Editorial: Intentional rounding: unpacking the ritual, routine and evidence impasse

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There is little doubt that the organisation of nursing work significantly impacts care delivery and the quality of care received by patients. Historically, routine was a common feature of the organisation of nursing work, and nurse rounding was an accepted and routine feature of nursing practice. For more than three decades a strong thread in the nursing discourse has been the turn away from ritual and routine (Schmahl 1964, Kerr et al. 2011). This discourse resulted in widespread abandonment of nurse rounding. In recent years there have been calls for the reinstitution of routine nursing rounds. The current move to return to routine rounding, and its reinterpretation through the lens of patient benefit, particularly in preventing harm to patients, provides a strong case exemplar for the re-examination of routine in nursing practice.

Conceptualising routine as ‘harmful ritual’

For many years, nurses working in hospitals performed care rounds. These rounds focused upon delivering particular aspects of nursing care, such as hygiene and comfort measures, pressure care or toileting and ensuring these aspects of care were met. The emergence of the nursing process with an emphasis upon holistic and patient-centred care models, created a focus on organising nursing work that was diametrically opposed to routine. Heavily critiqued in the nursing discourse of the 1970s and 1980s (Seaback 2013), routine nursing rounds were dismissed as archaic and representative of ritualised practice that had no real basis in evidence. The assumption was that these routines were thoughtless or mechanical. Consequently, nursing rounds were largely discarded, in favour of more contemporary models of nursing care delivery, such as patient allocation and team nursing models.

The idea that much nursing care revolved around routine and ritualised activities; and that these routinised activities somehow limited nursing, and degraded nursing care, positioned routine itself as unacceptable, and routines such as the nursing round came to be framed as groundless, empty ritual. Viewed pejoratively in the nursing literature, the ritual has been taken to mean actions that are carried out without thinking, or that lack a logical or thoughtful basis (Martin 1998), and viewed as the demonstration of unthinking, unsafe or outdated practice. The evidence agenda also contributed to the discourse of derision that surrounded practices that were seen as ritualised and unthinking.

Thus, routine practices such as hand-washing, routine pressure care rounds and nurse rounding were called into question or abandoned (Martin 1998, Zeitz & Mccutcheon 2005), often with little, if any, evidence or consideration as to whether this form of routine care was harmful or unpalatable to patients. The inability to conceive some aspects of ritualised practice as thoughtful or necessary has meant that in nursing, no intellectual bridges have been built between ritual and thought, or between routine practice and the beliefs that underpinned them (Shillbrack 2002). The consequence of dismissing routines as thoughtless rituals has meant that the connections between thinking, knowing and acting that were embodied in this routine nursing practice have remained largely unexplored.

Conjecture that rituals are thoughtless practices that are largely devoid of evidence (Sbaih 2001) turns on a set of views about knowledge and the type of knowledge that is valued. Practice knowledge, which represents understanding through action (Shillbrack 2002), became less valued in the context of modern views about scientific knowledge and evidence-based practice (EBP).

Polarised debate and the evidence void

Debate on the valuing of different forms of knowledge and their place in nursing has sustained a polarised debate in the nursing discourse. On one side, it has been argued that facilitating the spread and uptake of evidence is one of the main challenges faced in raising the standard of nursing practice (Cummings 2012). Others have argued a contrary view, noting that the pursuit of evidence has created a dangerous, obscene and imagined void that is without substance, with evidence-based guidelines viewed as ‘ready-made tools’ that limit critical thinking (Holmes et al. 2008). Others have argued that overly prescriptive and narrow views of what counts as legitimate evidence risks marginalising some forms of knowledge although privileging others (Saltman et al. 2013).

The reality of the EBP agenda for many clinicians is that it has failed to deliver evidence. Faced with continuing pressure to adopt evidence (Mazurek
Melnyk 2014), clinicians find themselves facing a void of low-level or no evidence. As an example, a recent Cochrane review identified only three trials published on the topic of whether repositioning prevents risk of pressure injury (Gillespie et al. 2014). Similarly, another Cochrane review failed to identify any randomised trials that established the best form of nursing handover to ensure continuity for hospitalised patients (Smeulers et al. 2014). Although another reported only one low-quality study could be identified in a Cochrane review examining organisational infrastructure for promoting EBP (Flodgren et al. 2012).

There are many possible reasons why nurses are faced with this evidence void on such fundamental aspects of practice. As already noted, in the nursing discourse practice routines and rituals have been framed as actions without thinking. The types of care that were delivered in these routinised rounds was care that some consider ‘basic’ – for example, hygiene, mouth care, pressure care, toileting and ensuring patients were comfortable. In some ways these have been taken-for-granted aspects of care, and therefore, have not necessarily attracted research interest.

In the absence of adequate formal nursing research on routine care interventions, a large volume of practice improvement is occurring at the level of quality assurance within health care institutions. The findings from these projects have limited dissemination and provide little substantive evidence to inform practice beyond the institution in which they occur (Mitchell et al. 2014). Other reasons for low levels of evidence on fundamental aspects of nursing practice include the difficulties in securing funding for this work, in a funding landscape dominated by competing agendas and biomedical research.

The re-emergence of nurse rounding

The polemic between theory–practice–routine is not new to nursing. But, it takes on new importance in the current environment where there have been widespread calls to ensure safety, quality and patient satisfaction with nursing care. These calls have seen the resurfacing of routine nurse rounding – driven in many instances by hospital administrators, government officials or politicians (Snelling 2013).

Although there has been critique that the push for reinstating rounding may be an evidence-free idea largely driven by political whim (Snellink 2003), the re-emergence of this practice has again focused attention upon rounding as a routine feature of nursing work. It has also provided a catalyst to reflect on notions of routine and ritual in this current evidence-based age.

Rounding with intent: the safety and patient satisfaction agenda

Currently, the terms for intentional or purposeful rounding have been used to describe a practice of rounding that is not dissimilar to the forms of rounding abandoned in previous decades. This recent practice emerged in the USA as a scripted process that includes specific rounding behaviours (focused upon positioning, personal needs, pain and possessions), reporting and scheduled reviews between team leaders and nursing staff (Meade et al. 2006).

This change in the way nursing work is organised in some contexts has (not unsurprisingly) attracted the interest of nurse researchers and clinicians who are keen to ascertain benefits of intentional rounding to patients and nurses. Rounding in specific environments such as coronary care has included proactive rapid response rounding, which are reported to lead to earlier identification of the deteriorating patient (Guirgis et al. 2013). Other researchers have evaluated the impact of rounding upon peer–peer learning, with nurse specialists rounding with ward staff on a regular basis as a means to prevent patients developing hospital-acquired pressure ulcers (Kelleher et al. 2012). This body of work has begun to refocus attention on routine in nursing practice, and calls into question the previous assumption that routinised aspects of care-reflected mindless ritual.

Conclusion

Both EBP and the patient safety agenda have become major foci in health care. The re-emergence of intentional rounding as a routinised nursing practice presents an opportunity for nurses to reflect on the place of routine in nursing practice. It also highlights the issue of evidence, and the assumption that adequate evidence exists about all forms of nursing practice. In fact, despite nearly three decades of urging nurses to base all practice on evidence, nursing continues to suffer a lack of empirical research to inform many aspects of practice.

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