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REVIEW

Leadership for Fundamental Care

Nurse manager intentional rounding and outcomes: Findings of a systematic review

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Abstract

Aim: To summarize the evidence available on Nurse Manager Intentional Rounding (NMIR) describing the main characteristics and methodological quality of studies available, the features of rounding and the outcomes as measured to date.

Design: A systematic review.

Data Sources: Electronic databases, including MEDLINE-EBSCHOST, PubMed, CINAHL, Scopus, Cochrane, Clinicalkey, ScienceDirect, OVID, Sage Journals and Web of Science, were searched up to June 2021.

Review Methods: The Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement guideline was used to summarize methods and report findings. The Joanna Briggs Institute Critical Appraisal tools were used to evaluate the methodology quality of the studies included.

Results: Seven studies were included with pre-post-test (n = 3), longitudinal, two-group post-tests, quasi-experimental, and retrospective study designs (n = 1, respectively). In five studies, the nurse managers were trained to conduct the rounding, which was shaped according to three main features: a structured (n = 4), a semi-structured (n = 1) and an unstructured rounding (n = 2) delivered from high (twice a day 7/7) to low intensity (once a day, 5/7). Two main outcomes have been measured to date, the patient satisfaction and some aspects related to the care quality. Five studies reported that the satisfaction scores of patients who received rounding were significantly higher than that perceived by patients not receiving rounding. About the other aspects of the quality of care, two studies documented significant improvements as a consequence of the NMIR (e.g. information accessibility, discharge instructions, coordination of care after discharge).

Conclusion: Studies available report in general a low methodological quality, mainly due to their pragmatic nature as quality improvement projects. Therefore, transforming this field of research by establishing a methodological rigour and a theoretical foundation in both interventions and outcomes and by designing experimental approaches, might expand the evidence available on the effects of nurse managers intentional rounding.

KEYWORDS
chief nursing, hourly rounding, intentional rounding, nurse leader, nurse manager, purposeful rounding, systematic review

1 | INTRODUCTION

Intentional rounding has attracted attention in recent years. This interest seems to be the consequence of the Francis Inquiry, which has investigated patient care failures at Mid Staffordshire National Health Service Trust, United Kingdom, thus establishing recommendations to increase local systems in their capacity to provide safe, compassionate, and person-centred care (Department of Health, 2013, p. 74). Specifically, the report has recommended the 'Regular interaction and engagement between nurses and patients and those close to them should be systematized though regular ward rounds' (Department of Health, 2013, pp. 42–43). However, an hourly round also called 'care rounds' or 'patient comfort rounds' has been documented for many years before the Francis Inquiry report (Dix et al., 2012).

Intentional rounding has been defined as a structured process where nurses in hospitals perform regular checks, usually on an hourly basis, by accessing the patient bedside using a standardized protocol to address issues (e.g. positioning, pain) (Ryan et al., 2019). In addition, it aids to ensure that patients' fundamental care needs are met (Christiansen et al., 2018). Intentional rounding has been documented as being of significant value for patients, nurses, NMs and the whole system. Thanks to intentional rounding, patients' satisfaction and safety have been reported to increase, also because their needs are anticipated by nurses (Sims et al., 2020). Nurses have been reported to perceive increased satisfaction and responsiveness (Mitchell et al., 2014) and a decrease in unnecessary tasks through intentional rounding (Ryan et al., 2019). Besides all, intentional rounding provides an opportunity to observe the care given and to prevent missed care (Willis et al., 2016). With these beneficial results, intentional rounding has been reported to increase the closeness to patients and the quality of holistic care provided at the managerial and at the system levels (Harrington et al., 2013). However, although deliberate rounding encourages caregiving in all its aspects (Krepper et al., 2014) as the fundamental of care, it has been emphasized in the literature that emotional or psychological needs are neglected, while focusing mainly on physical aspects (Forde-Johnston, 2014).

Alongside the 'intentional rounding', which is called the 'patient comfort round' performed by nursing staff, other rounds such as 'teaching rounds', 'matron rounds', 'safety WalkRounds' and 'Nurse Management rounds' have been established in recent years (Reimer & Herbener, 2014). Teaching rounds are devoted to students and to all those at need of learning competences at the bedside under the guidance of a mentor or supervisor (Ker et al., 2008). Matron rounds are performed by matrons or senior nurses across more units or at the hospital level, focusing on nursing care but also on other aspects, such as infection control measures and the cleanliness of the wards (Hill & Hadfield, 2005). Moreover, safety WalkRounds have appeared in 1990 (Eubanks, 1990) to increase the quality of care by enabling managers to monitor the care offered by observing the clinical practices, interacting with staff and patients and offering opportunities to improve issues (Singer & Tucker, 2014). Furthermore, NMIRs have been defined as those performed by Nurse Managers (NMs) to provide an overview of the conditions and needs of all

Impact: What problem did the study address?

- At the overall level, five different rounds have been established to date: 'comfort rounds', 'teaching rounds', 'matron rounds', 'safety WalkRounds' and 'nurse manager rounds'.
- Nurse Manager Intentional Rounds (NMIR) involve the nurse managers (NMs) providing an overview of the condition and needs of all patients and the capacity of the nursing staff to meet these needs.
- No systematic review has been performed to date summarizing the body of knowledge available on how NMs should perform rounding and which outcomes they can achieve.

What were the main findings?

- A few studies have been performed to date, mainly in the United States as quality improvement projects.
- Studies have measured the effects of structured, semi-structured, and unstructured rounding delivered with variable intensity in terms of frequency on a daily and on a weekly basis.
- Patient satisfaction has been measured as the main outcome by reporting positive findings.

Where and on whom will the research have an impact?

