part in this study be kept confidential?

Yes. All information which is collected about you during the course of the research will be kept strictly confidential, the information you provide through your interview will be

anonymous using a unique code. The interviews will be audio recorded and the audio tapes of the interview will be transcribed and then deleted. This information will be kept safe on a password protected computer, accessed only by the researcher and the research supervisor. The information will only be used for the research and will not be shared with anyone outside the research group which consists of me, a team of 4 research nurses, my supervisors and Trust's Research Office Managers.

What will happen with the results of the study?

Results will be published in scientific journals or presented at conferences. When the findings of the study are reported the opinions and perspectives of staff interviews will be discussed as a group with the identity of individual people being anonymous. The study will be completed in June 2015 and the researcher will then feedback the findings of the study to the ward staff at ward based information sessions.

Who has reviewed the study?

This study has been reviewed by the Trust's Research & Innovation Division and the University [redacted] Ethics Committee and the National Research Ethics Committee.

Who has paid for this research?

There are no specific costs related to this research.

Further information and contact details

[redacted]

Appendix 15

Date :Participant Identification Number :

CONSENT FORM FOR RESEARCH STUDY – STAFF

(for observation and interviews)

Title of Project**: Patient Rounding: a study of the impact of rounding on patient experience and care**

Name of Researcher: [redacted]

	Please initial to confirm
I confirm that I have read and understand the information sheet dated 16.1.14 (v2) for the above study.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	
I understand that relevant sections of data collected during the study, may be looked at by responsible individuals, from regulatory authorities or from the NHS Trust.	
I give permission for the information's to be accessed by the academic supervisor and hospital research committee members.	
I understand that if I require further support because of an issue(s) related to the research I have an independent advocate to contact.	
I agree to the use of audio recording the interview and the use of anonymised direct quotes	
I understand that if the research nurse when observing rounding saw unprofessional practice, the research nurse would inform the Ward Matron	
I agree to take part in the above research study	

Appendix 16

[redacted]

Research, Innovation and Academi
Engagement Ethical Approval Pane

[redacted]

10 March 2014

[redacted]

RE: ETHICS APPLICATION HSCR13/84 – Patient Rounding: an ethnographic study to understand the impact of rounding on patient experience and care in an acute NHS teaching hospital

Based on the information you provided, I am pleased to inform you that application HSCR13/84 has now been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

[redacted]

[redacted]
College Support Officer (R&I)

Appendix 17

[redacted]

[redacted]

[redacted]

Ref: R03479-Ltr 2-[redacted]

Dear [redacted]

PIN: R03479 (Please quote this number in all future correspondence)
REC Reference: 13/NW/0828
Research Study: Patient Rounding: An ethnographic study to understand the impact of rounding on patient experience and care in an acute NHS teaching hospital.

Thank you for submitting the above study for NHS R&D permission. [redacted] is the Sponsor for this study which ***is not*** on the NIHR portfolio.

I am pleased to confirm that the Research Office has now received all necessary documentation, and the appropriate governance checks have been undertaken. This letter is issued subject to the research team complying with the attached conditions, Trust SOPs, the DH Research Governance Framework, and any other applicable regulatory requirements. This approval is in relation to the documentation listed.

Your R&D Approval is subject to [redacted] attending (or providing evidence of having attended in the last 3 years), training covering aspects of Good Clinical Practice and Research Governance. To book a place on the NIHR GCP Training sessions (available monthly) please use the link **http://learning.nihr.ac.uk/Register.aspx** to set up an account.

[redacted] should attend within 2 months (or provide a Certificate of Attendance if you attended a course facilitated by another organisation). We will check our GCP attendance records in the next 2 months to confirm that you have met this requirement, otherwise we will contact you for evidence from an external Provider if not already provided.

[redacted] should not participate in the trial until his GCP training has been completed.

CMFT are required to report whether the research was initiated within 70 days or provide valid reasons for not doing so. The target date for this study is listed below;

- NIHR 70 Day from Valid Submission to 1st Patient Recruited: **23/05/2014**

Further information regarding the NIHR target can be found on the intranet.

Please update CRIMSON with the date when the first patient was recruited. If you or one of your team requires training on CRIMSON please contact [redacted]

I would like to take this opportunity to wish you well with your research.

Yours sincerely

[redacted]

Research Operations Manager
Date:

Encs. mCTA fully executed
NHS SSI form
cc. [redacted]

Documents Acknowledged/Approved

Document	Version Number / Reference	Date
Advertisement	1.0	08 November 2013
Evidence of Insurance or Indemnity	Professional Indemnity	15 July 2013
Evidence of Insurance or Indemnity	Employers' Liability	11 July 2013
Interview Schedules/Topic Guides	1.0	08 November 2013
Investigator CV	Langley	08 November 2013
Investigator CV	Ormandy	
Letter of Invitation to Participant	1 - Patient	08 November 2013
Letter of Invitation to Participant	1 - Staff	08 November 2013
Descriptive Questions Matrix	1.0	08 November 2013
Participant Consent Form: Staff	2.0	16 January 2014
Participant Consent Form: Patient	2.0	16 January 2014
Participant Information Sheet: Staff	2.0	16 January 2014
Participant Information Sheet: Patient	2.0	16 January 2014
Protocol	1.0	06 October 2013
REC Approval Letter	13/NW/0828	28 February 2014
R&D Form	3.5	26 November 2013

Conditions of Approval:-

- All researchers involved in the study need to have received training appropriate to their role covering aspects of Research Governance or Good Clinical Practice (GCP). Trust policy states GCP training needs to be renewed every 3 years.
- The Research Office must be informed of: (please forward copies of amended documents by email)
  - The actual start date of the project
  - Any changes to the protocol throughout the course of the project
  - Any amendments sent to the MHRA or Research Ethics Committee
  - Any changes to the management of the project
  - Any extensions to the project, and associated additional funding, if applicable.
- The Research Office must be notified immediately of all Serious Adverse Events (SAEs) and Suspected Unexpected Serious Adverse Reactions (SUSARs) via email adverse.events@cmft.nhs.uk or Research Office fax: 276 5766 and/or by copy of official notification to the regulatory authorities (NRES, MHRA as applicable).
- All research taking place on CMFT Trust premises is subject to the Trust monitoring programme, either as part of the annual 10% audit requirement or "triggered" monitoring[1]. The Chief and/or Principal Investigator is required to make him/her self available for any monitoring visit, on a mutually agreed date.
- All Principal Investigators are required to complete and submit an annual self-assessment at the request of the Research Office.
- All Principal Investigators are required to provide recruitment (accrual) data to the Research Office monthly.
- The Research Office must be given a minimum three months' notice, in writing, if the Principal Investigator leaves the employment of CMFT Trust.
- The Research Office must receive immediate notification if the Principal Investigator is unable to continue to fulfil his/her duties as PI for other reason e.g. long-term sickness
- Any evidence of fraud &/or misconduct must be immediately brought to the attention of the Research Office either via the Incident Reporting system, or by direct communication.

