

Untangling a complex skein on ward round terminologies, purposes, and main features through a rapid review

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Abstract

Aim(s): To increase conceptual clarity in the field of nursing regarding terms, purposes, and main features of rounding as investigated to date.

Design: A Rapid Review according to the Cochrane Rapid Reviews Protocol.

Review Methods: These were: (a) set the research question; (b) establish the study eligibility criteria; (c) search the databases; (d) select the studies; (e) extract the data; (f) assess the risk of bias; and (g) provide a synthesis using three methodologies, namely a qualitative content analysis, a thematic and a framework synthesis.

Data Sources: MEDLINE (PubMed), Cumulative Index of Nursing and Allied Health databases and grey literature from 2014 to 2022.

Results: A total of 72 studies were included; 88 different terminologies are used to describe the rounding from one up to five words. “Preparing the care by ensuring an effective care plan, team and environment”, “Delivering tailored and timely nursing care” and “Promoting the quality of care” are the three main purposes of the rounding, including several specific aims. Regarding the main features, these emerged from highly structured/prescriptive to low structured/prescriptive approaches to rounding intervention.

Conclusion: The word “round” alone seems to be not sufficient to communicate and describe the intervention, suggesting that this field of research is entering within the complex intervention framework. The different aims of the rounding have been conceptually categorized into three main purposes whereas the intervention features may range from simple to very complex, where several options regarding who to involve, how and when to deliver are expressed.

Implications for the profession and/or patient care: This rapid review followed by three data analysis methodologies have resulted in three main frameworks that may be useful to address the research, the clinical practice and the education regarding the terminologies, the different purposes and the main features of the rounding.

No Patient or Public Contribution.

No Patient or Public Contribution: There was no patient or public contribution in the conduct of this study.

Aysun Bayram and Stefania Chiappinotto are co-first authors.

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KEYWORDS

nurse, nursing, rapid review, round, rounding

1 | INTRODUCTION

As far as it is known, the importance of rounds in nursing practice has been established by some seminal historical papers (Nightingale, 2003) and then considered by researchers since the 1950s, when the first two studies regarding the education and clinical practice fields were published. Over the years, the interest in this intervention, combining behaviours (e.g., moving from one side of the unit to the other) and clinical judgement (e.g., checking the situation and detecting issues) with the main intent to review the clinical pathways and promoting health care professionals (Hutchinson et al., 2017) has increased. On the one hand, researchers have investigated rounding regarding its possible aims (e.g., East et al., 2020), effectiveness (e.g., Cody & Reed, 2018) and different implementation as structured (e.g., following a specific check list, Heip et al., 2020) or unstructured rounding according to the context (e.g., Ayaad et al., 2019). On the other, several facilities have implemented rounding to promote the quality of care, as suggested by some policy documents (Francis, 2013; Gulf Breeze, 2007; Medina & Merozier, 2020). Among them, the so-called Francis Report recommended “*systematic regular ward rounds*” to “*ensure regular interaction and engagement between nurses and patients and those close to them*” to prevent dysfunctional nursing that failed to respond to fundamental needs (Francis, 2013, p. 1610). Therefore, rounding has become a well-established nursing intervention, implemented in the practice, and according to the evidence available should be learned (Daniels, 2016) as a competence by the future generation of nurses (Ryan et al., 2022).

However, despite the well-established practices and policies, issues in the field of nursing rounding remain unresolved at the conceptual level.

1.1 | BACKGROUND

To contribute to clarify conceptually this research field, Hutchinson et al. (2017) have assessed all forms of nurse rounding. A bibliometric and content analysis of primary research on nurse rounding was performed identifying 38 manuscripts from MEDLINE, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and PsycINFO, published between 2000 and 2015. Four main variants of round were identified as the following: (a) scripted rounding, structuring the nurse-patient interaction that occurs within specified time frames and following a standardized script; (b) targeted rounding, involving a regular visit by nurses at the patient's bedside, targeting specific preventive or early detection activities; (c) leader rounding, involving nurse managers regularly attending the patient's bedside to monitor the care delivered; and (d) collaborative rounding, involving specialists regularly attending the patient's bedside to guide, lead or support nursing staff or the

interprofessional team in the delivery of nursing care (Hutchinson et al., 2017). Walton et al. (2016) have also contributed by classifying and describing the purposes of ward rounds, participants and their roles by performing a literature review including 39 studies retrieved in scientific journals and government publications between 2000 and 2014. Eight rounds were identified as: ward round, multidisciplinary round, consultant round, teaching round, post-take round, traditional round, working round and review of ward round.