- The findings of this review might inform hospitals in promoting the intervention among their NMs and higher education institutions to prepare future leaders to implement this intervention effectively.
- Future studies should be performed with high methodological quality, transiting from quality improvement initiatives to research projects.
- In expanding this field of research, outcomes measured should also be revised by understanding and evaluating the dimensions of patients' care affected by the Nurse Managers Intentional Rounding.

patients and the capacity of staff to meet their fundamental needs (Close & Castledine, 2005; ILC, 2013). However, no summary of the evidence has been provided describing the main characteristic of studies, the main features of the NMs' rounding, and the outcomes measured to date. Therefore, the main intent of this study was to fill in the gap of knowledge.

2 | BACKGROUND

In nursing systems, nurses may achieve different levels of managerial positions at the top (nurse directors or executive), middle (as the middle NM) and at the unit levels (NMs). NMs have been considered the closest level of the nursing leadership to the staff, having several responsibilities such as planning and managing resources, addressing care, supporting nurses and their teamwork, evaluating the services provided, and contributing to the achievement of optimal results for both the organization and the patients (AONL, 2019). In recent years, NMs have been ideally placed to detect the levels of missed care as care omitted or delayed by nurses, and the quality issues early, as they are in the best position to promote the best care (McCauley et al., 2020). In this context, NMIRs have been suggested as an intervention increasing the capacity of the staff to meet the fundamental needs of patients, their perceived quality and satisfaction; moreover, NMIRs have been documented to promote nursing team satisfaction and to affect the entire healthcare system by preventing issues related to the poor quality of care (Close & Castledine, 2005).

Specifically, NMIR, also called purposeful NM rounds or nurse leader rounds, have been defined as an intervention allowing nurse leaders to 'connect to patients, reinforce care, verify nursing behaviours, gain real-time responses, achieve instantaneous service recovery, recognize staff, follow up to ensure all patients' needs are met and develop a trusting relationship' (Tan & Lang, 2015, p. 156). Performing an intentional round might enhance both leadership and managerial competences. By doing regular checks at the bedside, NMs make themselves visible to the nursing staff and those closest to them; moreover, by doing rounds, they may serve as a role model (Manss, 2017), thus overcoming some barriers in spending time and staying at the bedside by nurses. Furthermore, by performing rounding, communication about patients' issues may increase in the team, while NMs might support nurses to better allocate their time along priorities and to improve the nurse–patient relationship (Harris et al., 2019). The recent study performed by Sundean et al. (2021), for example, documented that intentional rounding can be embodied by an influencing leadership style, which in turn promotes advocacy, communication skills, competences, confidence, credibility, and engagement. Therefore, NMIR is designed to support clinical leadership in ensuring that the fundamental needs of patients are meet thus to improve the quality and the safety of care.

However, in implementing the rounding, the NMs may experience some challenges. Firstly, the underlying theoretical mechanism explaining its effectiveness has not been documented to date (Harris et al., 2019). Secondly, with the increased complexity of the role expected by NMs (Labrague et al., 2018), asking them to also perform intentional rounding might increase their workloads. How to perform these roundings as a specific activity alone or integrated with other managerial tasks should be clarified: Intentional roundings performed by clinical nurses have been reported as rarely implemented as a discrete activity given; instead, rounds are delivered as a package with other nursing activities (Harris et al., 2019).

Thirdly, the clinical space occupied by NMs has been eroded in recent years given their prevalent organizational role (Nurmeksela et al., 2020). Therefore, introducing the dual role (managerial and clinical) might challenge NMs, given the expectations of the organization to have good, dedicated managers, on the one hand, and the lack of confidence of managers on clinical issues, on the other (Longhini et al., 2021). Moreover, differently to other intentional rounding performed by clinical nurses whose structures and outcomes have been relatively summarized by nurses in the literature (e.g. Christiansen et al., 2018), no summary of evidence is available for NMIR, leaving the related body of knowledge not systematized to date. Once its effectiveness is clarified, guidelines or pragmatic protocols on its application, frequency, integration with the other functions of the NMs and with those of clinical nurses can be designed and implemented.

3 | THE REVIEW

3.1 | Aim

The following research questions were addressed: (1) What are the main characteristics of studies available on NMIR and their methodology quality?, (2) What are the main features of NMs' intentional rounding?, (3) What are the NMIR outcomes measured, and (4) What effectiveness have been documented to date? Therefore, the aim was to summarize the evidence available on NMIR describing the main characteristic of studies available, the main features of the NMs' rounding, and the outcomes measured to date.

3.2 | Design

A Systematic Review was performed following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021) (Table S1).

3.3 | Search methods

Studies were searched in MEDLINE-EBSCOHOST, PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus, Cochrane, Clinicalkey, ScienceDirect, OVID, Sage Journals and Web of Science academic databases up to June 2021 by two researchers (AB, AÖ). On a preliminarily basis, the Medical Subject

Headings (MeSH) terms were searched and only one emerged, namely 'Teaching Rounds', defined as 'The systematic discussions and teaching conducted in hospitals and health care facilities related to patient care' (Teaching Rounds—MeSH—NCBI [nih.gov]). Given its inconsistency with the aims of the revision, researchers decided to use the following keywords: 'Intentional rounding', 'hourly rounding', 'purposeful rounding', 'nurse manager', 'nurse leader', 'chief nursing', and 'nursing management' (Table S2). To identify additional evidence, the reference lists of included studies were screened by hand searching.

Studies were included according to the inclusion and the exclusion criteria summarized in Table 1. To provide a comprehensive systematic review (Palese et al., 2021), no time limitations were imposed, and the last day of study inclusion was the 30 June 2021.

3.4 | Study selection process

In the first step, two researchers independently screened titles, keywords, and abstracts of studies against the inclusion and exclusion criteria. Consensus between researchers (AB, AÖ) was required for inclusion of two studies in the next stage of the process. In case of disagreement, a third researcher (AP) was involved for further discussion until consensus was reached. The screened studies were transferred to a reference manager programme for removing duplicate papers.

