

Round and Round We Go: Rounding Strategies to Impact Exemplary Professional Practice

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The literature demonstrates that diverse rounding methods have been shown to positively impact a wide variety of quality and safety outcomes, as well as patient and staff satisfaction. Rather than adopting one or two of these strategies, the concepts and recommendations from the literature associated with rounding have formed the foundation for an academic, community, Magnet® hospital to implement a compendium of rounding efforts: patient rounds, interdisciplinary collaborative rounds, daily clinical rounds by the unit educator and daily rounds by the unit manager, quarterly unit rounds by senior nursing managers, and safety rounds by senior executives. This article details each of these methodologies as implemented on a 26-bed hematology/oncology unit. Positive outcomes perceived to be associated with the rounds have been achieved for patient, employee, and physician satisfaction, as well as clinical quality indicators.

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A variety of rounding methods have been increasingly implemented in healthcare settings to improve patient safety and positively impact patient and staff satisfaction. At Lehigh Valley Hospital (LVH), an academic, community Magnet® hospital, six types of rounds were implemented within the inpatient, emergency, and ambulatory patient care areas (see Table 1). This article details each rounding methodology, including its purpose, structure, and outcomes, emphasizing implementation on the 26-bed hematology/oncology inpatient 7C unit at LVH.

Literature Review

Most of the literature associated with rounding methods relates to hourly patient rounds by healthcare personnel in an inpatient setting; however, the seminal article on this subject is the quasi-experimental research by Studer, Robinson, and Cook (2010). The study demonstrated that a protocol incorporating specific actions into patient rounds can reduce the frequency of patients' call-light use, increase their satisfaction with nursing care, and reduce falls (Meade, Bursell, & Ketelsen, 2006).

Other research reported that patient satisfaction was the most common outcome, with statistically significant improvements noted (Bourgault et al., 2008; Culley, 2008; Ford, 2010; Gardner, Woollett, Daly, & Richardson, 2009; Meade et al., 2006; Tea, Ellison, & Feghali, 2008; Weisgram & Raymond, 2008). Studies also focused on call-light use, finding reductions in use after implementing hourly rounds (Bourgault et al., 2008; Meade et al., 2006; Weisgram & Raymond, 2008). A third variable positively impacted by hourly rounds was staff satisfaction (Bourgault et al., 2008; Gardner et al., 2009; Leighty, 2007).

Collaborative rounding has long been supported in the literature and continues to be a mainstay in rounding methodologies. According to Edwards (2008), team rounding reduces the likelihood of error, thus increasing patient safety. In addition, Vazirani, Hays, Shapiro and Cowan (2005) reported increased collaboration among members of the healthcare team, particularly between nurses and nurse practitioners.

Teaching rounds performed by a unit-based nurse educator have been found to be conducive to staff development, particularly regarding the cultivation of critical-thinking skills (Segal &

Mason, 1998). This professional development strategy prompts multiple outcomes, such as documentation compliance, patient and staff satisfaction, and quality clinical care.

Senior executive rounding is another methodology reported in the literature. Termed “walk rounds,” the focus of a study by Frankel et al. (2008) was to improve the safety climate and the staff perception of patient safety through open dialogue and collaboration. Staff perceived that the walk rounds had a positive impact on the facility’s safety climate and patient safety. Campbell and Thompson (2007) corroborated those results in their retrospective study of patient safety rounds. Through rounding, Studer et al. (2010) described how nurse leaders can reinforce care delivery to patients, verify nursing actions, and recognize their employees. Studer et al. (2010) noted that this is “one of the most important actions . . . to improve patient perception of courtesy and respect and of nurse communication as a whole” (p. 46).

The literature demonstrates that various rounding methods have been shown to positively impact quality and safety outcomes, as well as patient and staff satisfaction. Rather than adopting one or two of these strategies, the concepts and recommendations from the literature associated with rounding formed the foundation for the current article’s authors to devise, implement, and evaluate a compendium of rounding efforts.

Rounding Methods

Hourly Patient Rounds

Hourly patient rounds are intended to increase patient safety and satisfaction of patients, family members, and staff. The aim is to anticipate and address patient needs. Rounds are completed by an RN or unlicensed assistive personnel every hour

from 6 am to midnight and every two hours from midnight to 6 am. For ease of memory and standardization, the authors focused on pain, positioning, and personal needs. A standardized electronic tool, the Patient Rounding Log, was used to monitor completion. The tool is a part of the permanent medical record and has proven useful when investigating quality issues.