According to the reviews available, a poor definitional clarity, with various labels used interchangeably, has been documented across studies reporting similar rounding interventions (Hutchinson et al., 2017). For example, the “intentional rounding”, is also called “hourly rounding”, “proactive patient round”, “comfort round” or “rounds with intent to care” (Harris et al., 2019). Therefore, a clear keyword to conduct systematic reviews or meta-analysis has not been established, leaving “teaching rounds” the unique Medical Subject Heading (MeSH) term in PubMed, with several entry terms (e.g., “clinical round”, “morning rounds”). Second, a map of all purposes of rounding has not been summarized to date, thus preventing a clear set of possible delineations of such intervention in the practice according to the different aims pursued. In addition to the most common intentional rounding, new rounds have appeared in the literature (e.g., virtual rounds, Kolikonda et al., 2022; palliative rounds, Koerner et al., 2021), suggesting the need to identify all rounds' purposes investigated to date. Third, the different features of rounds as structured or unstructured, intense or not, according to their frequency have not been summarized. Consequently, no map of rounding features is available; researchers are not addressed in their attempts to standardize the main intervention features of rounding, preventing comparison across studies and the accumulation of evidence due to the variability of the rounding investigated. Moreover, educational efforts in undergraduate and post-graduate programmes may be prevented in implementing effective educational intervention. Also clinical nurses and managers are not supported by clear indications regarding the rounding as an intervention. Identifying terminologies, purposes and main features of the round might increase conceptual clarity which will be useful for (a) researchers, while designing studies in the field, (b) educators, while teaching the intervention, (c) clinicians, while implementing daily care, and (d) managers while assessing and supervising the standard of care. Therefore, the intent of this review is to contribute to the increased conceptual clarity starting from the available literature.

1.2 | Aim

To increase conceptual clarity in the field of nursing rounding regarding the terms, purposes and main features of rounding as

investigated to date by: (a) summarizing the current knowledge of rounding in the nursing field; and (b) conceptualizing the terms, purposes and main features of rounding as investigated to date.

2 | THE REVIEW

2.1 | Design

This rapid review was performed according to the Cochrane Rapid Reviews Protocol of Garritty et al. (2021) which comprises: (a) setting the research question/topic refinement; (b) setting the eligibility criteria; (c) searching the database; (d) selecting studies; (e) extracting data; (f) assessing the risk of bias; and (g) developing a synthesis. Furthermore, methods and findings of this study were reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021).

2.2 | Setting the research question/ topic refinement

Two researchers (AB, AP) performed a preliminary investigation of the literature by retrieving two reviews (Hutchinson et al., in 2017; Walton et al., 2016) specific to the topic of interest as emerged from the assessment of their aims, methodologies and findings. Then, in the attempt to continue in the research efforts in the field, and according to the gap of knowledge that emerged from these reviews, three research questions were identified: (i) What are the terminologies used to date while investigating rounding in the nurses field?; (ii) What are the main purposes of the rounding investigated to date?; (iii) What are the main features of the rounding investigated to date?

2.3 | Setting eligibility criteria

There were eligible (1) primary studies, regardless of their design; (2) concerning the nursing field; (3) focused on rounding intervention; (4) in health-care setting(s); (5) published in English; (6) in the last 7 years (2015–13th April 2022) according to the available reviews, including studies up to 2014–2015 (Hutchinson et al., 2017; Walton et al., 2016).

Secondary studies were excluded following the methods used by Hutchinson et al. (2017), the most recent review, where only primary studies were included throughout a systematic approach using PRISMA guidelines as in our review. However, all retrieved reviews (Bhamidipati et al., 2016; Christiansen et al., 2018; Hutchinson et al., 2017; Mercedes et al., 2016; Ryan et al., 2019; Sims et al., 2018; Tan & Lang, 2015; Toole et al., 2016; Walton et al., 2016; Zamanzadeh et al., 2021) were inspected manually to ascertain if their aims were in line or not with our research question. In addition, books and abstract, and studies that did not meet the inclusion criteria, were all excluded.

