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Hourly Rounds: What Does the Evidence Indicate?

By Margo A. Halm, RN, PhD, CNS-BC

Hourly rounds—intentionally checking on patients at regular intervals—continues to be debated in nursing circles. Often, registered nurses make rounds on even hours and support staff make rounds on odd hours from 6 AM to 10 PM (and every 2 hours from 10 PM to 6 AM). While making rounds, staff engage patients by checking on the "4 P's": pain, positioning, potty (elimination), and proximity of personal items. Patients are told that staff will check on them frequently, so hourly rounds help manage patients' expectations. Patients become less anxious about getting their needs met as they learn to trust the process of hourly rounds.

Attending to patients' comfort, safety, and environmental needs may also prevent adverse events like falls, pressure ulcers, or unrelieved pain; and contribute to patients' satisfaction with nursing care. Proponents also attest that hourly rounds organize work flow, offering efficiencies by giving nurses time back as they proactively (rather than reactively) anticipate and attend to patients' needs. In this review I discuss available evidence about the effects of hourly rounds on clinical outcomes in inpatient settings.

Methods

MEDLINE and CINAHL were the search engines. Key search words were *hourly/patient rounding, falls, call lights,* and *patient satisfaction.* Evidence from research and quality improvement studies was included.

Results

Eleven reports were retrieved (Table 1). Evaluations were conducted in all hospital units, or telemetry, medical/surgical, orthopedic, rehabilitation, and gerontology settings. Most interventions were performed hourly by direct caregivers,[1-10] but 1 involved a charge nurse making rounds every 2 hours.[11] One study was quasi-experimental; the remaining 10 quality improvement designs lacked rigorous analyses on which to base conclusions about associated outcomes.

In 5 of 6 studies (83%) that examined use of call lights, the use was reduced. Meade et al[1] reported that nurses were summoned 12 to 15 times daily to respond to nonurgent needs such as toileting, positioning, or pain relief. By nurses' anticipating these needs through making rounds, patient care may be interrupted less with nonurgent calls. Albeit anecdotally, Leighty[12] further reported a 20% reduction in the distance that staff walked with fewer call lights once making rounds was instituted.

Fall rates were reduced in 7 of 9 studies (77%) in which falls were evaluated. In one study,[10] making rounds did not affect the rate of falls, and in another study[5] the rate of falls increased. Other studies uncovered less use of restraints[6] and attendants[2] when making rounds was instituted.

In 8 of 9 studies (88%), researchers discovered improvements in overall patient satisfaction and likelihood of recommending the hospital, as well as satisfaction with anticipation and attention to personal needs, timeliness of nurses' response, and management of pain. Woodard[11] reported that most patients (72%) who experienced charge nurses making rounds were very certain that caregivers would attend to their immediate needs (vs 52% of patients with no one making rounds who were neither certain nor uncertain that they would receive needed assistance).

Recommendations for Practice

Available evidence represents class IIa/b, indicating that making rounds is appropriate, safe, and useful for practice (Table 2). Making hourly rounds

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Table 1
Studies of hourly rounds

Reference	No. and setting	Call lights	Falls	Restraints	Attendants	Patients' satisfaction	Level of evidence
Meade et al[1]	14 hospitals, 27 units	Decreased[a]	Decreased[a]			Increased[a]	IIa
Johnson and Topham[2]	1 unit, rehabilitation		Decreased		Decreased		IIb
Haack[3]	1 unit, rehabilitation	Decreased	Decreased			Increased	IIb
Tea et al[4]	202 patients, 4 orthopedic units					Increased	IIb
Bourgault et al[5]	3 hospitals, all units (including intensive care units)		Increased			Increased	IIb
Sobaski et al[6]	335 patients, telemetry units					Increased	IIb
Culley[7]	3 units		Decreased			Increased	IIb
Assi et al[8]	2 units, oncology and acute care for elderly	Decreased	Decreased	Decreased		Increased	IIb
Weisgram and Raymond[9]	1 unit, telemetry	Decreased	Decreased				IIb
Kalman[10]	2 units, medical surgical	No effect	No effect			No effect	III
Woodard[11]	1 unit, medical surgical	Decreased	Decreased			Increased	IIb

[a] $P < .05$.

is certainly not novel in nursing. Instead, making rounds is a fresh twist on structuring the nursing process by actively engaging patients and their families.

As an autonomous intervention, making hourly rounds provides nurses with a surveillance mechanism to purposefully keep patients safe and comfortable by proactively meeting their needs. In the 1980s, leading researchers from the University of Iowa created the Nursing Intervention Classification to comprehensively define and catalog the spectrum of interventions that embody the professional practice of nursing. According to the *Nursing Intervention Classification*,[14] many intervention labels include activities done while making rounds (Table 3). Many nurses would agree these activities are "nursing 101," representing good basic nursing care. Therefore, making hourly rounds can be viewed as a bundle of interventions that promote not only comfort but safety of both patients and staff, akin to bundles for ventilator-associated pneumonia and catheter-related bloodstream infection. For example, imagine patients at risk of falling or harm due to "ABCs" (age, bones, coagulation, surgery). By contracting with these patients to call for assistance before getting up or by offering scheduled toileting, a fall may be averted.

