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Intentional rounding in the context of student learning

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ABSTRACT

Problem/background: Intentional rounding or regular patient checks were introduced in to healthcare settings to enhance patient safety and satisfaction. Patient and staff experiences have been explored in the literature, however the student nurse' experience of this intervention has not been explored in the context of their learning on clinical placement.
Aim: This study aimed to explore students' experience and understanding of intentional rounding in the clinical setting.
Methods: Semi-structured interviews were conducted with 18 student nurses.
Findings: Intentional rounding has raised many learning issues for students. The study found that intentional rounding creates a framework to reflect on the nexus between attending to patient need, and the learning student nurses undertake, and creates an avenue for them to be able to operationalise quality patient care.
Discussion: Student nurses need to be part of the ward 'team' to enhance their learning. There are limitations surrounding positive role modelling, sharing of information and formal education in such interventions, which impacts students' confidence, involvement and understanding. If done effectively, participation in intentional rounding can increase students' time management skills, assessment ability, and the safety of the patient.
Conclusion: Modelling positive behaviours, and encouraging active and educated involvement in intentional rounding will enhance confidence and skill, and reduce the theory practice gap.

1. Introduction

Clinical placement, part of all undergraduate nursing course requirements, enables the student to put learning into practice and work as part of a nursing team. Assisting with patient safety interventions such as intentional rounding (IR), ensuring that patients are seen on a regular basis, and that the patient's needs have been met (Forde-Johnston, 2014), is a reasonable expectation of student nurses. IR is an intervention utilised internationally (The Studer Group, 2007), introduced into clinical practice as a result of missed care opportunities in an effort to ensure additional precautionary interaction measures are undertaken by nursing staff (Francis & Mid Staffordshire NHS Foundation Trust, 2013). It involves a prompting tick box form often using acronyms (for example – pain, potty, possessions, position just to name a few) to ensure care needs are met.

Although responses to IR, its benefits and barriers have been explored within the literature from perspectives of patients, organisation and nursing staff, a recent review of the literature (Ryan, Jackson, Woods, & Usher, 2018) found no evidence related to nursing students' experiences of IR. Subsequently, this paper is one of two papers that report the findings of a large study exploring students' perspectives. The first paper presented the findings from a quantitative survey (Authors, xx). This current paper presents further insight into student nurses' experiences and understanding of IR through qualitative interviews.

2. Methods

Eighteen semi-structured interviews were conducted from July to August 2018 by the primary author. Open-ended questions were derived from responses to the quantitative survey of the study to gain further understanding of the issues identified.

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Summary of relevance

Undergraduate nursing students are our future workforce involved in patient safety initiatives.

Problem

Little is known about nursing students' understanding and experience of intentional rounding on clinical placement.

What is already known

The benefits and barriers to intentional rounding has been explored from the perspective of nursing staff and patients. Nursing students however have not been asked about their experience and understandings of intentional rounding during clinical placements.

What this paper adds

There are benefits to learning when students are able to engage in intentional rounding. Factors influencing engagement include education, role modelling and facilitation.

3. Ethics

Ethics approval for this study was obtained from the relevant Human Research Ethics Committees (HE17-100; H-20189-0099). Participants were contacted who had indicated further interest in being interviewed as part of a previous online survey, and were provided an information sheet outlining the study and its requirements. Consent was obtained prior to interview, and participants were informed they could withdraw at any time.

4. Participants

Participants were pre-registration nursing students enrolled in five Australian universities, who had attended at least one clinical placement as part of their undergraduate programme. Ninety-seven participants initially stated that they were willing to be interviewed, but not all responded to the follow up communication. Data analysis concluded after eighteen interviews with agreeing participants, as data saturation was achieved.

5. Data collection

Data were collected through semi-structured interviews. Participants ($n = 18$) were interviewed via phone ($n = 15$), or in person ($n = 3$). All interviews were digitally audio recorded, and transcribed verbatim. Transcriptions were checked against recordings to ensure accuracy. Face to face interviews were conducted in an office in a neutral location with the interviewer and participant only present. Interviews were 20–75 min in duration, with a mean of 39 min. Data saturation was deemed to have been reached when similar content/themes were heard and no new ideas revealed.