2.4 | Searching

Two electronic databases, namely MEDLINE (PubMed) and CINAHL, were searched by using the keywords “nurse”, “nurses”, “nursing”, “round”, “rounds”, and “rounding”. All these keywords were combined with the “OR” and “AND” in each electronic database (File S1). Grey literature, including dissertations, government policy reports, conference summaries and their reference lists were also searched, and the reference list of the included studies retrieved were checked by three researchers (AB, AP, SC), in an independent fashion and then agreed upon. All resources were transferred to a reference manager (Mendeley) and duplicates were removed.

2.5 | Study selection

Two different screening stages were performed: in the first, the titles, abstracts and keywords of retrieved studies were evaluated for their eligibility against the inclusion criteria by two researchers (AB, AP), independently. The other researchers screened all excluded abstracts and resolved disagreements, if any (SC, IM). Consensus between the researchers was essential for inclusion of a study in the next stage of the process. Then, the second screening stage was performed to define whether eligible studies met the inclusion criteria: the first researcher (AB), performed the screening whereas the second (AP) screened all excluded full texts. In any disagreement, the opinions of other researchers (SC, IM) were consulted. The study selection process was pilot-tested and evaluated in one study for each stage: in total, 72 studies met the inclusion criteria (Figure 1). The references of the included studies are provided in the Supplementary Table 2 (File S2).

2.6 | Data extraction

Three reviewers (AB, SC, IM) extracted data of the included studies, independently by using a grid preliminarily piloted in two studies where no changes were required. The grid was populated with the following data: (1) author(s), year, and country; (2) study design; (3) rounding terms utilized; (4) definition(s) given; (5) purpose(s) of the rounding; (6) main intervention features; and (7) health-care professionals involved. The extracted data were checked by the senior author (AP).

2.7 | Risk of bias

According to the aims of this Rapid Review, the quality assessment of the included studies was not performed. However, to prevent bias the following strategies were applied: (a) all researchers were involved in the study protocol refinement; (b) the literature search was conducted by two researchers independently; (c) the data extraction was performed by three researchers independently and supervised by the senior researcher; and (d) each stage was accompanied by a meeting, and the decision to move on to the next stage was undertaken collectively.