Although making rounds is an inherent part of practice, why does it remain controversial? Formal scripting is one of the first challenges from the field. Some nurses believe that scripting is too rehearsed. Indeed, key language is intended to standardize practice, helping patients know what to expect from rounds. By encouraging staff to customize the 4 P's

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to the most essential needs of the population of patients served and to use their own authentic voice while addressing the 4 P's, nursing leaders strengthen professional autonomy and ownership for outcomes in practice. For example, if critically ill patients are sedated or unable to respond, staff may make rounds on patients' families, showing concern for the needs of the patients' family members. Undeniably, positive perceptions about the attentiveness of care encourage patients and their families to share their excellent care experiences with others, including stories with the power to draw more patients to the hospital.

Skill mix is another ingredient for success. Having adequate support staff to partner with registered nurses by making rounds on alternate hours is crucial, otherwise nurses will be taxed if they are expected to make rounds every hour. Furthermore, the team must communicate frequently to ensure follow-through on needed interventions or referrals. For instance, if the patient reports a pain rating greater than 3 when the nursing assistant makes rounds, this situation must be communicated so the registered nurse can institute pain measures

Table 2
Evidence grading

Class	Criteria	Definition
Class I Definitely recommended	Supported by excellent evidence, with at least 1 prospective randomized controlled trial	Interventions always acceptable, safe, and effective; considered *definitive standard of care*
Class IIa Acceptable and useful	Supported by good to very good evidence; weight of evidence and expert opinion strongly in favor	Interventions acceptable, safe, and useful; considered *intervention of choice* by most experts
Class IIb Acceptable and useful	Supported by fair to good evidence; weight of evidence and expert opinion not strongly in favor	Interventions also acceptable, safe, and useful; considered *optional or alternative* by most experts
Indeterminate Promising, evidence lacking, premature	Preliminary research stage. Evidence shows no harm but no benefit; evidence insufficient to support final class decision	*Treatment of promise* but limited evidence
Class III May be harmful; no benefit documented	Not acceptable or useful; may be harmful	Interventions with *no evidence of any benefit*; often *some evidence of harm*

Adapted from "Part 1: Introduction to the International Guidelines 2000 for CPR and ECC,"[13] with permission.

Table 3
Nursing Intervention Classification activities related to hourly rounding[a]

Nursing Intervention Classification label	Pain	Positioning	Potty	Proximity
Pain management: Alleviating pain to a level of comfort acceptable to patients	X			
Environmental management–comfort: Identifying hazards and manipulating the physical environment to promote optimal comfort	X	X		
Environmental management–safety: Identifying hazards and manipulating the physical environment to promote safety			X	X
Environmental management–worker safety: Assessing and identifying issues in the work site environment to influence the health/safety of the health care team		X	X	X
Risk identification: Assessing for potential risk factors and prioritizing risk reduction strategies appropriate to individual patients	X	X	X	
Fall prevention: Instituting special precautions for patients at risk for falling or sustaining injury		X	X	X
Patient contracting: Negotiating agreements that reinforce specific behaviors	X	X	X	
Prompted toileting: Promoting safety through timed toileting			X	X

[a] Based on data from Bulechek et al.[14]

promptly. Another fairly common belief is that making hourly rounds has limited value in critical care units because nurses are constantly in patients' rooms. However, if the 4 P's are not intentionally addressed, targeted outcomes may not improve.

Acuity levels provide additional challenges. Cultivating critical thinking among staff is an essential role of leaders. At times it may be appropriate for registered nurses to remain with a high-acuity patient to guarantee good outcomes, forgoing routine rounds for a patient who is in stable condition. Again, communication with support staff about making rounds in nurses' absence is imperative to ensure that needs are met.

Another innovative solution is to view hourly rounds as an interdisciplinary practice. Other team members may make rounds while with the patient, intervening on the basis of each member's scope of practice. Perhaps a physical therapist can assess the 4 P's and assist the patient to the bathroom while assessing their transfer ability and gait. Patients' needs outside the caregiver's scope would then be communicated to a suitable staff member for follow-up.

A final challenge rests with documentation. Most nurses today have more than enough to document—whether it's assessment findings or therapeutic actions—not to mention regulatory requirements. Although logs of rounds drive accountability, they also may breed opposition and wavering adherence. Documenting completion of rounds on whiteboards concerns nurses because it may set up unrealistic expectations with patients and their families when unforeseen circumstances arise (eg, staffing challenges or patients in unstable condition). Alternatively, patients' responses during rounds (eg, positioning preferences) may be noted on whiteboards to allow patients' needs to be visible to all team members during subsequent rounds. Thus, not only does making rounds enhance open dialogue with patients, it establishes a consistent communication vehicle for the care team.[15]

In summary, Meade et al[1] reported reductions in falls (52%), use of call lights (37%), and development of pressure ulcers (14%). It is important to realize that units with already low fall rates and high patient satisfaction may not achieve the same degree of positive change from instituting hourly rounds. Units must examine their historical baseline outcomes to determine what degrees of improvement are associated with practice changes. Higher quality study designs are needed to assess the effect of hourly rounds in a variety of settings—including units with a history of good outcomes—to determine what promise making rounds holds for further improvements. Consequently, making hourly rounds is not a panacea, but another apparatus in nurses' toolkit to advance nursing quality outcomes. And when nurses' professional autonomy in how they connect with patients at the bedside is promoted, the true art of nursing blossoms.

FINANCIAL DISCLOSURES
None reported.

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