6. Data analysis

Data analysis was conducted through reading and re-reading of transcribed data using constant comparison then clustering data into themes and subthemes, based on the thematic analysis framework of Braun and Clark (2013). Using this six-step approach of familiarising with the data, generating initial codes, searching for themes, reviewing, subsequently defining the themes and then writing up, commonly occurring themes were assigned from the transcribed data, and a thematic map naming themes was developed, and themes further reported (Braun & Clark, 2013). Two authors undertook initial coding and theme identification (XX and XX). This was initially undertaken separately, then these results were shared with the larger research team. During this meeting, the team reflected on the data and the two analyses and through the team meeting, further analytical synthesis occurred to produce the final themes.

7. Findings

Findings were analysed using thematic analysis, and subthemes reported and described (Fig. 1). There was some discordance in the findings, consistent with previous literature discussing staff views (Ryan et al., 2018), in that participating students thought of intentional rounding as one aspect of the 'mundane' tasks' they were required to undertake. This was also reflected in participating students' impressions that some nurses' viewed intentional rounding as simply a token gesture of the quality and safety checks required for their patients, evidenced by students witnessing nurses' simply ticking off a checklist at the end of shift to indicate the checks had been done. However, participant students also articulated the value of IR to them as students indicating participating in IR gave them more confidence in the clinical environment due to the routinised nature of IR. Each theme is discussed individually in more depth below.

7.1. Having the skills but not the knowledge

While participants had beginning education and skills around activities such as comfort measures, positioning patients and offering fluids, they did not have the knowledge to understand the meaning of IR in relation to providing an opportunity to assess and authentically engage patients. Participants reported that they had learnt the physical skills required to be able to conduct IR; however, with further exploration they lacked understanding of the importance of the concept and why it was necessary, instead framing IR as nothing more than a series of '*mundane*' tasks.

> *I've heard other students say, like, oh, why are we doing this? This is a silly sort of thing. . . like, mundane tasks. . ..* (P5).

Participants recognised IR as a task rather than seeing the need for higher order thinking to integrate the information that had been sourced. Thus, many saw it superficially – as a set series of independent tasks – rather than a more holistic strategy for framing an encounter to engage and assess a patient and provide care to meet their individual needs. Because of this they struggled to see the relevance or the importance of IR.

> *'It was just sort of something that was sort of thrown at you . . ., 'You just need to do this' sort of thing'* (P6).

As indicated in Fig. 1, this theme of having the skills but not the knowledge comprises of two subthemes: (1) *gaining knowledge: learning on the job*, and (2) *wanting to know more*.

7.2. Gaining knowledge: learning on the job

Students described learning about IR predominately within clinical settings rather than university, where participants indicated it was not addressed. Students recognised the value of learning on the job, but also expressed wanting to have more knowledge about IR prior to commencing placement, through their academic teaching. As a result, the knowledge level they held about IR including its rationale, was considered insufficient, resulting in participants' feeling poorly prepared.