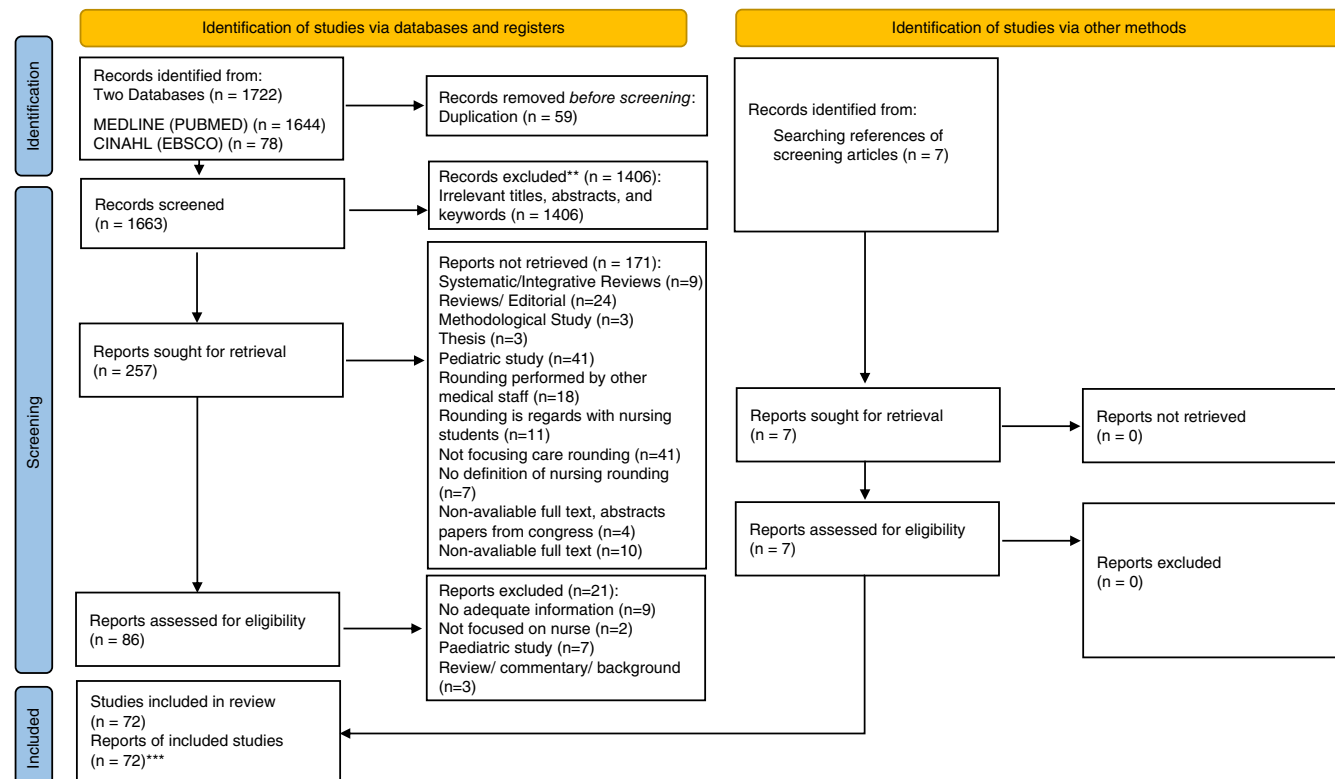


FIGURE 1 Rapid Review flow diagram (Page et al., 2021).

2.8 | Synthesis

After the textual description (Popay et al., 2006) describing the included studies at the overall level, three methodologies of analysis of the data extracted were used according to the research questions of this Rapid Review:

1. *What are the terminologies used to date while investigating rounding in the nursing field?* A qualitative content analysis (Hsieh & Shannon, 2005) was used to analytically code the terminologies used to date while defining the rounding intervention in order to organize the content of textual data into fewer content categories. Specifically, the terms used while referring to the round were first compared and when exactly expressed in the same manner were considered as a unique term; then, the different terms that emerged were counted. These were categorized inductively to identify the elements considered to date in defining the rounding interventions and the main features of such terms.
2. *What are the main purposes of the rounding investigated to date?* A thematic synthesis (Thomas & Harden, 2008) was then used to categorize and summarize the different purposes of the rounding across studies by performing a line-by-line coding, developing descriptive subthemes and then generating themes. This was then used to generate a conceptual map reflecting all possible rounding purposes as documented to date.
3. *What are the main features of the rounding investigated to date?* A framework synthesis (Booth & Carroll, 2015) to summarize

all aspects reported to date while describing the rounding intervention according to the a priori model, was performed. The data extracted regarding the main features of the rounding intervention were analysed line by line according to the Template for Intervention Description and Replication checklist (TIDieR, Hoffmann et al., 2014). This checklist implies the description of a given intervention as

- *What*, (i) Materials needed: any physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers; and (ii) Procedures: each procedure, activity, and/or process used in the intervention, including any enabling or support activities.
- *Who*, indicating the provider (e.g., psychologist, nursing assistant), his/her expertise, background and any specific training given.
- *How*, the modes of delivery of the intervention (e.g., face to face or by some other mechanism, such as Internet or telephone) and whether the intervention was provided individually or in a group; and
- *Where*, describing the type(s) of location(s) where the intervention is delivered, including any necessary infrastructure or relevant features.

When the TIDieR framework was not capable of capturing all elements included in the descriptions of rounding as reported in the studies, new items were developed. Differently, the underlying rationale (*Why*), as well as the “*Tayloring*”, “*Modifications?*”,

and "How well" elements of the TIDieR framework (Hoffmann et al., 2014) were not analysed because out of the aims of this Rapid Review.

The data analysis was performed in a preliminary fashion by one author (AB) and then refined by two authors (AP, SC), independently and then shared. Discrepancies were resolved in the research team by also involving the fourth researcher (IM).