Standardization is a key component in the hourly rounding process within the hematology/oncology inpatient unit and throughout the hospital (see Table 2). Patients and families were notified that hourly rounding occurred in a standardized manner, no matter the point of entry or unit placement. However, because the oncology population demonstrates a heightened need for uninterrupted rest, based on their condition and needs, patients would be offered a customized rounding schedule.

Interdisciplinary Collaborative Rounds

Interdisciplinary collaborative rounds are conducted in a variety of ways, and several factors determined the methods used, such as ideal times for family involvement, optimum times for physicians and other members of the interdisciplinary team, and patient diagnosis. Despite the use of various methods, the common purpose of collaborative rounds is to review the current plan of care, determine care priorities, and resolve patient care issues. Rounds always include the patient and family.

On the inpatient oncology unit, the interdisciplinary team may include the patient’s primary nurse, attending physician, oncology medical fellow, medical resident, advanced practice nurse, physician assistant, pharmacist, and case manager. Rounds are completed daily for every patient and twice daily for patients who require reevaluation because of the acuity of their illness or who have complex discharge planning issues.

TABLE 1. Rounding Strategies in Use at Lehigh Valley Hospital

Strategy	Purpose or Focus	Participants	Frequency	Script
Hourly patient rounds	Increase patient safety and the satisfaction of patients, family members, and staff. Anticipate and address the patients’ needs.	Patients, RN, technical partner	Hourly	Yes
Interdisciplinary collaborative rounds	Review the current plan of care, determine the care priorities, and resolve patient care issues.	Patient, physicians, nurse practitioner, physician assistant, RN, pharmacist, case manager	Daily	No
Daily clinical rounds by unit educator	Offer support to staff from a clinical expert to facilitate critical thinking related to care delivery; promote patient safety, collaboration of team members, and quality patient care; and positively impact nurse sensitive clinical indicators and regulatory standards.	RN, patient or family, patient care specialist, technical partner	Daily	Audit tool
Daily patient rounds by unit manager	Ensure patient and family are satisfied with their care, build relationships, and be proactive to resolve patient issues.	Patient or family, RN	Monday through Friday	Yes
Quarterly unit rounds by senior nursing	Recognize staff’s hard work and dedication to patient care, and encourage discussion regarding nursing sensitive quality outcome metrics.	Patient or family, RN, technical partner	Quarterly	No
Safety rounds by senior executives	Demonstrate to frontline staff that senior executives care about and are invested in resolution of staff safety concerns. Enlighten executives about depth of frontline staff concerns.	All unit staff, patient safety officer, senior vice president of quality and safety, representative of the senior hospital executive team	Monthly	Yes

TABLE 2. Lehigh Valley Health Network Patient Rounding Standard Work

Action	Script and Accompanying Work
Knock on door	–
Introduce self	“Hi, I’m Kim Smith. I am your RN today.”
Explain	“A staff member will be coming around every hour from 6 am through midnight and every two hours from midnight to 6 am”
Ask	“Can I get you anything for pain? Do you need to go to the bathroom? Can I help you get repositioned? Is there anything I can do to help you get comfortable?”
Scan the room	Check if call bell, telephone, and bedside table are in reach; cords are safely positioned to prevent trip hazards; and the pathway to the bathroom is free of clutter and fall hazards. Is there anything else that needs to be cleaned up?
Plan for future	“We will round again in about an hour to check on you, but if you need something or you need assistance to get up, please use your call bell.”

Two types of physicians complete rounds on the unit, gynecologic oncologists (starting at 7 am) and hematologic oncologists (starting at 9 am). The consistent times promote participation by all attendees and ensure that a nurse does not have more than one physician rounding at the same time. Buy-in for all disciplines to participate was driven from the onset because each discipline quickly saw the value through gained efficiencies and resultant patient and staff satisfaction.

