Nursing Practice
Discussion
Rounding

Intentional rounding: a critique of the evidence

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Many of the studies supporting intentional rounding are not robust. Nursing managers need to look less to political obedience and more to the evidence base.

Keywords: Intentional rounding/ Evidence base/Francis report

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Abstract

Intentional rounding has been heavily promoted by the prime minister David Cameron and others and is being widely implemented in UK hospitals. It is claimed that the practice has a number of benefits, including reduction in call bell use, falls and pressure ulcers and increased satisfaction. In this article, I will submit these claims to close scrutiny and argue that the evidence base is too flimsy to support the claims.

Similarly, the Friends and Family test is being implemented despite the absence of any supportive evidence. The Francis report stated that change cannot be implemented through top-down pronouncements, and yet this is exactly what is happening with rounding and the Friends and Family test.

Individual nurses and nurse managers should look more to evidence than to political expedience when implementing nursing policies.

Intentional rounding is the practice of visiting patients every hour and offering care within a standardised protocol. It has been heavily promoted by the prime minister David Cameron and others and is being widely implemented in UK hospitals. It is claimed that the practice has a number of benefits, including reduction in call bell use, falls and pressure ulcers and increased satisfaction.

In this article, I will submit these claims to close scrutiny and argue that the evidence base is too flimsy to support the claims.

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Many of the studies supporting intentional rounding are not robust. Nursing managers need to look less to political obedience and more to the evidence base.

5 key points

1. Intentional rounding is the practice of visiting patients every hour and offering care within a standardised protocol.

2. Much of the evidence behind intentional rounding comes from US studies – where the healthcare environment is characterised by profit and competition between providers.

3. Many of the studies also use “call light use” as an indicator of poor care, a measure that is arguably flawed.

4. The evidence that rounding reduces falls and pressure ulcers is not robust.

5. The Francis report stated that change should not be implemented through top-down pronouncements and should be evidence based.

for those assessed as being in need of them, while others favour the blanket approach of rounding on all patients whether they need it or not. In the former case the intervention simply amounts to requiring nurses to do what they assess as being required. However, the latter case is in need of a more rigorous assessment (Snelling, in press). A number of benefits have been claimed for intentional rounding, but there has been no systematic review and the evidence that exists is weak and inconclusive. Suggested benefits, identified by the King’s Fund (Bartley, 2011) are:

> 38% reduction in call lights;
> 12 point mean increase in patient satisfaction;
> 50% reduction in patient falls;
> 14% reduction in pressure ulcers.

Who would not want results like this on their ward? The study that provides the most influential evidence for the claims for intentional rounding, as cited above, was undertaken by Meade et al (2006). This study was performed in US hospitals, and there are a number of criticisms that should have limited the claims made for it.

For example, two of the three authors are employed by the StuderGroup, a management consultancy that sells an instructional DVD for intentional rounding. There was no randomisation between groups and it was acknowledged that hospitals may have arranged to be entered on the arm of the trial that suited them. Data was excluded from units where more than 5% of data was missing.

Vest and Gamm (2009) offer additional critiques. This flawed study has been given far more influence than its quality deserves, possibly because it confirms what supporters of rounding want it to confirm. A
Call bell use
These studies supportive of rounding were mainly undertaken in the US where the healthcare environment is characterised by profit and competition between providers, and the stated rationale was often to reduce call light use. This measure is not frequently used in the UK and appears to have been presented as a measure of quality of care. It might well be the case that good care is associated with lower call bell use, but it does not follow from this that reducing call bell use means that better care is being provided. Conversely, Tzeng and Yin (2009) found increased call bell usage was associated with less fall-related harm and recommended that ward managers seek to maintain the usage of call bells.

Falls
It is also claimed that the number of falls is reduced after the implementation of rounding and the 50% reduction in Meade’s study appears promising. The evidence is mixed on this point. For example in a more robust study, Tucker et al (2012) found that although rounding was associated with lower fall rates, the association was not statistically significant and the rates drifted back towards baseline after a year. A more detailed review is needed but, until this is available, caution should be exercised. It is not clear how rounding for all patients is better than close monitoring of those identified at risk for falls.

Pressure ulcers
It is also claimed that pressure ulcers are reduced by rounding. Meade et al (2006) are cited on this point by a number of studies, but there is no such finding in Meade et al’s paper. A further StuderGroup (2007) publication states that a reduction was found but no data or citations are given. Saleh et al (2011), in a paper since retracted, claimed a 50% reduction based on a decrease from two pressure ulcers to one. There does not appear to be a single good-quality study that supports the claim, and yet it appears already to have become accepted truth.