3 | RESULTS

3.1 | Main study characteristics

A total of 1722 studies were retrieved, and 1663 of these were screened after the elimination of duplicates ($n=59$). At the end of the process, 86 studies were retained for data extraction; specifically, 21 of these 86 were then excluded for different reasons and seven other studies were retrieved from the references of included studies. In total, 72 studies were included (Figure 1; Files S2 and S3).

As summarized in Table 1, the earliest studies were published in 2015 ($=9$; e.g. Dalmaso et al., 2015) and the most recent in 2022 ($=2$; e.g. Gross et al., 2022). These studies were mainly authored in the United States of America ($=44$; e.g. Manss, 2017), in Australia ($=7$; e.g. Basic et al., 2018) and in the United Kingdom ($=7$; e.g. Shaughnessy & Jackson, 2015). The remaining 12 studies were conducted in various countries from different continents such as Brazil, China, Jordan, Nigeria, South Africa, and Spain. Most studies were quasi-experimental pre-post studies ($=31$; e.g. Ram et al., 2019) in design, followed by qualitative ($=10$; e.g. Walker et al., 2015), cross-sectional ($=7$; e.g. Chau et al., 2017), survey ($=4$; e.g. Lahiri et al., 2021), descriptive ($=3$; e.g. Al-Danaf et al., 2017), randomized controlled trial ($=3$; e.g. Gross et al., 2022), mixed method ($=2$), retrospective ($=2$), prospective ($=1$), observational ($=2$) and methodological ($=1$) studies. The remaining six have not reported the design of the study (Table 1).

3.2 | The terms used to label rounding

As reported in Table 2, out of the 88 terminologies used in all studies, researchers have described the intervention using a total of 238 words, from one ($n=2$, "Rounding", Walker et al., 2015, Willis et al., 2016) to four ($n=12$, e.g., "Structured Hourly Nurse Rounding", Brosey & March, 2015) and up to five words ($=1$, "Daily Intentional Nurse Leader Rounding", Hudson-Covolo et al., 2018), with an average of 2.69 (standard deviation 0.82, median 3). All of them included the terms "round"/"rounding" (or "visit") followed by other words as categorized in the File S4.

The core concepts are rounds (51/88) and rounding (36/88); in near to half of terminologies used, there is a specification regarding the actors involved (65/88) in a mono-professional composition, as bedside nurses ($n=25$), nurse leader ($n=15$) or other (e.g. consultant, $n=1$) or as multiprofessional, as interdisciplinary

TABLE 1 Studies main characteristics ($n=72$).

Study characteristics	$n=72$
Year of publication	
2015	9
2016	8
2017	13
2018	12
2019	7
2020	12
2021	9
2022	2
Country of origin (first author)	
Australia	7
Australia & United Kingdom	1
Belgium	1
Brazil	1
Canada	1
China	1
Germany & Switzerland	1
India	1
Jordan	1
Nigeria	1
Singapore	1
South Africa	1
Spain	1
Switzerland	1
United Kingdom	7
United States of America	44
United States of America & Canada	1
Study design	
Quasi-experimental pre-post study	31
Pre-post design	18
Quasi-experimental	3
Before-after	2
Pre-post implementation in a prospective way	2
Post-intervention	2
Baseline/post-intervention	1
Baseline implementation	1
Two-group post-test design	1
One-group pre-post design	1
Qualitative	10
Qualitative	8
Ethnographic	1
Phenomenology	1
Cross-sectional	7
Cross-sectional study	4
Cross-sectional exploratory study	1

(Continues)

TABLE 1 (Continued)

Study characteristics	n = 72
Cross-sectional survey	1
A prospective cross-sectional analysis	1
Survey	4
Purpose-designed questionnaire	1
Separate survey	1
Post-intervention survey	1
Survey research	1
Descriptive study	3
Randomized controlled trial	3
Cluster randomized controlled trial	1
A multicentre randomized controlled trial	1
Qualitative interviews, embedded within a large randomized control trial	1
Mixed-methods study (qualitative and quantitative)	2
Retrospective study	2
Observational study	2
Prospective study	1
Methodological study	1
Not reported	6

($n=11$), interprofessional ($n=8$), multidisciplinary ($n=3$) or care team ($n=1$) round. The third most frequent word included in the current terminologies relates to the setting ($n=25/88$), distinguishing that physical space where the intervention is performed (e.g. at the bedside [$n=11$], or at Unit/ward level [$n=11$]) and regarding the care processes (e.g. transitional care, board rounding expressing the meeting of the professionals [$n=3$]). With the same occurrence, the format of the round is qualified ($n=24/88$) by specifying how it is delivered (e.g. structured, $n=7$), its main mission (intentional, $n=6$; purposeful $n=3$; proactive $n=3$, anticipatory, $n=1$), or the methodologies used to deliver it (virtual, $n=3$). Then, terminologies used also include the frequency of delivery ($n=19/88$) (e.g. hourly) followed by the focus of the round ($n=15/88$) as summarized in Table 2.