Interdisciplinary collaborative rounds begin with a presentation of an earlier assessment by one of the aforementioned team members. All members of the collaborative team, inclusive of the patient and family, then discuss and agree on the plan of care. Efforts are made to ensure that every participant offers input. For example, the physician normally ends the discussion by inquiring if there are any questions or if anyone has anything else to add. Special emphasis also is made to encourage questions from patients and family and then to ensure understanding of responses. This normally is the responsibility of the primary nurse. Based on her established relationship with the patient and family, she is aware of their issues and concerns and makes certain, using strategies such as Teach Back, that these have been addressed. This rounding approach is organized, efficient, and predictable. For example, collaborative rounds for a patient with acute leukemia focus on such things as determination of the appropriate chemotherapy regimen, anticipated nadir, patient and family preference for managing anticipated treatment side effects, and discharge needs.

Group dialogue through rounds can identify various outcomes. In some instances, rounds identify that a consultation is needed with an ancillary team member, such as a dietitian, spiritual counselor, and/or pain management specialist. Clinical practice guidelines and other care standards are found to require development or revision at other times.

Daily Clinical Rounds by the Unit Educator

LVH has a unit-based educator role, termed a patient care specialist (PCS). The role requires a master’s degree in nursing, and most units have 1.0 full-time equivalent in the position. The PCS participates in identifying, planning, and implementing educational programs within specialty areas for hospital healthcare providers, patients, families, and/or community groups.

The PCS conducts daily clinical rounds with staff regarding their patients. The rounds began because bedside nurses expressed a need for support by a clinical expert to facilitate critical thinking related to their care delivery. As a result, the rounds promote patient safety, collaboration of team members, and quality patient care. The rounding process fosters a learning environment, promoting critical thinking and patient care planning.

A more specific focus within the rounds is to positively impact nursing-sensitive clinical outcomes and regulatory standards. The PCSs within the medical-surgical division, working collaboratively with the Nursing Quality Department staff, developed a comprehensive 125-indicator tool to guide the rounding process and collect data. This template, referred to as the Quality Bundle Tool, includes prioritized content in the format of a quality checklist. Examples include documentation of fall and pressure ulcer assessment scores and associated interventions in the plan of care.

The PCS conducts rounds from Monday–Friday, with one nurse daily, and rotates to all shifts. Patients are selected by the PCS for a variety of reasons, including complexity of care, patient and family knowledge deficits, high risk for falls and pressure ulcers, request for follow-up by unit manager, and the bedside nurse’s identified learning needs. The PCS considers the patient’s history, plan of care, and current assessment and engages the bedside nurse through focused questioning to critically think through the care. For example, a PCS noted a fungal toenail in a febrile and profoundly neutropenic patient. She led the nurse through discussion to critically examine implications of the toenail to the immunocompromised patient.

Following rounds, the PCS communicates significant findings to the entire healthcare team, as well as to patients and families. That transparency for the neutropenic patient prompted notification to an infectious disease consultant and a podiatry consultation. In short, the educator rounds prompt opportunities for improvement and risk reduction.

Daily Rounds by the Unit Manager

All managers reserve 8–11 am from Monday–Friday for responsibilities, including patient and staff rounds. The goal is to interact with all patients and staff; however, realistically, prioritization often is necessary. An organization-developed survey tool on an electronic tablet is used by the manager to ensure question standardization and recording of answers for data collection and follow-up. Patients are asked evidence-based standard questions based on prioritized service and quality issues. Priority topics include ensuring high reliability for adherence with standards for hourly patient rounds, bedside shift report, and patient room communication white boards.

Implications for Practice

- ▶ Use a compendium of rounding strategies to link qualitative and quantitative outcomes.
- ▶ Be vigilant in reinforcing and validating rounding processes within daily work after achieving initial successful outcomes.
- ▶ Standardize rounding structures and processes throughout a healthcare setting to reinforce staff and patient expectations.

Staff rounds are formal and require the manager and staff to meet in a quiet location. The purpose is to build relationships and be proactive versus reactive. Five standard questions related to those appearing in the biannual employee satisfaction survey are used: What's going well? Who are the individuals that need to be recognized? Do you have the tools and equipment to do your job? Where can we improve? What else would you like me to know? Managers are able to gather information in a constructive way and in a timely manner. The rounds enhance manager visibility and communicate to the employees that their opinions are valued to create the ideal practice environment.

Because oncology nurses are particularly vulnerable to compassion fatigue (Perry, 2008), the oncology nurse manager pays specific attention to possible signs and symptoms when rounding with staff. When noted, the manager recommends interventions to avoid and/or mitigate compassion fatigue (Reimer, 2013).