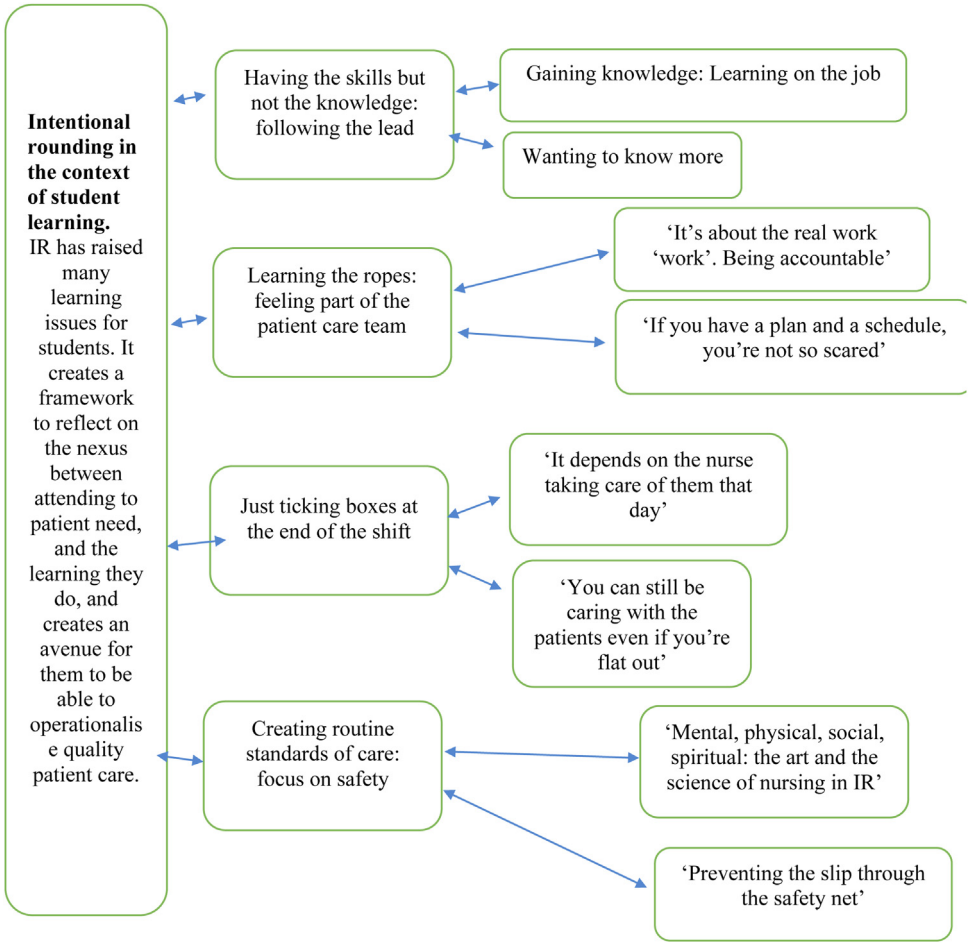

Fig. 1. Intentional rounding: insights from students.

'It would be sort of good if we got a little bit more training in uni before we go out, or just go over it in one of our tutes, to say, "Okay, this is what an hourly rounding sheet is. This is what it's for" so by the time we do go out on placement we know what to expect" (P11).

Participants indicated their learning occurred through observing and replicating behaviours seen in the clinical setting. Statements such as '*I mostly just observed her* [clinical nurse] *practice and that was it'* (P10), were common throughout the interviews. This way of learning meant that while participants observed that IR was accepted and practiced within clinical settings and needed to be incorporated into their clinical working days, they did not necessarily have the opportunity to question or discuss the ideas underpinning the concept of IR, therefore they were delivering care without fully understanding why. Reflecting on experience, one participant commented, '*no, she didn't really provide like education. I mostly just observed her practice and learnt from that*' (P10).

In the absence of full understanding, student engagement with the IR process was dependent on a number of factors, including staff and ward dynamics. Their lack of exposure to education around IR meant that participants had considerable uncertainty: '*Still I don't have complete knowledge of this intentional rounding because we don't have this content in our course.. I just see in the clinical practice and that's it and I haven't used it now so I'm not sure it is 100% right. I don't think I got the full knowledge and skills to do the intentional rounding. . . I'm still in (the) learning phase. . .*' (P3).

Participants had varied experiences including some where they benefitted from nurses who made the effort to ensure students understood the responsibilities, with one participant commenting *I had some really good buddy nurses, who were very thorough in making sure that I understood . . . the responsibilities that came with the rounding (P16).* However, others expressed: *I mean, no one was talking about it where I went. I mean even at uni, no one's talking about it. I think it could be improved a thousand percent. If it was presented and taught, if you know what I mean* (P13).

As alluded to in the aforementioned narrative, some participants faced difficulties in the clinical environment, because they felt that IR and its rationale was assumed knowledge, with clinical staff holding the assumption that they had been provided with relevant education through university.

(Staff). . . sort of assumed that you knew. And also, depending on who you're with depends on whether or not they show you the paperwork part as well and what they do. (p6)

7.3. Wanting to know more

Participants reported that while they learned most about IR on clinical placement, not all staff mentioned it on placement or did not bother to share information about IR with them. Generally, participants saw benefits in IR, but were disheartened by their lack of knowledge and wanted to know more. They expressed confusion about why they had not been better prepared for this aspect of clinical practice.

'I think it's great like that to be organised like that, but I think, like I said, it doesn't come natural. It's only come natural to me now after, when I can see I'm like. . . I wish they could have taught me these

other things . . . why couldn't they like, [ask] *do you understand?' (P4)*

While participants considered clinical staff to be sources of knowledge:

'I think I did [understand] *but I had some pretty good nurses. I know a lot of my friends say that they didn't really understand, like they understood why it was important but they didn't, they were just kind of, given the paperwork, and just told to do it. So, it really depends on your nursing preceptors and the environment'* (P16), they also perceived that not all clinical staff were necessarily interested or able to teach, with one participant commenting *'Look, some RN's are great teachers, and others, it's just not their skill'* (P18). As a result of the varied opportunities for teaching and learning, students were not always involved, and there was no shared understanding of expectations or reasoning surrounding IR. However, because participants wanted to know more about an activity that took up a large amount of clinical time, they actively sought out information from a range of sources. Once they had ascertained that staff were unable or unwilling to provide the necessary information, they looked further afield: *'So the staff can't explain further, so I just Google it but it's like, it makes it hard a bit to understand. . .'* (P7).