Failure to comply with any of the above may result in withdrawal of approval for the project and the immediate cessation of the research. Persistent failure to comply may result in disciplinary action.

Appendix 18

28 February 2014

Dear M

Study title:	**Patient Rounding: An ethnographic study to understand the impact of rounding on patient experience and care in an acute NHS teaching hospital**
REC reference:	**13/NW/0828**
IRAS project ID:	**140623**

Thank you for your letter of 14 February 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Anna Bannister, nrescommittee.northwest-gmwest@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Advertisement	1	08 November 2013
Evidence of insurance or indemnity	Professional Indemnity	15 July 2013
Evidence of insurance or indemnity	Employers" Liability	11 July 2013
Interview Schedules/Topic Guides	1	08 November 2013
Investigator CV	Langley	08 November 2013
Investigator CV	Ormandy	

Letter of Invitation to participant	1 - Patient	08 November 2013
Letter of Invitation to participant	1 - Staff	08 November 2013
Other: Descriptive Questions Matrix	1	08 November 2013
Participant Consent Form: Staff	2	16 January 2014
Participant Consent Form: Patient	2	16 January 2014
Participant Information Sheet: Staff	2	16 January 2014
Participant Information Sheet: Patient	2	16 January 2014
Protocol	1	06 October 2013
REC application	3.5	26 November 2013
REC application	3.5	15 February 2014
Response to Request for Further Information		14 February 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/NW/0828	**Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely

[redacted]
Chair

Email:nrescommittee.northwest-gmwest@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: [redacted]

Appendix 19

Table 17: Patient rounding field work codes

Date	Ward	PARTICIPANT OBS Round Time/Observer	PATIENT Interview	Audio file ID	STAFF Interview	Audio File ID	Code	COMMENTS
Monday	1	12.30 / A	43	510 13	59	510 12	1	
12-May-14	1	14.30 / B	42	511 16	47	X	9	Staff too busy for interview
	2	10.30 / C	36	101 4	56	101 3	25	
	2	14.30 / D	39	101 8	54	101 7	14	
Tuesday	1	10.30 / B	47	102 10	67	X	10	Staff too busy for interview
13-May-14	2	14.30 / E	49	512 22	60	512 20	20	
Wed	1	10.30 / D	46	512 25	17	512 23	15	
14-May-14	2	10.30 / C	50	103 12	73	103 11	26	
	1	18.30 / A	28	X	72	103 13	2	Patient treatment
Thursday	2	14.30 / C	51	104 18	63	104 14	27	
15-May-14	1	16.30 / A	41	104 17	62	104 16	3	
Friday	1	14.30 / E	52	105 22	48	105 21	21	
16-May-14	1	16.30 / A	55	515 27	61	515 26	4	
Saturday	1	13.30 / A	33	516 28	26	516 29	5	Rounding 13.30 not 12.30
17-May-14								
Monday	2	13.00 / A	54	108 24	57	518 32	6	Delayed from 12.30
19-May-14	1	14.30 / D	56	108 24	82	108 23	16	
Tuesday	2	10.30 / E	37	518 37	66	518 35	37	
20-May-14								
Wed	1	10.30 / A	53	519 40	91	519 38	38	
21-May-14	1	14.30 / D	65	X	92	110 25	17	Patient treatment
	2	16.30 / C	58	520 42	75	520 41	28	
	2	10.30 / E	57	1125	6	1124	22	
Thursday	2	12.30 / E	61	1127	95	1126	23	
22-May-14	1	16.30 / A	66	52143	45	52144	7	
Friday	2	10.30 / B	68	52140	43	52141	11	
23-May-14	1	12.30 / A	64	52146	30	52145	8	
	2	16.30 / C	60	52248	65	52247	29	
Sunday	2	16.30 / C	59	52650	7	52449	30	
25-May-14								
Tuesday	1	14.30 / B	63	116 29	22	X	12	Staff too busy for interview
27-May-14								
Wed	1	14.30 / D	70	527 51	85	527 52	18	
28-May-14	1	16.30 / C	67	1131	53	1130	31	
	1	20.00 / C	71	1135	97	1133	32	
	2	22.30 / C	74	X	99	1134	33	Too late to interview patient
Thursday	1	10.30 / D	62	527 54	101	527 53	19	

29-May-14	1	14.30 / B	77	X	55	X	13	Problem with tape
Friday	2	10.30 / C	75	1190	5	1191	34	
30-May-14	1	12.30 / E	69	529 56	78	528 55	24	
	2	14.30 / E	73	528 56	32	52857	36	
Tuesday	1	16.30 / C	76	14038	88	14037	35	
03-Jun-14								

Appendix 20

Table 19: Patient safety and experience data

Date	Patient Safety			Patient Experience Data			
Data Period 1	Falls	Pressure Ulcers	Call bells	Responses	Communication%	Pain%	Overall%
Pre Feb 12	7	3	NA	12	71.9	70.8	76
Pre March 12	4	6	5	42	80.4	88.5	85.2
Pre April 12	4	0	6	38	82.7	75	83.3
Post May 12	5	0	4	20	84.9	90.9	87.7
Post June 12	6	0	9	14	77.3	84.4	83.5
Post July 12	9	0	7	NA	NA	NA	NA
Data Period 2							
Post Feb 13	5	5	NA	35	87.5	91.2	90
Post March 13	13	3	NA	45	76.3	85.4	83.5
Post April 13	7	7	NA	68	82.6	90.8	88.1
Post May 13	5	2	NA	42	73.5	90.4	82.4
Post June 13	2	0	NA	25	75	73.1	81.8
Post July 13	2	0	NA	12	70.4	92.9	86
Data Period 3							
Post Feb14	5	1	NA	100	93.6	98.1	93.5
Post March 14	7	2	NA	122	94	91.7	89
Post April 14	3	2	NA	72	92	91.8	89
Post May 14	2	0	NA	108	78.8	87.9	86.2
Post June14	2	3	NA	169	91.1	94.3	88.1
Post July 14	4	2	NA	108	91.1	98.3	89.9

Data period1 pre rounding, data periods 2 and 3 post rounding implementation
Falls: All recorded falls with or without harm
Pressure Ulcers: All recorded pressure ulcers with or without harm, grade 1 to 4
Call bells: Measured for 1 hour per month, number of call bell heard ringing recorded
Responses: Patient responses to electronic patient survey recoded over a month

Communication: Yes answer to “did you find somebody on the hospital staff to talk about your worries and fears?”
Pain: Yes answer to “did you have your pain assessed and reviewed during your stay?”
Overall: Overall score from the patient survey based on yes answers to questions

Appendix 21

Rounding Project - Data Review by Nurse Observers: Half Day Workshop 15/12/14

Ask the group what were the key things they saw?