Any concern noted in patient or staff rounds that relates to quality of care is promptly communicated to the involved nursing staff. The manager then provides education and clarifies expectations, promoting staff professional development. Positive comments are immediately and personally communicated to the caregiver, and a commendation is placed in the employee's file.

Quarterly Unit Rounds by Senior Nursing Managers

Members of the senior nursing management team, including the chief nursing officer and the team that oversees multiple patient care units, perform rounds on clinical units at least quarterly but often more frequently. The primary goals are to recognize the work and dedication of the staff related to patient care and to encourage discussion regarding nursing-sensitive quality outcome metrics.

The rounding schedule is communicated prior to the visit. The unit manager encourages her staff members to be prepared to relate designated stories that illustrate their professional practice as well as specific staff achievements. In turn, the senior leaders recognize and congratulate these staff members.

The senior managers are on the unit for 20–30 minutes and make efforts to greet every caregiver. In addition, every unit has a visibility board displaying the most recent nursing-sensitive quality outcomes and goals as well as the number of staff recommendations made during a designated week for nurse manager staff rounds. Nurse leaders use the visibility boards to stimulate dialogue with staff. The rounds also are an opportunity for unit staff to ask questions of the senior management representative.

Safety Rounds by Senior Executives

Senior hospital executives, including the patient safety officer, the senior vice president of quality and safety (a physician), and a representative of the senior hospital executive team (chief executive officer, chief medical officer, and chief operating officer), conduct safety rounds throughout the network, visiting one unit per month. The purpose of the rounds is twofold: to demonstrate to frontline staff that the senior hospital executives care about and are invested in the resolution of their safety concerns, and for the senior hospital executives to be enlightened about the depth of frontline staff's concerns, witnessing firsthand their passion for patient and staff safety.

Each rounding session includes frontline licensed and non-licensed assistive personnel. Scripted questions, based on Institute for Healthcare Improvement Idealized Design Group and Frankel (2011), are used to facilitate the discussion of safety concerns and include the following.

- "Have there been any near misses that almost caused patient harm but didn't?" (p. 4)
- "Is there anything we can do to prevent the next adverse event?" (p. 5)

Executives clearly share their expectations for open, honest discussion at the beginning of the session. Their informal and relaxed approach helps to create an open environment. The findings from the discussion are then entered into an electronic database for tracking and evaluation. All findings are shared with the entire senior executive team as well as with the managers of affected areas, with status reports generated by the patient safety officer on a quarterly basis until the issues are resolved.

Opportunities for improvement that are able to be rectified easily are addressed quickly. Some suggestions that require long-range planning but were accomplished included revisions to unit architecture to promote medication safety, trials with wireless telephones in patient rooms to eliminate the fall hazard caused by long cords, and purchase of defibrillators for each area of the cancer center.