8. Learning the ropes: feeling part of the patient care team

Participation in IR practices provided opportunity for students to gain confidence, skills and a greater understanding of their role through active membership in the clinical nursing team. Students saw the value of IR to patients, and performing IR contributed to feelings of being a useful team member. Participants felt they were afforded a greater skillset, understanding and surety in their ability if given the opportunity to be involved and accountable for IR.

Feeling useful, and feeling they made an authentic and important contribution to patient care through their IR activities was identified as being important to participants, contributing positively to their clinical experience, '*Yes, I feel like you need to be treated like you're a part of the team. . .it really does change the aspect of the placement. . .'* (P1).

This theme is represented through two subthemes, (1) *it's about the real world, being accountable*, and (2) *if you have a plan and a schedule you're not so scared*.

8.1. 'It's about the real work world. Being accountable'

Clinical learning is an important aspect of learning for undergraduate nurses and these participants revealed their desire to fully engage, learning as much as possible during clinical placements. For example:

'Well we're going to be in the workforce sooner or later, I think we should be doing everything, including documentation, taking all aspects of nursing care including down to things like intentional rounding should be part of the student nurse's role' (P15).

For students to be engaged and learn, they need to be exposed under guidance to all aspects of nursing care, and adequately prepared for the task. Students engaged in IR expressed feeling as if they were doing 'real' nursing work; they were able to be effective and useful by attending to care involved in IR, then completing the associated documentation.

'It really helps with planning your shift, just planning your next hour, and your cares. You don't miss anything' (P9).

Participants indicated that this gave them structure within each shift, and confidence in knowing that they could meaningfully contribute both to the care of patients, and the workload of the nursing team.

8.2. 'If you have a plan and a schedule you're not so scared' (P4)

Students expressed feeling more confident with IR, as they could use IR to plan, be prompted to patient's care requirements, and gain greater familiarity and understanding of their patients.

'I feel like.. by doing rounding.. can assist with that. . . get to know the patients a bit better, get to know how to develop more trust with the clients.. and get to effectively work in the team. . . I feel like it is important to do.. It also develops a confidence as well. . .' (P1).

Participating in IR contributed to participants' sense of confidence and autonomy in the clinical environment, evident throughout the narratives.

'I felt more confident, I felt more like a nurse rather than just me. . . just being a shadow to my buddy nurse. . . I felt like I'm part of the team' (P4).

Students could actively plan their day and feel more organised and in control. Through IR, participants were able to develop schedules and plans for the shift and foster their organisational skills.

'I think it was great [IR]*, because I had a plan. . . it was a set plan, and so I knew exactly what to do. . . I think that helped a lot. Just being more organised, definitely'* (P4).

They found the checklist prompts to be beneficial in covering all necessary assessment components in a timely manner. One participant explained additional knowledge as power, and IR as '*the hidden skill*' that assists them in the organisation and subsequent unfolding of their day (P14). With students conducting these regular assessments, they were armed with a greater amount of knowledge about their patients, and then could feel a greater sense of authority.

9. 'Just ticking it off at the end of the shift' (P13)

Through their clinical placement experiences, current IR practices were shared with participants. Students observed role-modelled positive and negative behaviours related to IR. Variability in the quality of the documentation depended on the nurse they were working with. The documenting of IR was revealed as contentious – *'It's another piece of paper that we have to fill out just to say that we're doing our job'* (P6). Participants reported variances in documentation with some occurring once a shift, '*I never saw anything filled out hourly. I only saw it filled out at the end of the shift*' (P13).

Role modelled behaviour was seen to be important and influential to participants, shaping their views. Participants reported situations where reporting of IR was seen as onerous and just a tick-the-box exercise with comments such as '*Oh you just need to tick this, this and this, and put this down*' (P6) and '*some nurses that I've had. . . they were just. . . yeah, just tick it off' (P16)* common throughout the data.

This theme comprises two subthemes: (1) *it depends on the nurse taking care of them that day*, and (2) *you can still be caring with the patients when you're flat out*.

9.1. 'It depends on the nurse taking care of them that day' (P1).

Inconsistencies in care were noted by participants between wards and nursing staff. Participants observed a perceived lack of care and interaction with patients, although IR logs were completed at the end of the day. '*At no time was it ever discussed. The first time I ever saw it was on the paperwork at the end of the shift and the girls that I was sitting with just ticked it off that they'd done it every hour*' (P13).