- Use of closed questions to prevent further discussion
- Pressure Ulcer prevention care not part of the rounds, patients propped up in bed but pressure areas not check or position changed
- Staff didn't know abou the 4 Ps
- More conversation than care, more cups of tea

What do the group members think is important eg patient experience is that important?

- Not for rounding to be a checklist, rounders need to be interested in the patients
- Rounding needs to have the importance of the drug round, time and focus
- Rounding not part of the ward routine
- Most patients like the visits even if they are brief

What surprized them / didn't surprize them?

- No checking of bed spaces for slips and trios hazards
- No checking of call bells close to patients
- Minimal clinical issues
- Some patient pretending to be asleep
- All patients treated the same long stay patients short stay/new patients
- Squabbles about allocation
- Standing in the middle of the bay to round
- Patient saying thank you for their care
- Staff and patients didn't understand rounding

Ask group highlight themes from observations

- Importance of nurse in charge round
- Presence of rounder was limited
- Process often very rushed
- Not seen as part of ward core business

Appendix 22: Table 21

Table 21: Concept of Activity – descriptive indexing and coding

Nurse observer A	Nurse observer B	Nurse observer C	Nurse observer D	Nurse observer E
18 patients, answered questions about observations and tests (Obs1) 27 patients, 5 patients asleep , 5 patient requests/actions returned to these 5 patients, some nurses didn't appear to act on the tasks/actions asked by the NA (Obs2) 4 patients asleep, 2 away from ward all patients asked the question but the question wasn't clear but some patients just answer yes but I am not sure they know the question (Obs3) 20 patients, 7 away from bedside, 1 asleep (Obs4) 18 patients, 9 asleep, 1 patient away from ward (Obs5) 16 patients rounded, 11 asleep (Obs6) 28 patients, 4 away from ward, 1 asleep, very busy round re requests, pain referred to S/N, spoke with families (Obs7) 28 patients 6 away from bedside, 11 asleep (Obs8) 21 patients 5 away from ward 2 busy with doctors (Obs38)	23 patients rounded, 2 sleeping, 2 for discharge (Obs9) 25 patients rounded x1 sleeping, x3 in theatre 1 patient not asked question on phone (Obs10) 26 patients rounded on 3 sleeping (Obs11) 26 patients rounded 2 away from ward (Obs12) 20 patients rounded, 5 away from ward, round interrupted as Sister had to answer other queries , rounding seen as less important (Obs13)	23 patients 5 patients away various tests procedures, few patients asleep (Obs14) 24 patients rounded, 4 away from ward (Obs15) 25 patients 3 away from ward most patients sleeping following lunch (Obs16) 26 patients 2 away from ward a few were sleeping (Obs17) 26 patients 2 patients away from ward, 5 patients sleeping (Obs18) 22 patients 6 were off ward, 4 patients asleep (Obs19)	2 patients were absent 4 patients asked for something 26 patients rounded (Obs20) quite a few of the patients were absent (Obs21) he carried the clipboard around and filled in the information on it after speaking with each patient (Obs22) 2 who were sleeping and 1 who was on the phone (Obs23) the nurse was looking out for other things such as opportunities to update fluid balance chart's empty catheters she clearly had awareness of the bigger picture (Obs23) several patients were absent from the ward at the time of rounding (Obs24)	number of patients seen 25 three absent (Obs25) 3 bed's patients absent (Obs26) a lot of the patients didn't ask that anything (Obs2) patient having an echo patient on and (Obs27) number of patients seen 24, 2 asleep 2 absent (Obs27) 28 patients a few sleeping (Obs 29) 2 patients sleeping, 3 patients off the ward (Obs30) two patients seen doctors at bedside, very busy (Obs31) 22 patients rounded 5 asleep (Obs33) ward very quiet, lights still on, a lot of patients sleeping, those not asleep were in bed reading watch to the (Obs33) 2 patients sleeping 2 patients absent 24 patients rounded (Obs34) lots of the patients didn't require anything (Obs35) 23 patients rounded 4 patients absent 1 patient sleeping (Obs36) 24 patients rounded 4 patients absent (Obs37)