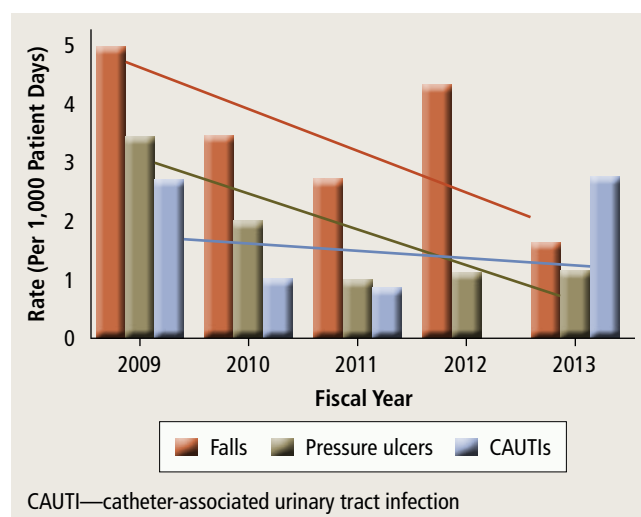


FIGURE 1. 7C Falls, Pressure Ulcers, and CAUTIs for Fiscal Years 2009–2013

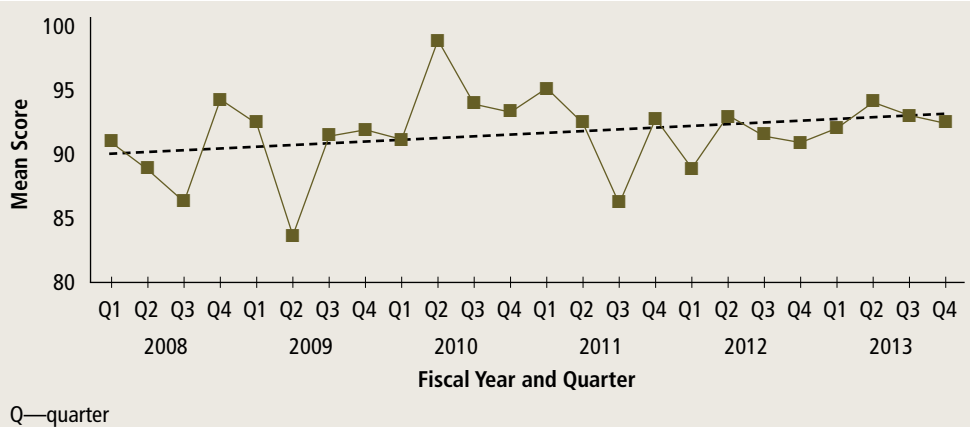


FIGURE 2. 7C Press Ganey Attention to Special or Personal Needs, 2008–2013

Note. Data courtesy of Lehigh Valley Health Network. Used with permission.

Findings

Quantitative Outcomes

Quantitative evaluation of the rounding methods is associated with four distinct metrics: nursing-sensitive patient outcomes and patient, employee, and physician satisfaction. Hourly patient rounds and safety rounds by senior executives were implemented in their current form in 2008; all other rounding methods were instituted in 2008 and 2009. Therefore, metric time frames include these years.

Among nursing-sensitive patient outcomes, trends were identified for pressure ulcers, falls, and catheter-associated urinary tract infections (CAUTIs). The overall trend for falls and pressure ulcers decreased from fiscal year (FY) 2009 to 2013. The trends also was true for CAUTIs, except for FY 2013 (see Figure 1).

Regarding patient satisfaction, two specific Press Ganey items were used as metrics: attention to special or personal needs and adequate precautions to protect safety. Both of these items demonstrated an upward trend (see Figures 2 and 3).

Formal employee satisfaction surveys are completed at LVH every two years. Table 3 details the 2013 satisfaction scores for questions that could be perceived as associated with the various rounding methodologies. Scores for all questions exceeded the national work group and national comparisons of the database used (HealthStream™).

The most recent physician satisfaction survey asked, “How satisfied are you with nursing care?” Ninety-seven percent of the staff was either satisfied or very satisfied, which is the 93rd percentile nationally. This score

could be perceived as impacted by the rounding methods.

Qualitative Outcomes

Qualitative outcomes have been achieved from the rounds. For example, during the manager’s daily rounds, an actively dying patient mentioned he was frustrated in his unsuccessful attempts to access the Internet from his personal computer. The manager arranged for an information services technician to immediately come to the patient’s bedside to troubleshoot the issue. Within minutes, Internet access was obtained. In

addition, examples of issues that were identified and addressed during safety rounds by senior executives include the following.

- Soiled linen bags piled up in the soiled linen storage areas on the weekends, preventing door closure. To address this issue, additional weekend staff was hired to remove soiled linens.
- Cords in patient rooms created a fall hazard for patients, staff, and guests. The solution was to order special carabiner-type clips placed under the beds to hold cords off the floor and away from traffic areas.
- Staff described difficulty in obtaining IV pumps and bed alarms when needed. Additional pumps and alarms were added to the unit par levels.

Challenges and Recommendations

Challenges encountered are associated with change, management, and lean theories. First, even after rounding processes