In the second step, the full text of eligible studies was screened by three researchers (AB, AÖ, AP). In case of disagreement, a fourth researcher was consulted for consensus (JL). The references of the eligible studies were also manually searched and scrutinized, and a few studies were emerged (e.g. the systematic review, Tan & Lang, 2015). Given the international panel of researchers, online meetings were conducted to pilot the entire process by analysing three studies.

3.5 | Data extraction

The studies that met the inclusion criteria underwent data extraction performed by two researchers (AB, JL), independently. The grid of data extraction was piloted in one study, and the final version was approved by including the following elements: (a) first author, publication year, and country; (b) study aim(s), design and setting(s); (c) sample and main characteristics; (d) intervention (=rounding) description; (e) outcomes and data collection/tools (statistic tests included, when reported) and (f) main findings. After completing the data extraction, the researchers checked the accuracy of the data entered; in case of any discrepancy, an open discussion was held among researchers to achieve an agreement.

3.6 | Quality appraisal

Given that four studies did not report their design, based on the information contained in the article, one was categorized as an observational longitudinal study (Morton et al., 2014) and the other three as pre-post-test studies (Hudson-Covolo et al., 2018; Manss, 2017; Winter & Tjiong, 2015) by two researchers independently and then agreeing on the categorization. Findings were discussed, and disagreements were solved by discussion at a research team online meeting.

Then, the Joanna Briggs Institute (JBI) Critical Appraisal tools checklist (Moola et al., 2020; Tufanaru et al., 2020) was used to assess the methodological quality of quasi-experimental studies by applying nine quality indicators. In the case of cohort studies, the

TABLE 1 The inclusion and exclusion criteria

	Criteria
Inclusion	(i) written in English and with abstract available, (ii) designed as quantitative studies as single or multicentre, (iii) performed by NMs (or by other managerial roles), (iv) focused on patients in hospital units.
Exclusion	(i) not written in English, (ii) presented as: mixed methods, secondary studies (e.g. systematic reviews, Tan & Lang, 2015), letters to the editor, or doctoral dissertations, (iii) focused NMs perceptions as outcome (e.g. Woodard, 2009), (iv) focused on different targets (e.g. staff + patients, Reimer & Herbener, 2014), (v) focused on other elements of rounding (e.g. Tothy et al., 2018), (vi) performed in outpatient settings or emergency departments exclusively (e.g. Baker, 2010), (vii) combined with other interventions (Kennedy et al., 2013; Setia & Meade, 2009).

Abbreviation: NM, nurse manager.

checklist was used with 11 indicators, whereas for cross-sectional studies, a checklist was used with eight indicators. Each indicator was applied after a careful reading of the full text by two researchers (AB, JL) independently before agreeing on. Answers were given according to the methodology suggested by the JBI checklist. Moreover, findings were used to assess the overall quality of the research methodology performed in this field, not as a reason for study inclusion/exclusion.

3.7 | Data synthesis

The data extracted have been analysed and summarized by two researchers according to the study aims: (a) first, the main characteristics of included studies and their methodological quality have been synthesized; then, (b) the rounding intervention as described in the studies included have been summarized in its main features; (c) the outcomes measures used to date have been described, as well as (d) the outcomes documented to date: With this regards, two subgroups were identified, one related to patient satisfaction and one related to other elements of quality of care as emerged from the study findings.

4 | FINDINGS

4.1 | Studies included and their methodological quality

As reported in Figure 1, a total of 114 studies were identified, and 83 screened after duplicated articles (n = 31) were removed. At the end of the process, seven studies were retained, all evaluating the effectiveness of NMIR. As summarized in Table 2, studies were based on pre-post-test design (=3, Hudson-Covolo et al., 2018; Manss, 2017; Winter & Tjiong, 2015), a two-group post-test (=1, Ayaad et al., 2019), a quasi-experimental (=1, Pattison et al., 2017), an observational longitudinal (=1, Morton et al., 2014), and a retrospective descriptive design (=1, Cody & Williams-Reed, 2018).

Studies were published between 2014 and 2019 mainly in the United States, except for one that was conducted in Jordan (Ayaad et al., 2019). Study settings were variable, from a singular inpatient unit in a community hospital (Cody & Williams-Reed, 2018) to several units (oncology in Ayaad et al., 2019; medical/surgical in Pattison et al., 2017; intensive, progressive and acute care units at an acute hospital in Winter & Tjiong, 2015) up to a hospital (Manss, 2017) or several hospitals (25 in Morton et al., 2014). All studies involved patients apart from one that used the number of rounding as a sample (Manss, 2017). The sample method was random stratified for units (Ayaad et al., 2019), random for patients (Winter & Tjiong, 2015), convenience for patients' rooms (Pattison et al., 2017) and not reported in four studies (Cody & Williams-Reed, 2018; Hudson-Covolo et al., 2018; Manss, 2017; Morton et al., 2014).

Patients with different profiles were considered eligible, from all admitted (Hudson-Covolo et al., 2018; Manss, 2017; Morton et al., 2014) or discharged (Winter & Tjiong, 2015) to specific subgroups, including those with a certain number of days of hospitalization (e.g. Ayaad et al., 2019; Pattison et al., 2017). In total, there were included from 76 (Pattison et al., 2017) to 93,589 (Morton et al., 2014) patients. Three studies included more female than male participants (Ayaad et al., 2019; Pattison et al., 2017; Winter & Tjiong, 2015), while in the remaining studies the gender was not reported (Cody & Williams-Reed, 2018; Hudson-Covolo et al., 2018; Manss, 2017; Morton et al., 2014). Moreover, four studies did not report patient's age, while, when available, most were aged 50–60 years (n = 55; 32%) (Ayaad et al., 2019), 60–69 years (n = 22; 28.9%) (Pattison et al., 2017) and 65–79 years (n = 218; 31%) (Winter & Tjiong, 2015).