Patient satisfaction and the “net promoter score”
Although the evidence is weak, the claim that increased patient satisfaction results from rounding is more plausible, and provided the stated rationale for some American studies, where there is more competition between providers. It also appears plausible that this is transferable to the NHS. Measuring patient satisfaction has been in the forefront of government attempts to improve the NHS, despite the National Institute for Health and Clinical Excellence stating that: “The concept of satisfaction has been explored in various formats over the last two decades within the NHS; it is now widely acknowledged that it is a poor indicator for evaluating quality from a patient experience perspective” (NICE, 2012).

Recent attempts to measure patient satisfaction have been centred on the Friends and Family test, which is to be implemented widely in the NHS. The test is a version of a tool known as the net promoter score, which was developed to help small businesses grow (Reichheld, 2003). However, even in the business environment there is evidence that the claims made for the test as an indicator of growth are not supported (Keiningham et al, 2008). Again in the US, the score has been used in the competitive environment of healthcare. For example, Kinney (2005) while noting that many institutions refer to patients as customers, used the tool not to increase quality of care but to calculate the potential lost revenue from dissatisfied customers as $2.3m.

A UK study commissioned by the Care Quality Commission found that net promoter score: “caused problems in all rounds of testing because interviewees objected to and misunderstood the term ‘recommend’. As this is a fundamental part of the question it was not possible to address this through revisions to the wording, and we conclude that the NPS is unsuitable for use in NHS settings,” (Graham and MacCormick, 2012).

Those undertaking the surveys may well have difficulty understanding what they are asking, but at least there will be a number allocated to the units and hospitals undertaking the test. League tables will be compiled, numbers will be allocated. When called upon to explain what the number actually means the Department of Health (2013b) advice is to use these words: “The score is calculated using proportion of patients who would strongly recommend minus those who would not recommend or who are indifferent.” I suspect that this will not easily be understood by nurses or patients. Certainly, it is much more complex than the recommended reporting of similar Likert scales, such as those suggested by Graham and McCormick (2012), or the National Student Survey, which will be familiar to student nurses and university departments.

The Francis report
The current healthcare environment is dominated by the Francis report, which was clear that required change in culture in the NHS will not be brought about by “top-down pronouncements” (Francis, 2013). It also recommended that “professional bodies should work on devising evidence-based standard procedures wherever possible”. The recent vision on developing the culture of compassionate care (Department of Health, 2012) also recognised the need to “deliver evidence-based care and extend evidence through research”, and as all nurses know, the need to base care on evidence forms part of our professional code.

Recent policies on rounding and patient satisfaction scores have been developed as a result of top-down pronouncements from the prime minister himself, and yet there is no sound evidence for either.

Nursing Times’ Speak Out Safely campaign to safeguard whistleblowers is one response to a call to change the culture of the NHS. However, in order for this to happen, all nurses must be willing to engage critically and reflectively with everything they do; not simply report bad practice but challenge all practice. Many cases of bad care are the result of nurses becoming sucked into an existing culture and, not wanting to rock the boat, doing what they are told. And yet blindly following policy is what the profession is being required to do by visiting all patients every hour and repeating a standard formula regardless of need, and by utilising (and being judged by) a satisfaction score that is clearly unfit for purpose.
Conclusion
Individual nurse managers being required to implement rounding, as well as individual nurses being required to undertake it, are faced with a difficult decision. Will they follow the evidence or the policy? Will the government policy of empowering health professionals extend to personally accountable decisions not to perform rounding for everyone, or to decline to distribute flawed questionnaires? Courage is one of the 6Cs in the nursing vision (DH, 2012) but it would take a very courageous nurse to say to their manager that they are declining to undertake a top-down pronouncement because there is simply no evidence for it.

I cannot ask my practice colleagues to do this, nor can I expect that they will have the time to look at and appraise the evidence discussed in this article. However, I can recommend that they robustly challenge managers’ understanding of an appraised evidence base. It might well be that good-quality supporting evidence becomes available and that the practice of rounding develops in line with local assessments and evidence. It will require a more nuanced approach than blunt satisfaction scoring. If this is the case, I will withdraw my scepticism. But, until this happens, I will continue to find it grimly ironic that the same unthinking and unreflective behaviour that contributed to the mess we are in, is being promoted as the solution. I ask that nursing managers look less to political obedience and more to the evidence base.

If nursing is content to allow political pressure to drive rounding practice then it is unethical to claim that it is an evidence-based intervention. But if nursing really does base practice on evidence it would be unethical not to do it properly. NT

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