Appendix 22; Table 22

Table 22: Concept of Goal - descriptive indexing and coding

Nurse observer A	Nurse observer B	Nurse observer C	Nurse observer D	Nurse observer E
Engagement with patients and staff (Obs1) The question wasn't clear but some patients just answer yes but I am not sure they knew the question (Obs1) Asked all patients is there anything I can do (Obs2) The patient 'like what' NA couldn't explain it to the patient (Obs2) Patients seemed to know the question before it was asked (Obs2) Patients asked like what and NA couldn't explain to patient All patients asked the question (Obs2) Introduced self to patients they had not spoken to today (Obs3) Always said if there anything I can do for you (Obs4) Only introduced herself to one patient who was new to the ward (Obs4) Didn't explain what they were doing (Obs4) Didn't seem to be aware that call bells should be in reach of the patients (Obs4) Didn't introduce self or explain	No introductions (Obs9) Asked the question is there anything I can do for you (Obs9) Asked question but no explanation of what rounding is all about (Obs10) Did ask if they had any needs (Obs10) No explanation of what rounding is about (Obs10) No introduction by the NA, some of the patients didn't know what the rounding procedure was about (Obs11) Some were asked "are you ok" stood at the door to ask "are you ok" (Obs11) NA introduced self to the patients and had contact with some patients (Obs12) Purpose of rounding not explained, Is there anything I can do asked to all but 5 patients (Obs12) Some patients appear not to know what rounds is about (Obs12) Introduced self as nurse in charge spoke to patients about going home (Obs13) Some patients appear not to	X4 patients did not understand what intentional rounding was about (Obs14) 4 Ps not assessed or explained (Obs15) No introduction of self but thought patients knew them , no 4 Ps (Obs16) Didn't introduce self, rounding question asked, every patient could clearly hear question and answered/responded, call bells moved for patients if needed, patients seemed to be aware about rounding (Obs17) introduce self, asked question, assessed pain, did engage in conversation, most patients seemed to know what rounding was about (Obs18) Rounding question asked loud and clear, patients aware/seemed to know purpose of rounding (Obs19) Rounder asked if there anything I can do for you at every patient (Obs14) Asked are they ok or is there anything I can do Rounding question asked (Obs18)	Intoroduced self and said name, 7 call bells observed to be out of reach no attempt made to move them within the patients reach (Obs20) all patients asked the question is there anything I can do for you patients were not asked the worries and fears question feeling (Obs20) the support worker asked only if patients were okay no other questions were asked (Obs21) the patient who I interviewed did not seem to understand the process of rounding and all this made it difficult for him to do the interview (Obs21) The NA commented that she says she saw only positives to rounding no negatives and that she enjoyed speaking all patients (Obs21) the charge nurse went to all the patients to ask about any assistance they required he asked all patients a direct question is there any think I can get for you (Obs22) direct questions were asked all patients were asked is there	some patients did looked confused when asked is there anything I can do for you (Obs25) no explanation given about the purpose of the questions or rounding (Obs25) patients with chest pain immediate help sought and actioned (Obs25) introduced herself (Obs26) check all patients had buzzers (Obs26) politely asked is there anything I can do for you (Obs26) put buzzer on beds of patients sleeping (Obs26) patients and relatives didn't appear to understand the purpose of the questions (Obs27) asked how are you doing can I get you anything (Obs28) No introduction (Obs29) X1 venflon removed (Obs29) carer asked what the options were when asked if there anything that you need (Obs30) some staff some staff will do things like get a cup of tea at the time of doing the round

rounding, question changed as per patient All patients asked the question, most patients didn't request anything (Obs5) Always asked the is there anything I can do question but then started an open conversation which is when patient asked for something (Obs5) Call bell given to patient (Obs6) Introduced self to all new patients and family (Obs7) Explained to the family what they were doing when asked Asked everyone is there anything I can do for you (Obs8) Didn't introduce self to patients (Obs8) Only did what the patient asked, didn't "read the situation" ie moving bedside tables, call bells (Obs8) Didn't Introduced self, ask if all patients at once OK didn't check call bells (Obs38)	know what "rounds is about" (Obs13)		any think I can do for you and is everything okay some patients were asked additional questions such as does your pain feel better has anyone updated you on the discharge yet (Obs23) unfortunately some of the buzzers were out of reach of the nurse did not pick up on this I did feel as with other people I have observed that the patients would possibly have requested more if the nurse had entered the side rooms and offered more privacy to talk (Obs23) staff nurse was aware of patient safety aspects of rounding hence he remembered to check all the call bells were reached in patients and the patient's immediate environment (Obs24) he asked two questions how are you, can I get you anything (Obs24) staff nurse check the immediate environment of the patients ensuring call bells were in reach and drinks were within reach (Obs24)	some staff will make a note of it and say that they will go back (Obs30) some patients in fact quite a lot of the patients looked puzzled when asked the question is there anything I can do for you (Obs30) some relatives asked what it was all about reply was quite vague and didn't add impact or reason for the rounding (Obs30) introduced herself (Obs32) two patients asked for a drink given at time of round (Obs32) patient expressed the he had no complaints (Obs34) did not elaborate on the question just asked any think I can do for you (Obs34) used how are you doing are you all right all okay (Obs35) patients relative appeared anxious that they hadn't had anything to eat full explanation given by RN to patient and relative, patient relative appeared calmer once explanation given (Obs35) Introduced self, checked patients were ok asked if anything can do, didn't check buzzers (Obs36) Didn't introduce self, asked are you ok, very routine in approach (Obs37)

Appendix 22; Table 23

Table 23: Concept of Feeling - descriptive indexing and coding

Nurse observer A	Nurse observer B	Nurse observer C	Nurse observer D	Nurse observer E
Friendly, smiling confidence, good use non verbal skills (Obs1) Engaged well with patients and staff (Obs1) Organised friendly approachable to the patients (Obs2) Smiling, good non verbals and good interaction with patients (Obs2) Caring, friendly, smiling, good verbal and non verbal skills (Obs3) Engaged in additional conversation (Obs3) Friendly, smiling, good interaction actions with patients (Obs4) Very rushed (Obs5) Good bedside manner friendly knew all the patients, smiles (Obs6) Caring, friendly good staff engagement after the rounding (Obs7) Patient who had been there longer for longer seem to say no as we walked to the bed (Obs7) Rushed bur smiling (Obs8)	Round took longer as a patient was complaining that staff often turn down their request for food (Obs11) Rounding rushed seen as a low priority (Obs9) Most patients don't understand what rounding is about, NA resenting patient requests (Obs9) x1 NA caring for a confused patient which they gave the impression that was more important than rounding (Obs9) They said they needed more help and support (Obs9) Sisters presence appears reassuring to most patients (Obs10) One patient said it would be nice if they said what they are doing (Obs11) Rounding didn't appear important no one allocated to do rounding, took the coordinator a long time to find someone to do the rounding, patient said staff never comeback if you request a cup of tea (Obs12) Rounding rushed sister did	Rounding appeared rushed but caring (Obs14) Rounder didn't not engage in any other conversation, eye contact smiling (Obs15) Appeared really rushed, NA mentioned to nurse observer she had a number of things to do after rounding, didn't engage in any other conversation (Obs17) Smiled at patients and maintained eye contact with all patients, no quality to interactions rounding carried out for the sake of doing it (Obs15) Some patients appeared to be asleep as the support worker approached the bed to carry out rounding (Obs 15) rounding appeared abit rushed but very caring, good eye contact (Obs18) Good eye contact, good quality interactions, rounding appeared very rushed (Obs17) Eye contact, smiled appeared very caring, sorted problems out by self rather than delegation interactions were of	very rushed nurse observer thought patients may have felt that they couldn't ask for anything it was easy to tell the housekeeper was in a rush (Obs20) housekeeper said she was doing a lot of the rounding many the nurses didn't get involved I sensed the housekeepers frustration due to her tone of voice (Obs20) housekeeper had built a rapport previously with some of the patients as they seemed to appreciate her sense of humour shared one or two joked with her between visits to other patients on the round (Obs20) housekeeper came across as friendly despite being rushed (Obs20) patient voiced a lot of worries and concerns the housekeeper appeared uncomfortable and out of her depth because they were medical problems this may have come across as a lack of empathy is the housekeeper appeared to have no engagement with the patient to	whole process appeared valuable to the patients all patients interacted with (Obs25) round not rushed (Obs25) excellent/prompt response to patient with chest pain patient hadn't complained re chest pain until asked (Obs25) interacted with patients having some banter (Obs25) calm, friendly interaction (Obs25) whole process ran calmly and smoothly (Obs26) patients appeared comfortable to interact with care support worker her approach properly facilitated this (Obs26) warm and welcoming approach with all patients (Obs26) interacted and use touch when greeting and leaving patients (Obs26) Some Patients and Looked Confused Even Apprehensive When Asked the Question (Obs27) Appeared a little rushed (Obs27) nurse was busy getting patients