Some wards formalised IR, whilst others did not. This impacted on the students' own engagement in IR.

'Whereas some nurses will go–no, no, no, you don't have enough time to do that. Just go and do your documentation! Just do your paperwork! It's more important than going to check on them [patients]' (P4).

Inconsistencies were observed both in the documentation that was completed, and the related interactions with patients. Between each ward variances were found, confusing students. '*You'd go on different wards and different wards had different perspectives about it. So it's not consistent' (P14).*

For example, some wards had formal documentation, their own individual rounding tools, formal education and support, and others had no formal rounding practices, and little emphasis on the practice. This created contradictions, resulting in participants not seeing the importance of IR, as practice was so different between wards and facilities.

'*I guess you kind of follow the lead, when you're a student. You do what is the norm of the facility you're at'* (P17). It was apparent to participants that some staff did not effectively engage with IR, and negativity from staff was noted. '*they [nurses] always said, 'oh yeah, you're meant to be checking this much but it's not practical'* (P4).

9.2. 'You can still be caring with the patients even if you're flat out' (P13)

IR afforded students the opportunity to recognise care provision. IR was seen as a positive contribution to patient care, despite the obstacles surrounding getting this done amongst conflicting time constraints.

'If I feel like my patients are happy and comfortable then I feel satisfied, so that would enhance just ensuring that everything was well, and I would feel like I'd done a better job' (P10).

Given the sense participants had of the importance of IR to patients, they generally felt IR was a good use of time with one participant noting that '*it doesn't take very long*' (P9). The practicalities of hourly IR however, were perceived to be difficult in a busy ward, and participants felt fellow nurses at times expressed unrealistic expectations; '*I think nurses are always time poor'* (P18). Effective time management, prioritisation of care, and individualising IR to different ward and patient requirements were suggested improvements from participants.

10. Creating routine standards of care: focus on safety

The routine of IR assisted participants in being able to establish positive habits in patient safety, ensuring that patients were checked and assessed regularly, and organising their time as part of contributing to the safety of the ward. '*I can see positively the benefits and the purposes of how you can achieve best possible outcomes for a patient that way'* (P14).

Some participants were clearly able to articulate the benefits of IR in keeping focused on patients and contributing to a safer and more engaged clinical environment.

'I think we all become a bit task oriented, and we forget to focus on our patients, so I think it's really important to reinforce that, you know, to go and do your observations every hour and actually check in' (P10).

This theme consists of two subthemes. These are (1) *mental, physical, social, spiritual: the art and the science of nursing in IR* and (2) *'preventing the slip through the safety net'*. These are discussed in detail below.

10.1. Mental, physical, social, spiritual: the art and the science of nursing in IR

IR encompasses underpinning knowledge of pathophysiology, observation, assessment and general patient care, as well as communication, empathy, comfort and engagement. '*. . . it's an all-rounder really!.. communication skills. . . you can observe things, like their resps, the colour of their skin, you can smell things.. you have to be an all-rounder, I think. . . visualise, touch, talk. . .*' (P13).

Participants had considerable variability in age and experience. Some participants demonstrated beginning understanding of the significance of IR in the wider context of holistic care, and were able to link the connections between all of these components. These participants predominately mentioned previous experience or training in the health field and were more mature in age than others who could not articulate the connections as clearly. '*. . .Cos you're building on your skills all the time. You're monitoring, assessing, tracking. I mean, that's one of the strengths of a nurse, of a nurse who's working day after day looking after the same patient, you're tracking. So you're learning how to track really, and observe for change, and so you can see it when it happens'* (P18).

10.2. 'Preventing the slip through the safety net' (P16)

IR is seen as an effective pre-emptive and proactive care strategy that can prevent harm to patients and enhance safety culture. '*I think you need, like a basic understanding of patient needs, sort of thing, and a basic understanding of safety. So, I think you definitely need the skills to be able to identify risks and safety hazards and stuff, and obviously if somebody's not well, you need to be able to have the skills to determine if somebody needs like immediate help or something like that'* (P 5).

Participants perceived that patient safety was enhanced through IR, facilitating monitoring for deterioration and care needs, creating improved general wellbeing and a better work environment for nurses. Some participants recognised the value of IR to patient safety '*You know, I'm thinking it could save a lot of lives. They've buried a lot of people over the years, haven't they, with their mistakes'* (P 13). Participants also expressed that IR provides an effective guide for students in knowing what they need to do and when, giving them more security in their ability to complete their required work and provide safe care to patients, '*By the time we get to. . . be a RN is should be more automatic or it should be more ingrained* (P13).