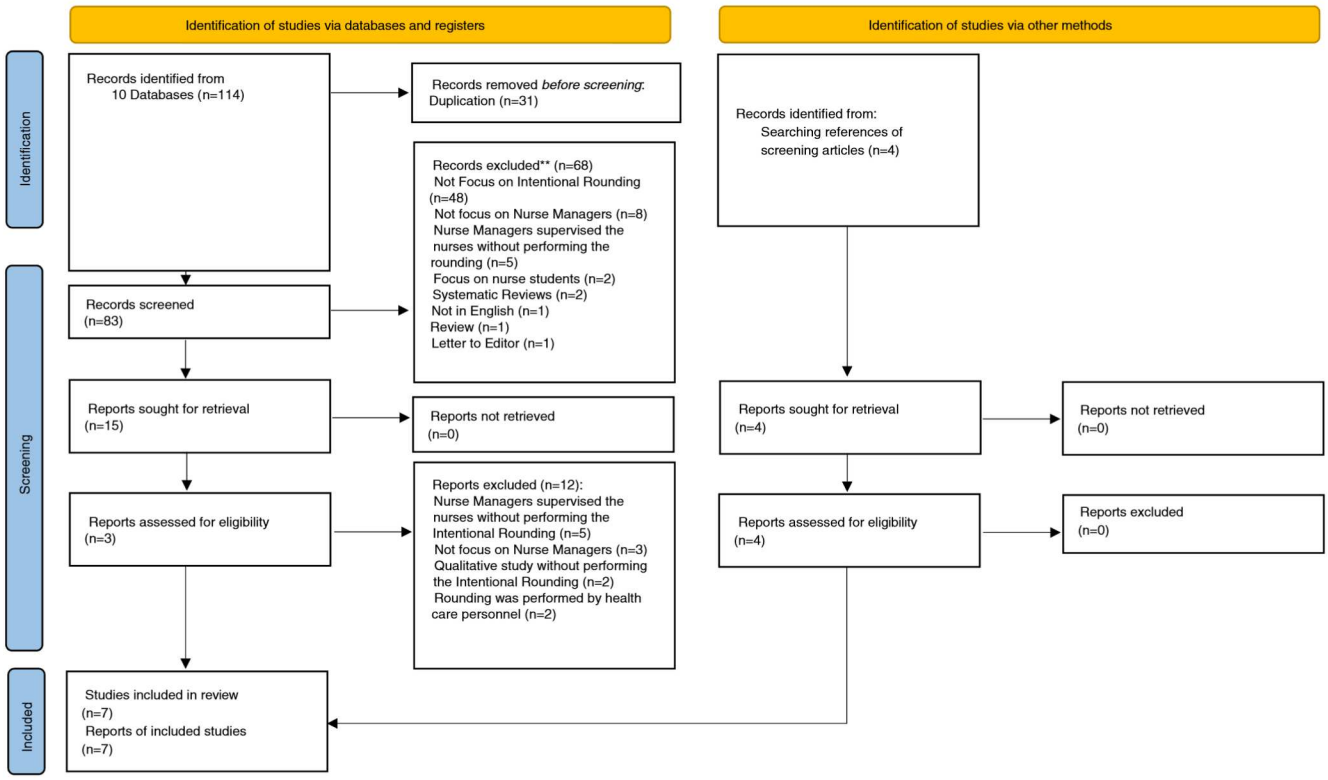
As reported in Table S3, the quasi-experimental studies clearly expressed the 'cause' and the 'effect(s)', and the outcomes were measured in the same manner across participants; however, the statistical analysis was unclear (Hudson-Covolo et al., 2018; Manss, 2017; Winter & Tjiong, 2015) and no control group was identified in most studies, except for that performed by Ayaad et al. (2019).

In the cohort study, the exposure measure and outcomes were assessed in a reliable manner (Morton et al., 2014). However, the remaining quality criteria (e.g. participant information) were unclear (Morton et al., 2014). Similarly, in the cross-sectional study, the objective and the standard criteria used for measuring the condition as well as the outcomes were measured in a valid and reliable manner; however, in the remaining criteria (e.g. detailed description of the study participants), unclear or no data were reported (Cody & Williams-Reed, 2018).

4.2 | Rounding intervention

As reported in Table 2, the rounding was conducted on the basis of (a) a structured approach in the form of closed-ended questions guiding the conversation with patients (Ayaad et al., 2019; Hudson-Covolo et al., 2018; Morton et al., 2014; Winter & Tjiong, 2015), (b) a semi-structured approach with questions about patient's satisfaction focusing on problematic area in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (Cody & Williams-Reed, 2018) and (c) an unstructured approach (Manss, 2017; Pattison et al., 2017). In the latter, the core was to evaluate the effects of the sit and stand-up posture of NMs (Pattison et al., 2017) and to implement the transformational leadership model (Manss, 2017). Moreover, five studies trained the NMs in doing the rounding (Cody & Williams-Reed, 2018; Hudson-Covolo et al., 2018; Manss, 2017; Morton et al., 2014; Winter & Tjiong, 2015).

Different approaches emerged with regards to the duration and the frequency of rounding: (a) 5 min/per patient/twice daily structured rounds for more than 3 days in the experimental group and 3 min/per patient/once daily unstructured rounds for more than 3 days in the control group (Ayaad et al., 2019); (b) 7 days/per week/



*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).
**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

FIGURE 1 PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources

twice daily rounding (Hudson-Covolo et al., 2018); (c) 1 h/5 days/per week rounding, and then team debriefing was daily conducted for 15 min on patient/environmental needs (Manss, 2017); (d) twice daily/2 days a week for 6 months rounding by 25 members of the multidisciplinary leadership team, one leader/three rooms each month (Winter & Tjiong, 2015) and (e) daily rounds (Morton et al., 2014).