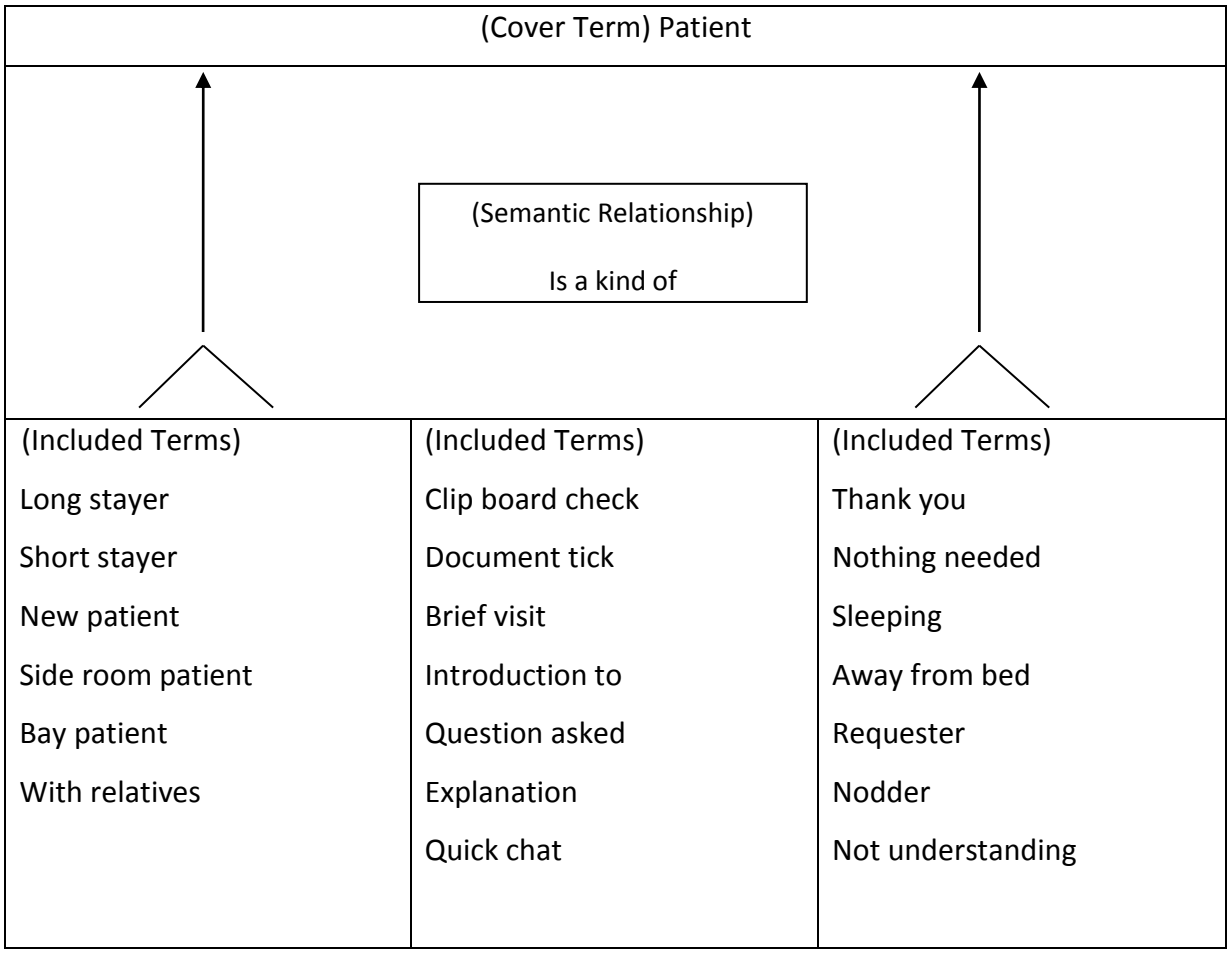
Good rapport with patients, spoke with family if language barrier didn't use back of rounding form (Obs8) Smiled, friendly didn't appear rushed but asked all the patients the question at the same time (Obs38)	round as no one allocated and no volunteer (Obs13)	a good quality (Obs18) Good eye contact additional conversation, smiling, appeared very caring and interactions of good quality (Obs19)	when the patient was quite upset housekeeper did asking them is to speak to the patient (Obs20) there appeared to be a lack of teamwork amongst staff went patients needed registered nurses the pain relief for information nurses would not assist patients if they were not their own nurse and also seemed annoyed frustrated at being interrupted from other tasks such as paperwork in order to assist patients I got the impression that some did not regard rounding as important to busy to help with it (Obs20) patient interview gave very positive feedback on rounding and his experience as a patient in general he thanked the team during his interview however he also commented that he was someone who really didn't require much help or support from the staff and he was fully mobile and self caring (Obs20) support worker was smiling, good eye contact, she was polite and friendly and had a lovely tone of voice when speaking to patients it did convey a caring and compassionate nature (Obs21) the rounding appeared rushed	ready for cardiac catheter lab when asked to do the rounding by the band 6 RN appeared flustered and rushed before commencing the rounding (Obs28) spent time with each patient asked generally about patient which appeared to elicit more response an open dialogue from patients (Obs29) relaxed and calm round (Obs29) warm friendly interacted with patients sensitively (Obs29) patient saying thanks for asking (Obs30) round not rushed (Obs30) calm approach to patients (Obs30) interacted with patients very well (Obs30) two patients took the opportunity to say thank you to the nurses (Obs31) interacted very well patient. (Obs31) two-way interaction nurse appreciated thank you is from the patient (Obs31) the nurse did engage in conversation with the patients although I think this was I think this is an essential aspect of rounding it does it does increase the time (Obs31) patients relatives also felt they