11. Discussion

Nursing students are taught many skills, processes and interventions within their undergraduate degree, but it takes time to transition from knowing the skillset requirements and fully understanding and implementing these requirements utilising clinical judgement, holistic care and higher-level assessment skills. It has been shown in this study that students have a desire to recognise what they are doing and why, but are not provided sufficient information to have a comprehensive understanding. As a result, students feel underprepared. Student nurses want to participate, sense the importance of the task, yet through the limited education provided, negative role-modelling and reluctance to share information, do not always get a true sense of IR in a holistic way. Not only is IR in place to ensure safety and that important aspects of clinical care are undertaken, it is a means to ensure that the patient has regular personal contact and engagement with staff, providing opportunity to build relationships and well-being.

Findings highlight the continued discord between theory and practice, and a lack of understanding of the basic concepts behind IR from both staff and students. Sufficient preliminary education with

a strong theoretical underpinning about interventions such as IR should be provided through undergraduate education to promote knowledge translation and the application of theoretical knowledge to practice. Greenway, Butt, and Walthall (2019) discuss three primary reasons for a theory-practice gap – practice not reflecting theory, theory not perceived as relevant to practice, or relational issues/discord between universities and clinical practice. All need to be considered in this instance.

The bridging of the theory practice gap can be supported by positive mentorship/preceptorship (Jokelainen, Turunen, Tossavainen, Jamookeeah, & Coco, 2011), reflective practice and practical experience combining theoretical knowledge (Hatvelik, 2011). Appropriate staff that have time to assist with the facilitation of further learning for students is important for students' experience. Yet staffing issues are recognised as a contributing factor to missed care, and also the appropriate teaching of students within the workplace (Ball et al., 2018).

This research emphasised that for students to be actively involved in practices such as IR, they need to feel part of a team within the workplace. This complements the work of Materne, Henderson, and Eaton (2017) who proport the importance of social inclusion and assimilation into the ward environment. Students feel more engaged and in control when they are given a task such as IR, providing them accountability and organisation practice. A sense of belonging is also linked to increased accountability in learning and empowerment for students, which can be achieved through their participation in IR (Levett-Jones & Lathlean, 2008; Perry, Henderson, & Grealish, 2018).

Students have an expectation that nurses they are buddied with on clinical placement have knowledge and are happy to share it, but this does not always occur (Anderson, Moxham, and Broadbent (2018). Jokelainen et al. (2011) concur that a positive relationship involving sharing of expertise between ward mentors and students does not always naturally arise, thus influencing the learning and overall experience for the student. The role of the registered nurse within clinical placement is integral to students' learning. However, it is reported that nurses with additional education on how to formally precept had greater success in assisting nursing students (O'Brien et al., 2014). Ion, Smith, Nimmo, Rice, and McMillan (2015) found students are often likely to follow the lead of those around them rather than questioning practices, in order to stay under the radar in a move towards the end goal of passing the placement and gaining registration. The observation of missed or substandard care impacts on the student nurse negatively however, and they are more likely to imitate these behaviours (Bagnasco et al., 2017), evident by the results of this study, where participants stated that their actions depended on who they were buddied with and what the ward environment was like. By providing a welcoming and accommodating atmosphere, the student experience can be enhanced and learning increased (Doyle et al., 2017). Sundler et al. (2013) state that continuity of the mentor/preceptor is a positive factor in students' experience.

12. Conclusion

This study has highlighted the lack of IR education occurring in university undergraduate nursing courses, putting students at a disadvantage in terms of knowledge, skills and preparedness for clinical practice. To compensate for the lack of education, students role-model the staff they work with on clinical placement which has implications if staff hold negative perceptions about IR, or role model negative practices in documentation. It is imperative that university undergraduate nursing courses incorporate education about IR to ensure that the nursing workforce of the future is fully prepared in terms of both the understanding and skills required to provide best practice in patient safety.

Ethical statement

Ethics approval for this study was obtained from the relevant Human Research Ethics Committees (HE17-100; H-20189-0099). Participants were provided an information sheet outlining the study and its requirements, and consent was obtained prior to interview.

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Authors' contribution

Substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; drafting the article or revising it critically for important intellectual content.

Conflict of interest

No conflict of interest has been declared by the author(s).

Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at https://doi.org/10.1016/j.colegn.2020.09.008.

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