3.3 | The purposes of the rounding

By categorizing the main aims as reported in the included studies (Figure 2) three main purposes of the rounds emerge, namely rounding aimed at “building an effective care plan, team, and environment” that may be designed and implemented to achieve different specific aims:

1. Engaging health-care professionals and improving their communication (e.g. engaging all team members in a patient-centred, system-of-care delivery; Dunn et al., 2017).
2. Sharing clinical data (e.g. sharing information and care-treatment plans for patients at a prescheduled time each day; Amaral et al., 2018).

3. Designing/discussing/updating the care plan (e.g. meeting to synthesize data, think collectively, and formulate a plan of care; O'Brien et al., 2018).
4. Ensuring the continuity of care across settings (e.g. improving collaboration between hospital and facility at a rural facility with COVID-19 pandemic; Archald et al., 2021);
5. Promoting the quality of the work environment (e.g. discerning inconsistencies in the care environment; Gillam et al., 2017).

These roundings are usually performed in a hospital room (e.g. Archald et al., 2021; Dunn et al., 2017) or Intensive Care Units (e.g. Amaral et al., 2018; O'Brien et al., 2018).

There are rounds aimed at “delivering tailored and timely nursing care” and these are performed at the point of care (e.g. at the bedside, Willis et al., 2016; at the home, Koerner et al., 2021; in a room; Al-Danaf et al., 2017, Daniels, 2016) with variable specific aims:

1. Ensuring the fundamental needs are met (e.g. assessing and managing patients' fundamental care needs, Willis et al., 2016).
2. Protecting patients from risks and safety issues (e.g. decreasing the occurrence of patient preventable events, Daniels, 2016).
3. Providing multidisciplinary care (e.g. enhancing communication between the surgeon, nurses and the patient, Moyses et al., 2021).
4. Involving patients and family members in the care processes (e.g. meeting to discuss the care of the patient with the patient/family, Hendricks et al., 2017).

Then, there are rounds aimed at “promoting the quality of care”: these can be performed at the bedside or away from patients and may be aimed at

1. Supervising the care delivered (e.g. providing a nurse leader to verify nursing manners, giving response in real time, Ayaad et al., 2019).
2. Promoting patient satisfaction (e.g. assessing patient experience, Gormley et al., 2018).
3. Ensuring organizational/professional outcomes (e.g. making invisible practices visible in clinical settings, Bonaconsa et al., 2021).
4. Promoting research and evidence-based approaches (e.g. promoting workplace learning for nurses, Tobiano et al., 2019; supporting a culture of evidence-based practice, Haigh et al., 2016).
5. Promoting clinical learning (e.g. enabling junior physicians to present a patient's case under the supervision of a senior physician to make shared decisions, Vatani et al., 2020).

3.4 | Intervention features

As reported in Table 3, rounding might be supported or not by physical or informational material: when required, these range from books to memory forms, checklists and informatic support. The format of the rounding is described as unstructured (Ong et al., 2020), partially

TABLE 2 Categorization of the terms used by included studies when naming the rounding intervention ($n = 88$).