4.3 | Rounding outcomes

As summarized in Table 2, two main outcomes have been measured to date:

a. The patients' satisfaction: The most used measure was the HCAHPS (Cody & Williams-Reed, 2018; Hudson-Covolo et al., 2018; Manss, 2017; Morton et al., 2014; Winter & Tjiong, 2015). There were included some additional questions about (a) the overall hospital rating, the individual unit rating, and the nursing bundle rating (nurse courtesy and respect, nurse listening, nurse explanation, got help) (Cody & Williams-Reed, 2018), and (b) if the 'Nurse leader visited you during your stay' (Morton et al., 2014).
b. The quality of care: The remaining two studies used the Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ) (Ayaad et al., 2019) and a Likert survey, providing the patients' perceptions of the estimation of the length of the interaction, the appropriateness of that length, and other elements about the quality of the interaction with NMs (Pattison et al., 2017).

Four studies evaluated the HCAHPS mean score outcomes at pre- and post-rounding intervention (Cody & Williams-Reed, 2018; Hudson-Covolo et al., 2018; Manss, 2017; Winter & Tjiong, 2015). The remaining three also evaluated the post-test after the rounding intervention (Ayaad et al., 2019; Morton et al., 2014; Pattison et al., 2017). Specifically, the post-test was performed immediately after rounding (Pattison et al., 2017) and 5 days after discharge (Ayaad et al., 2019). The measurement time of five of these seven studies was unclear when performed (Cody & Williams-Reed, 2018; Hudson-Covolo et al., 2018; Manss, 2017; Morton et al., 2014; Winter & Tjiong, 2015).

As reported in Table 2, the satisfaction scores of patients who received rounding were found to be significantly higher than those who did not receive rounding (Ayaad et al., 2019; Cody & Williams-Reed, 2018; Hudson-Covolo et al., 2018; Manss, 2017; Morton et al., 2014). Moreover, higher satisfaction emerged on 'the nurse explained things in a way you could understand' (72.4 vs. 83.5, $p = .004$) (Cody & Williams-Reed, 2018), and significant improvements in 'understood the purpose of taking needed medications' ($p = .033$) and 'good understanding of managing my health' ($p = .027$) (Hudson-Covolo et al., 2018). However, significantly

TABLE 2 Main characteristics of the included studies

Author(s), year, country	Aim(s), design, setting	Sample and main characteristics	Intervention description and approach	Outcome assessed data collection/tools	Main findings
Ayaad et al., 2019, Jordan	To assess the effects of structured nurse leader rounds on cancer patients' satisfaction Two group post-test Four adult inpatient oncology units at a cancer centre	***Inclusion criteria***: conscious cancer patients ≥18 years, oriented to the nursing care, with ≥3 days of hospitalization ***Sampling***: random stratified for units ***Main resulting characteristics***: 169 patients (80 intervention group; 89 control group), 90 females, 55 patients between 50 and 60 years of age	***Experimental group***: structured rounds by nurse leaders according to the Scripted Nurse Leader Tool 5 min per patient twice daily (at 9 a.m. and 2 p.m.) for ≥3 days ***Control group***: unstructured rounds by nurse leaders 3 min per patient once daily for ≥3 days ***Structured approach***: scripted nurse leader tool including 11 questions: • Patient education and knowledge assessment • Nursing care management • Nurse responsiveness • Nursing caring and attention • Pain assessment and management • Open questions about patient feelings and experiences about nursing care	PSNCQQ (19 items, 5-point Likert scale, 5 = excellent)	Higher patient satisfaction total score in experimental group (4.75 vs. 4.13, $p = .001$) and in all items except for privacy experience (4.76 vs. 4.61, $p = .066$)
Cody & Williams-Reed, 2018, USA	To evaluate the effect of nurse manager intentional rounding on patient satisfaction Retrospective descriptive study Five inpatient units at a 210-bed community hospital	***Inclusion criteria***: hospitalized responders to the HCAHPS survey ***Sampling***: NR (consecutive[a]) ***Main resulting characteristics***: 2387 patients (1285 pre-intervention surveys, 1102 post-intervention surveys). Age and gender NR.	Trained nurse manager intentional rounding every day, at least 90% of patients cared for ***Semi-structured approach***: questions aimed at detecting issues in patient satisfaction focusing on problematic areas in HCAHPS pre-intervention scores (≤75th percentile). Questions filled in via tablets.	HCAHPS (overall hospital rating [score 0–10], nurse courtesy, nurse listening, nurse explanation, got help (never, sometimes, usually, or always)	In a unit, lower satisfaction in 'nurses listened carefully to you' (90.3 pre - 81.1 post, $p = .002$); in another unit, higher satisfaction in 'nurses explained things in a way you could understand' (72.4 vs. 83.5, $p = .004$)
Hudson-Covolo et al., 2018, USA	To evaluate the effect of daily nurse leader rounding on the patient care experience NR (pre-post study[a]) 34-bed inpatient medical/surgical unit, preoperative area, and post-anaesthesia care unit at a hospital	***Inclusion criteria***: all patients admitted ***Sampling***: NR (consecutive[a]) ***Main resulting characteristics***: NR	Trained nurse leaders daily rounding, 7 days per week, twice daily (in the morning and evening) with an electronic rounding tool. A charge trained nurse performed rounding in the night when daily rounding was not completed. ***Structured approach***: electronic checklist • Is the quality of care good? • Is the pain controlled during your stay? • Can you tell me about the plan of care for today? • Is the nurse in charge of your care today responsive? • Have you used the call lights? • Are the staff assisting you in the bathroom when they come in to check on you? • Are you being kept comfortable and repositioned frequently for your comfort? • Do you have questions/concerns about medications that I can relay to the nurse? • What is your overall hospital experience? • Patients were given occasions to also share positive comments or experiences	HCAHPS	No difference in HCAHPS global score ($p = .155$); improvement in 'understood the purpose of taking meds' ($p = .033$); changes in 'good understanding managing my health' ($p = .027$)