			most patients I believe did not actually ask for anything because they were not invited to do so they were only asked are you okay to which they replied yes thank you or just yes (Obs21) as with the previous rounding by observed I got the impression that the NA and fully avoided engaging too much with patients as she was very busy (Obs21) the charge nurse was pleasant to the staff and patients had a good sense of humour which the patients responded well to and seem to appreciate (Obs22) interestingly the patients inside rooms did not make any requests for assistance or engage in any conversation I did wonder if this was because they were being addressed from the doorway which gave the impression the charge nurse was in a rush and also does not avail for much confidentiality if patients wanted to talk about worries and concerns (Obs22) the nurse came across as polite compassionate and genuinely interested in the patient's concerns (Obs23) she did not seem in a rush or too busy (Obs23)	The patients in side rooms did not make any requests for assistance or engage in any conversation, I did wonder if this was because they were being addressed from the doorway which gave the impression the nurse was in a rush and also it does not avail much for confidentiality if patients wanted to talk about worries and fears (Obs 28) very rushed (Obs 29) could ask questions reassures them as well as the patient (Obs31) thumbs up sign used alot (Obs32) nurse was busy had to leave what she was doing to do the rounding this resulted in the nurse appearing rushed, distracted and disengaged in the process at times (Obs32) it didn't feel timely or appropriate to ask patients to be interviewed this at such a late hour (Obs33) the process at this time appeared much less rushed it felt like patients were being asked if they needed anything before they go to sleep it was almost like getting ready for bed (Obs33) felt the rounding had more

			I thought it was a really nice that the rounding was individualised and that she had remembered to ask if pain had improved and other questions relevant to each patient (Obs23) including relatives seem to be well received (Obs23) I was very impressed by the way patients were approached by the staff nurse he was caring and compassionate staff nurse gave the patients all the time they needed to discuss any concerns (Obs24) the patient spoke to the staff nurse about a variety of things and I believe this was because he did not give the impression of being too busy (Obs24) the patients all seem to be very pleased by the way they were approached many of them smiled at him and said thank you in a tone that seemed genuine (Obs24)	meaning in daytime rounding (Obs33) warm approachable manner (Obs34) a little rushed (Obs34) rounding appeared rushed in to get finished before tea was given out (Obs35) I felt the questions were asked without any meaning behind them (Obs35) approach patients in a calm friendly manner(Obs35) patients who were unwell following procedure had less interaction on the rounding could have spent a little more time questioning (Obs35) Rushed but smiled and friendly conversation (Obs36) No time for conversation, little interaction with patients (Obs37) Round appeared rushed (Obs37)

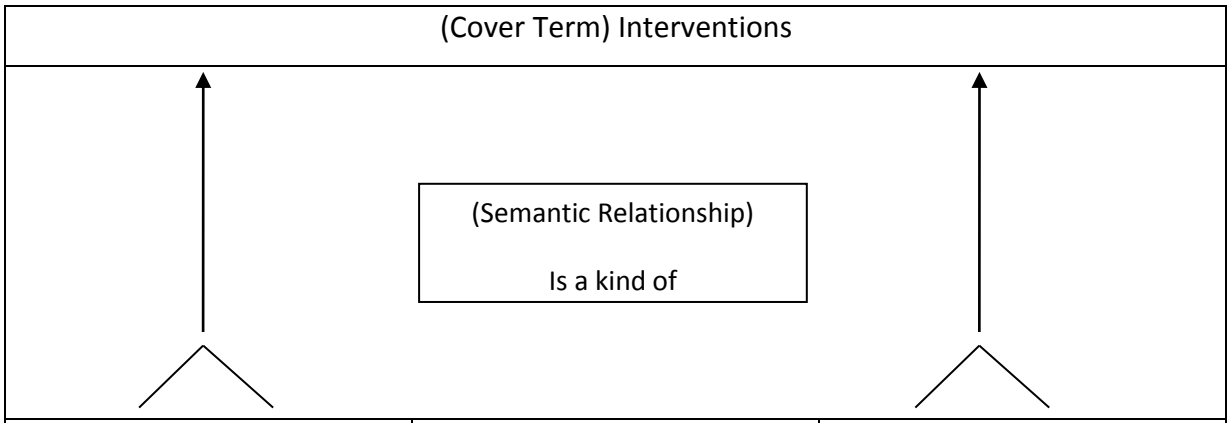
Appendix 23: Table 26

Table 26: Semantic relationship within domain of patient



Appendix 23: Table 27

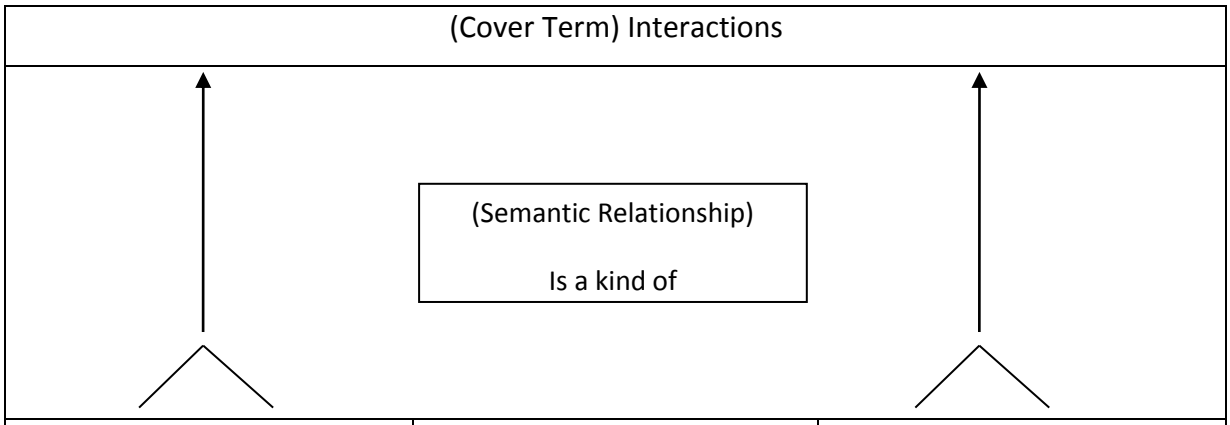
Table 27: Semantic relationship within domain of intervention



(Included Terms)	(Included Terms)	(Included Terms)
Discharge info	Hot drink	Assessment
Info relatives	Cup of tea	Observation
Explanation	Call bell check	Unwell patient
Introduction	Bed table move	Analgesia need
Joke	Possession	Dressing change
Banter	Hygiene need	TED stocking assistance
	Toilet request	