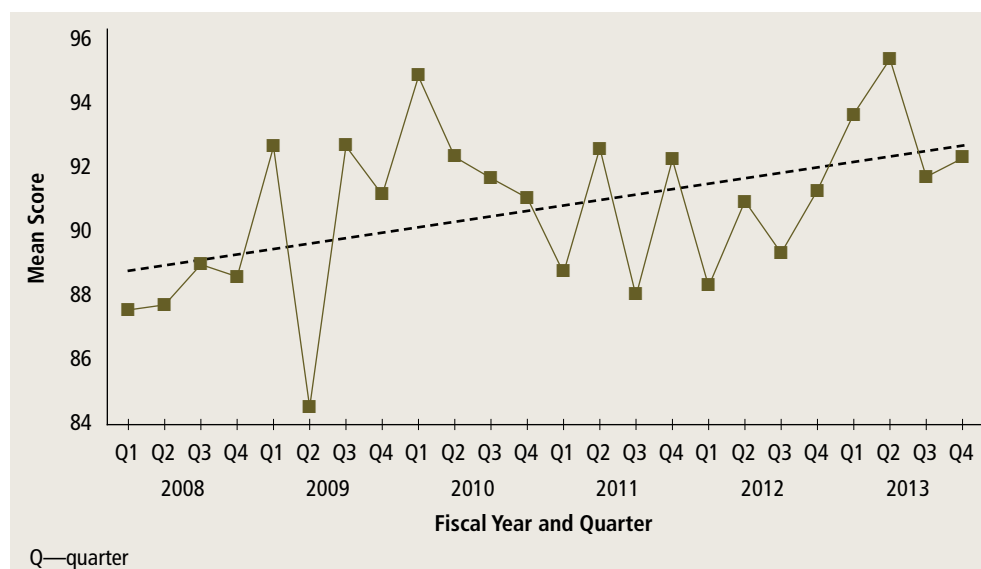


FIGURE 3. 7C Press Ganey Adequate Precautions to Protect Safety, 2008–2013

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TABLE 3. Lehigh Valley Hospital 7C Medical-Surgical Unit Employee Satisfaction Survey Results for 2013

Attribute	2013 Group \bar{X}	Health-Stream™ Comparison Group \bar{X}	Health-Stream™ Research National \bar{X}
Overall satisfaction	3.4	3.03	3.15
Communication: How openly and honestly immediate manager communicates	3.61	3.16	3.2
Constructive feedback: Letting you know when and how your work can be improved	3.5	3.12	3.18
Personal recognition	3.44	2.95	3.07
Understanding needs: How well executive management understands needs of your department	3	2.51	2.66
Communication: How openly and honestly executive management communicates	3.07	2.64	2.77
Safe and secure environment	3.44	3.16	3.26

Note. Data courtesy of Lehigh Valley Health Network. Used with permission.

were established within the daily work and achieving successful outcomes, the unit management team must continue to be vigilant to reinforce the efforts. For example, the unit experienced periodic increases in patient falls and CAUTIs as well as decreases in patient satisfaction scores below target goals. As soon as those issues were noted, they were shared with staff to ensure transparency and reinforce expectations, inclusive of rounding, to improve the deficiencies.

In the beginning of the project and on an ongoing basis, staff engagement must be strategized. Staff champions should be identified and promoted, and staff successes should be celebrated and rewarded. Staff accountability to complete hourly patient rounds and collaborative rounds is enhanced by communicating expectations to patients and families. In addition, processes can be changed, particularly to correct something that is not working. For example, in FY 2011, LVH researchers conducted an ethnographic study to examine issues associated with hourly patient rounding (Deitrick, Baker, Paxton, Flores, & Swavely, 2012). A gap regarding the benefits of hourly rounding was identified between administrators and staff, and clarity was lacking related to implementation of hourly rounding into the patient care workflow. The study findings prompted redesign of the rounding process in which direct care staff were included on the redesign team, education and communication became more robust, and staff performance was validated using a standard checklist.

Although lean theory promotes standardization (Shook, 2008), it can be difficult within a large organization. Because LVH is committed to lean principles, processes have been standardized throughout the institution for all rounding methods, except interdisciplinary collaborative rounds. The variations in these latter rounds are caused by patient care unit structures, functions, and patient populations. For example, a surgical unit may conduct rounds without the primary surgeon because he or she being in the operating room during the time frame that other disciplines and family members are available. The standardization communicates to staff, patients, and families the commitment to consistent expectations that have proven effective in producing positive outcomes.

Implications for Nursing

Various rounding strategies can be tied to qualitative and quantitative outcomes. By standardizing rounding structures and processes throughout a healthcare setting, staff and patient expectations are reinforced. However, even after establishing rounding processes within daily work and achieving initial successful outcomes, continuous vigilance is necessary to re-inforce and validate processes. No single change can achieve patient and staff satisfaction and exemplary clinical outcomes; instead, multiple rounding methodologies can assist in goal attainment.

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3. Which of the recommendations would you consider implementing in your setting? Why or why not?
4. What would be the next steps in applying the information presented in the article in your setting?

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