(Continues)

TABLE 2 (Continued)

Author(s), year, country	Aim(s), design, setting	Sample and main characteristics	Intervention description and approach	Outcome assessed data collection/tools	Main findings
Manss, 2017, USA	To describe the effect of daily senior leader rounds on patient satisfaction and the team NR (pre-post study[a]) A hospital	***Inclusion criteria***: all patients admitted ***Sampling***: NR (consecutive[a]) ***Main resulting characteristics***: 5 and 10 patients on a typical day/one leader, 250 patients/day in the inpatient, outpatient, and emergency departments	One-hour (9–10 a.m.) senior nurse leader rounding (46; hospital president, executive team, clinical/ancillary directors, managers) 5 days/week. One leader for one clinical area in the hospital in a unit-based team (4 leaders for large units, 2–3 leaders for small units). Identification of the golden hour; 15-min daily team debrief on patient/environmental needs after rounds. ***Unstructured approach***: model of transformational leadership Individual orientation/training about how to formulate the open-ended questions	HCAHPS	Statistically significant increase in 1-year post-implementation communication with doctors (+11.5%, $p = .007$), pain management (+11.9%, $p = .045$), cleanliness (+10.1%, $p = .027$), quietness (+8.3%, $p = .049$); three-year post-implementation communication with nurses (+4.8%, $p = .025$), communication about medication (+7.8%, $p = .018$), and discharge information (+5.1%, $p = .032$)
Morton et al., 2014, USA	To evaluate the impact of nurse leader rounds on patient perception of care NR (observational longitudinal study[a]) 25 hospitals (inpatient setting and emergency departments)	***Inclusion criteria***: all patients admitted ***Sampling***: NR (consecutive[a]) ***Main resulted characteristics***: 52,868 patients in inpatient setting, 40,721 patients in emergency department	Daily trained nurse leader (department managers, assistant managers, supervisors, and charge nurses) rounds with a systematic process ***Structured approach***:• Introduce yourself as a leader • Ask about patients' experience of care • Ask patients or family members if there is anyone who has made their stay extra special • Address each gap or concern • Follow up the round by providing documentation and feedback to the staff Coach support for nurse leaders performing the round	HCAHPS + 'Did a nurse leader visit you during your stay?' (yes/no/not sure)	Better HCAHPS scores in who received nurse leader round compared with those who did not ($p \leq .001$); improvement in HCAHPS overall rating of care top box over time ($p \leq .001$)
Pattison et al., 2017, USA	To evaluate the effect of the nurse leader's posture (sitting vs standing) on patients' perceptions of time at the bedside and quality of the interaction Quasi-experimental study Three medical-surgical patient care units for adult patients	***Inclusion criteria***: ≥18 years, speaking/writing English, no dementia/confusion at admission, no limiting severe illness, in the medical-surgical unit for ≥24 h; not being an employee of the centre or HCP, no isolation precautions ***Sampling***: convenience ***Main resulting characteristics***: 76 patients (39 standing group, 41 sitting group), 46 women, 22 aged between 60 and 69 years	Sitting or standing posture in rounding performed in the day shift (7 a.m.–7 p.m.) Monday to Friday, without visitors in the patients' room ('Do Not Disturb' sign on the door) ***Sitting group***: rounding was performed in sitting posture ***Standing group***: rounding was performed in standing posture ***Unstructured approached***: the discussion focused on questions about the patient satisfaction with care and concerns	A Likert-type survey (estimation of the length of the interaction; appropriateness of that length; nurse leader's bedside manner, caring, and understanding of patient problems; and the patients' confidence in the nurse leader), minutes spent by stopwatch	No difference in patients' perception of time (p = .57), in the actual time spent between the nurse leader's sitting or standing posture (p = .93), and in patients' perceptions of the quality of the interaction with the nurse leader (p = .80)

TABLE 2 (Continued)

Author(s), year, country	Aim(s), design, setting	Sample and main characteristics	Intervention description and approach	Outcome assessed data collection/tools	Main findings
Winter & Tjiong, 2015 , USA	To evaluate patient satisfaction after implementation of leader rounds NR (pre-post study[a]) Three main nursing units: intensive care unit (10 beds), progressive care unit (16 beds), and acute care unit (32 beds) at a 95-bed, full-service acute care hospital	***Inclusion criteria:*** all discharged adult patients able to understand English and answer questions ***Sampling:*** random ***Main resulting characteristics:*** 711 patients, 469 female, 178 patients <34 years of age and 301 patients aged >65 years, 590 white non-Latino Hispanic and non-Latino	Trained leadership rounds performed by 25 members of the multidisciplinary leadership team (supervisors, managers, directors, and senior executives) twice daily, on Tuesdays and Thursday each week for 6 months, from 1 to 2 p.m. One leader/3 rooms each month ***Structured approach:*** a leader rounding form developed by investigators: questions about • Nurses treat you with courtesy/respect • Nurses listen to you carefully • Nurses explain in a way you understand • Responsiveness of the staff • Pain management • Staff tell you what the new medication is for • Staff describes medications' adverse reactions	HCAHPS (your care from nurses, your experiences in this hospital, and overall hospital rating sections), leader rounding form	No differences in HCAHPS overall scores (p = NR) Statistically significant reduction in staff responsiveness question in the ICU (p = NR)

Abbreviations: HCAHPS, Hospital Consumer Assessment of Healthcare Providers and Systems; HCP, healthcare professional; ICU, Intensive Care Unit; NR, not reported; PSNCQQ, Patient Satisfaction with Nursing Care Quality Questionnaire; USA, United States of America.