Appendix 23: Table 28

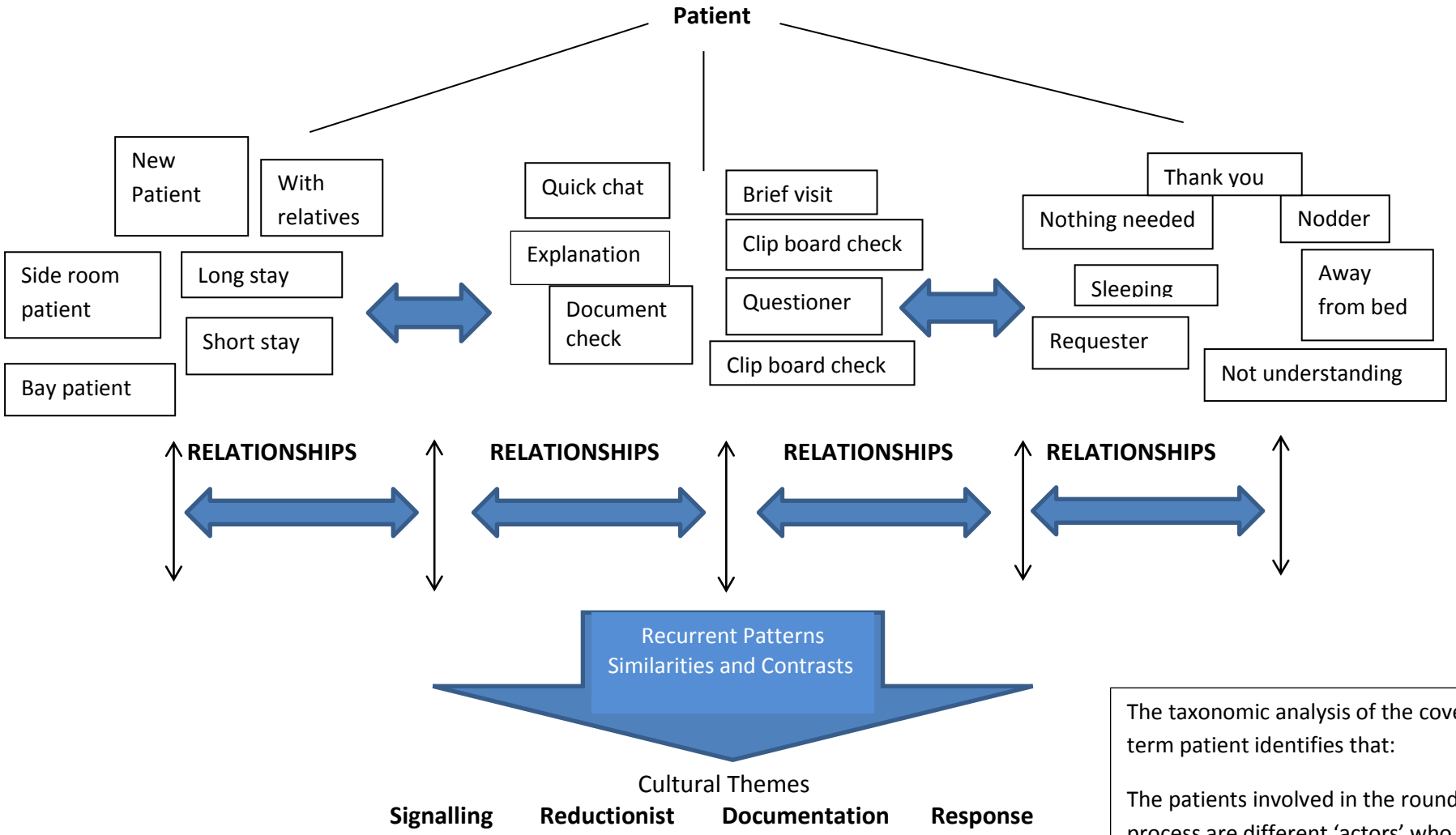
Table 28: Semantic relationship within domain of interaction



(Included Terms)	(Included Terms)	(Included Terms)
Caring	Rushed	Reading situation
Kindness	Minimal	Conversational
Reassuring	From door way	Chat
Responsiveness	Thumbs up	Adapted
Smiling	Whole bay at once	Engaged
Eye contact	End of bed	Knowing patient
Touch		