[a]The information is not declared, and it was hypothesized based on study article information.

lower satisfaction in 'nurse listened carefully' (90.3 pre, 81.1 post, p = .002) was reported by Cody and Williams-Reed (2018), and no significant findings emerged about 'staff responsiveness' in Winter and Tjiong's (2015) study.

About the other aspects of the quality of care, information accessibility (p = .001), discharge instructions (p = .001), coordination of care after discharge (p = .001), and patients' experience with nurses' concern and caring (p = .042) were significantly higher in the group of patients exposed to the NMIR (Ayaad et al., 2019). A significant difference after rounding was found in 1-year post-implementation with regards to communication with doctors (+11.5%, p = .007), pain management (+11.9%, p = .045), unit cleanliness (+10.1%, p = .027) and quietness (+8.3%, p = .049), whereas in 3-year postimplementation, significant improvements emerged in communication with nurses (+4.8%, p = .025), communication about medication (+7.8%, p = .018) and discharge information (+5.1%, p = .032) (Manss, 2017). About privacy, no significant differences were detected by Ayaad et al. (2019).

In addition, no significant difference in patients' perception of time (p = .57), the actual time spent between the sitting or standing posture of the nurse leader (p = .93), and patient perceptions of the quality of the interaction with the nurse leader (p = .80) emerged between the exposed and the control group in Pattison et al. (2017).

5 | DISCUSSION

5.1 | Studies included and their methodological quality

Although the intentional rounding of nurses with leader/managerial positions has been reported in seminal historical papers (Nightingale, 2003), only recently the NMIRs have been launched as promoting the capacity of staff to meet the fundamental needs of patients (Close & Castledine, 2005). However, a sparse number of studies evaluating its effectiveness have been performed in the last 10 years mainly in the United States as a hospital pragmatic strategy to promote the perceived satisfaction of care with quality improvement projects. NMIR has been assessed in its effectiveness in different settings from oncological to long term, including single units to large, in one hospital to several, suggesting different degrees in its implementation complexity. In large studies, an ample strategic plan is needed to involve all NMs in implementing the same intervention, a process that might require a profound revision of the entire soft and hard structures of the facilities.

Although studies have omitted several demographic data of patients, some patterns have emerged suggesting reflections for future research: Studies (a) have included from all to only a subgroup of patients; (b) with some experience in terms of hospitalization days or after the discharge; and (c) able to answer a questionnaire or to express their point of view. These choices seem to reflect those typical of studies exploring patient satisfaction (Westbrook, 1993), thus excluding those who cannot understand, speak in English, or report

their perceptions, as in the case of patients with cognitive decline. Future studies should consider the need to better describe the profile of patients, to identify with regard to whom this intervention is most effective, debate also the required duration of the rounding exposure, for example, if 2 or 3 days are sufficient (Ayaad et al., 2019; Pattison et al., 2017) and when the data should be collected, as a process measure during the in-hospital stay or at the discharge, to assess the final outcomes of the NMIRs.

The methodological quality of studies showed some unclear or negative evaluations, and this might be interpreted under different lines. First, given some missed data about the study design, four manuscripts (e.g. Hudson-Covolo et al., 2018) have been categorized by researchers in one study design and therefore evaluated with a tool, which might have led to misclassification; moreover, some data (e.g. p-values) were not reported in some studies, thus threatening the accuracy of the methodological assessments' interpretation. Second, this field of research seems to be led by organizational or professional reasons as quality improvement projects, and a pragmatic approach might have prevented attention towards some methodological issues. Third, difficulties in conducting these studies must be considered, given their intrinsic challenges as, for example, controlling all confounders, dealing with the high turbulence of the work environments, as well as considering the potential influences of the individual personality of each NM. Therefore, future studies should be based on a strong rational basis to overcome the methodological issues, transiting from improvement projects to methodological sound investigations.

5.2 | Rounding intervention

Three approaches have emerged: (a) highly structured rounding, focusing the attention of the NMs on major elements of the nursing and hospital care experience collecting dichotomic answers (e.g. Ayaad et al., 2019); (b) a semi-structured (Cody & Williams-Reed, 2018) and (c) an unstructured rounding (Pattison et al., 2017), leaving the patients free to talk about the care received. With the first, researchers seem to apply an important control over the quality of the nursing practice, while with the latter they allow patients to express their satisfaction and concerns about nursing care and the hospital experience in a more open way. Moreover, only two studies reported that patients were also invited to share positive experience or extraordinary care (e.g. Morton et al., 2014), thus suggesting that elements under investigation during the rounding are mainly missed or critical elements of nursing care (Sist & Palese, 2020). Alongside the lack of homogeneity across studies in the rounding approach, the use of a checklist asking patients if specific care aspects have been delivered should be investigated also in their implications for the (a) same NMs, who are expected to tailor their interventions to the specific needs, and not to work in a prescriptive manner and (b) for clinical nurses who are fully responsible for the nursing care and willing to have control over the practice. The long-term effects of the NMIR on the patient–nurse relationship and on nurses' control over practice are worthy of investigation. Other strategies might be implemented to promote the quality of care by participating in handover sessions to ameliorate the communication standards of the whole nursing team (Kitson et al., 2014).

The number of roundings over the day and over the week by also considering the night (Hudson-Covolo et al., 2018) has been variable across studies expressing a different quantity for the presence of the NM at the bedside. The duration (e.g. 5 min) (Ayaad et al., 2019), which might be considered a quality indicator of the interaction, was also variable across studies as well as the shift when the rounding is scheduled (e.g. 7 a.m. and 7 p.m.) (Pattison et al., 2017). Therefore, the rounding seems to range from high to low intensity, with three main implications alongside the challenge in comparing its outcomes: (a) NMs should be protected during the rounding to prevent distractions and excessive workloads (Manss, 2017), (b) with intentional roundings NMs have the opportunity to show their passion supporting the staff to deliver fundamental care (Mudd et al., 2022); however, (c) a perception of intrusion in the practice might be higher in units with intensive rounding, suggesting that implications for nurses and for patients about the trust in the nurse responsible for their care should be investigated. Clinical nurses might expect to lead the entire nursing care, and with the proliferation of advanced roles, they are expected to lead the entire process of care. Consequently, these different expectations and needs might trigger tensions between clinical nurses and NMs by increasing the perception of managerial control over the clinical nurses and the prioritization of risk management issues above the fundamental needs of patients. It is an undeniable fact that clinical nurses are leaders of the care provided and how to integrate their rounding with that provided by the NMs is needed.