Appendix 24: Figure 4

Figure 4: Taxonomic and component analysis of the cover term patient

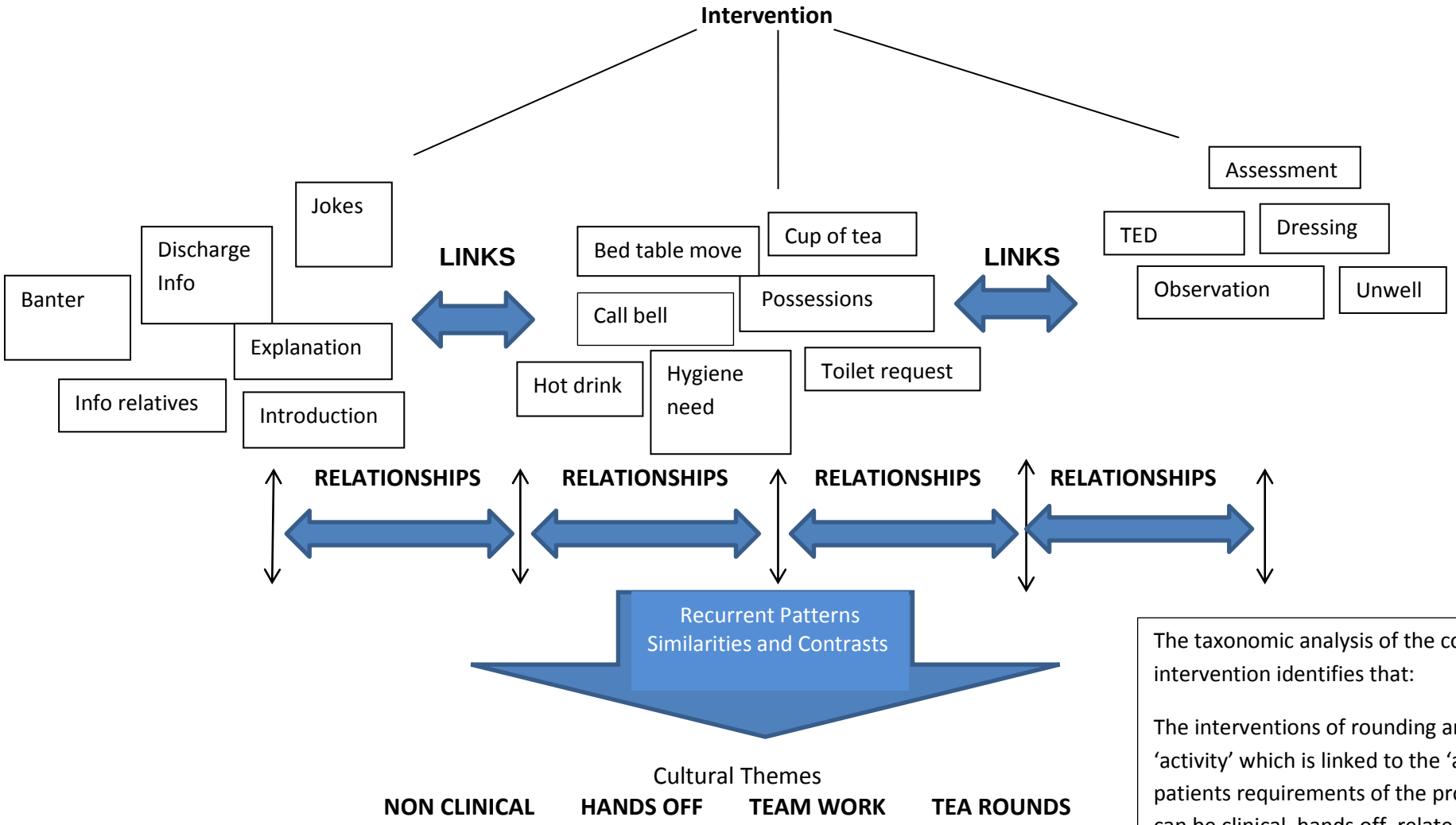


The taxonomic analysis of the cover term patient identifies that:

The patients involved in the rounding process are different 'actors' who depending on the situation display and adopt different 'activities'.

Appendix 24: Figure 5

Figure 5: Taxonomic and component analysis of the cover term intervention

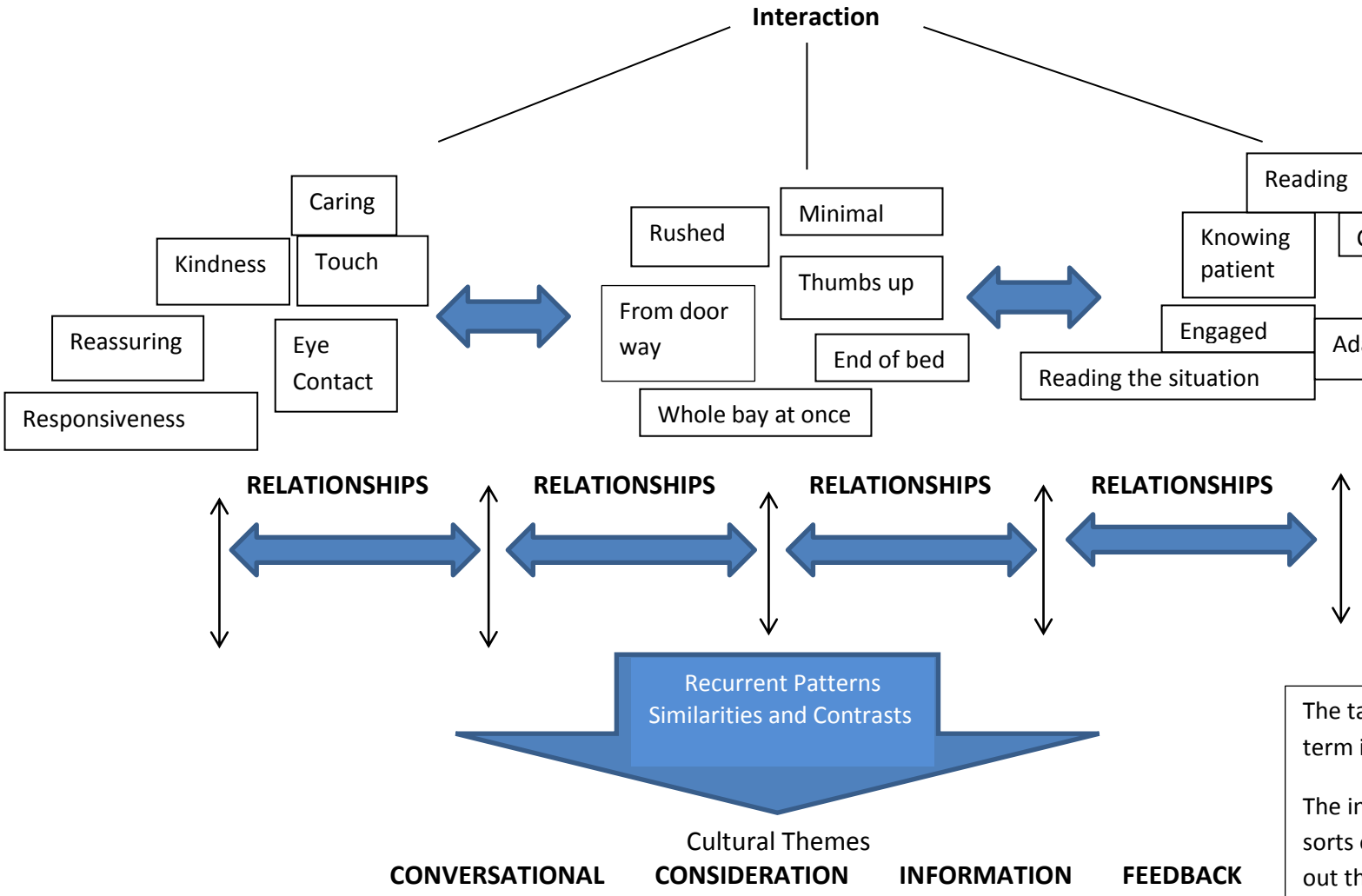


The taxonomic analysis of the cover term intervention identifies that:

The interventions of rounding are an 'activity' which is linked to the 'actors' patients requirements of the process these can be clinical, hands off, relate to teamwork or the tea round.

Appendix 24: Figure 6

Figure 6: Taxonomic and component analysis of the cover term interaction



The taxonomic analysis of the cover term interaction identifies that:

The interactions are linked to the sorts of 'actors' rounders who carry out the rounding, the actors can be conversational and/or considerate