In addition, NMIR should be not seen as an isolated intervention but a part of a strategy supporting the nursing work environments and the quality of care requiring a specific competence that should be developed while preparing future NMs for their complex role. Therefore, future studies should also describe the context to identify the contribution of the rounding over the other strategies implemented to promote safety, patient-centred care and nurses' support.

5.3 | Rounding outcomes

To date the outcomes investigated regarded substantially the patients' satisfaction by using mainly the HCAHPS, followed by the PSNCQQ tool and the Likert scale survey developed by researchers. The HCAHPS has been defined as the first US national, standardized, publicly reported survey of patients' perspectives of hospital care to measure patients' perceptions of the hospital experience. Since 2012, it has played a role in hospital payment through the Hospital Value-Based Purchasing programme (CMS, 2021). Therefore, the tool is not specific for nursing care, and its relevance in reimbursements might have introduced biases. Differently, the PSNCQQ (Ayaad et al., 2019) measures the perception of the nursing quality of care, and no data about its connection with reimbursement systems has been retrieved.

However, some dimensions evaluated by the PSNCQQ (e.g. pain assessment) and HCAHPS (e.g. treats with courtesy/respect) and measured by the Likert survey (e.g. care, concern) seem to have similarities with that included in the Fundamental of Care Framework (e.g. connect with patients, build relationship, being present) (ILC, 2013). Despite this visible link, the connection between NMIR and the framework has not been formally established across studies, and the data that emerged in this review seem to be preliminary in this context. Future studies are suggested to use the Fundamental of Care Framework in establishing the set of nursing outcomes at merit of measurement while investigating the effectiveness of NMIR. Moreover, given that NMIR is aimed at promoting the person-centred care (Lin et al., 2019), it might be interesting to develop a set of nursing-sensitive quality indicators (Li et al., 2014) to evaluate its effectiveness in the scope of the Fundamental of Care framework (Di Giulio et al., 2019). Moreover, a few process measures have been considered to date to inform the development of NMIR itself (Morton et al., 2014; Pattison et al., 2017). The complexity of nursing work environments might introduce several confounding factors and barriers to NMs while implementing this intervention. Therefore, confounding and fidelity measures should be considered in this field of research aimed at assessing whether, for example, NMIR based on a structured approach is implemented as intended. In addition, instead of measuring if the care has been provided or not, assessing how nurses establish and maintain relationships with patients in a variety of settings (Feo et al., 2020) might be vital in promoting the quality of care.

5.4 | Limitations

This study has several limitations. The grey literature has not been accessed (e.g. Walker, 2012), and although we included many databases and the keywords that, to date, best express the underpinning concepts in this field, some studies might have been missed. Moreover, given that rounding was established long ago (e.g. Nightingale, 2003), some publication bias might have been introduced by keywords not fully reflecting the changes in the terminologies in this field that occurred over the years. Furthermore, the established inclusion criteria considered only quantitative studies, suggesting that future studies might also include studies with qualitative or mixed-methods designs. Furthermore, literature about matrons or senior nurses was excluded as well as those named 'safety WalkRounds' (e.g. Mennim & Moen, 2019), and given that some competences between NMs and matrons might overlap (e.g. Scott, 2003), future studies are suggested to also include them. Additionally, studies including executive roles (Kline & McNett, 2019) and roles of administrators (Haas & Gold, 1993) were also excluded, suggesting that an overview of different managerial roles involved in rounding might be interesting. Moreover, in evaluating the methodological quality, articles not reporting indications about the study design (e.g. Hudson-Covolo et al., 2018) were categorized by the researchers, which might have introduced misclassifications. According to the quality of the methodologies used and the missed data that emerged in the assessment as well as the heterogeneity both in the rounding implementation (e.g. intensity) and outcomes measured, a meta-analysis was not performed.

6 | CONCLUSIONS

NMIR has been investigated in terms of the research quantity and quality produced to date, in the approaches documented to perform the rounding, and in the outcomes measured. A few studies have emerged in this field, mainly conducted in the United States, where intentional rounding is connected principally with the intent to promote patients' satisfaction also associated with the hospital reimbursement systems.

Different profiles of rounding have been documented, from structured to unstructured processes, delivered with different frequencies and durations, resulting in different degrees of intensity, from high to low. Moreover, different tools have been used to detect outcomes and have been applied to different time frames, suggesting a lack of standardization in the methods, which affects both the comparability and accumulation of the evidence produced in this field.

Despite the studies of low methodological quality mainly due to their pragmatic nature as quality improvement projects, findings suggest that NMs rounding might increase patient satisfaction and some elements of the quality of the nursing care. Therefore, developing appropriate educational and health-care policies in this field capable of encouraging NMs to consider this intervention as an element of their strategy aimed at supporting nursing care might be important. In this context, the NMIR should be not seen as an isolated intervention, but it should be placed inside a culture of safety, quality and person-centred care embodying the nursing work environment. Moreover, given that clinical nurses are leaders of the care provided, how to integrate their responsibilities with the rounding provided by the NMs is required. In addition, transforming this field of research by reinforcing its methodological rigour, establishing strong theoretical foundations in both interventions and outcomes, and designing studies embodying the complexity of the NMIRs might expand the evidence available about their effects. Rounding will also influence the hospital costs that should be investigated in future studies with also cost-effective analysis.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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