Core element ($n = 88$)	Actors ($n = 65$)	Setting ($n = 25$)	Format ($n = 24$)	Time/frequency/duration ($n = 19$)	Focus ($n = 15$)
	Administrative (1)				
	Care team (1)				
	Consultant (1)				
	Manager (1)				
	Medical (1)				
	Seniors (1)				Coaching (2)
	Staff (1)		Anticipatory (1)		Grand (1)
	Multidisciplinary (3)		STARS (1)	Morning Ward (1)	Death (1)
	Interprofessional (8)	Board (1)	Proactive (3)	Rapid (1)	MRSA (1)
	Nursing (8)	Transitional Care (1)	Purposeful (3)	Real-Time Random (1)	Palliative Care Needs (1)
Visit (1)	Interdisciplinary (11)	Trauma (1)	Virtual (3)	Timely (1)	Research (1)
Rounding (36)	Leader (12)	Ward/Unit (9), ICU (2)	Intentional (6)	Daily (5)	Safety Audits (2)
Round(s) (51) ^a	Nurse(s) (16)	Bedside (11) *	Structured (7)	Hourly (10)	Patient-Centered (6)

Note: STARS, Safety, Technology, Activity, Relief, and Surroundings; Grand, to support the culture of evidence (Haigh et al., 2016); *Included the MICRO (Mobile Interdisciplinary Care ROunds) model (Dunn et al., 2017); MRSA, Methicillin-Resistant Staphylococcus Aureus.

Not categorized the following words: Led (4) (Costanzo et al., 2019; Fisher et al., 2016, Garvey et al., 2019; Gormley et al., 2018); driven (1) (Marshall et al., 2018); care (3) (Chapman et al., 2020; Dunn et al., 2017; Ong et al., 2020); Comparative module (1) (Zheng et al., 2021).

^aAlso including 'mobile'.

Building an effective care plan, team and environment	Delivering tailored and timely nursing care
<ul style="list-style-type: none"> ▪ Engaging health-care professionals and improving communication ▪ Sharing clinical data ▪ Designing/discussing/updating the care plan ▪ Ensuring the continuity of care across settings ▪ Promoting the quality of the work environment 	<ul style="list-style-type: none"> ▪ Ensuring the fundamental needs ▪ Protecting patients from risks and safety issues ▪ Providing multidisciplinary care ▪ Involving patients and family members in the care processes
Rounding away from patients	Rounding at the point of care*
Improving the quality of care	
<ul style="list-style-type: none"> ▪ Supervising the care delivered ▪ Promoting patient satisfaction ▪ Ensuring organizational/professional outcomes ▪ Promoting research and evidence-based approaches ▪ Promoting the clinical learning 	
Rounding away/at the point of care	

*Bedside, ambulatory room, home

FIGURE 2 Main purposes of the rounding according to their setting.

structured (e.g. Anderson et al., 2017) or structured, where those involved must apply a checklist (Brown et al., 2020; Chapman et al., 2021), formulate some specific questions (Al-Danaf et al., 2017) or act according to the expectations regarding role and time (Malec et al., 2017) or according to established work processes/priorities (O'Brien et al., 2018). The intervention might be provided by one health-care professional (nurses, e.g. Ndie et al., 2015) or by multiple health-care professionals, in a multidisciplinary fashion (nurses and surgeons; Moysse et al., 2021), responsible for the care of patients

(e.g. clinicians; O'Brien et al., 2018) or with managerial responsibilities (nurse managers; Blake et al., 2020), working internally in or externally of the unit, such as nurse researchers or students (Thomas, 2017; Zheng et al., 2021). The intervention might be delivered face to face (e.g. Haigh et al., 2016) or mediated with some technologies (e.g. telemedicine; Archald et al., 2021) away from patients (e.g. Huang et al., 2017) or close to them (e.g. Bodi et al., 2017).

Regarding when the intervention is delivered, the features are variable and expressed at the unit (e.g. Al-Danaf et al., 2017), month/

TABLE 3 Template for intervention description and replication checklist^{a3} (Hoffmann et al., 2014): analysis of the rounding as described by included studies.

Element and description (TIDieR)	Approaches emerged according to the studies included in this rapid review	Examples as extracted from studies included in this rapid review
What		
Physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers	Supported/unsupported	Tablet, digital platform, electronic records, electronic script, book, checklist, a protocol based on 4Ps, memory form (e.g., Bodi et al., 2017; Chapman et al., 2021; Willis et al., 2016)
Procedures: Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities	Unstructured	Unstructured approach that was flexible to the participants' input (Ong et al., 2020)
	Partially structured	Reading/revising or reporting/presenting the data/concerns/needs/updates collecting/ revising the vital signs; identifying patients with uncontrolled signs and symptoms; asking questions, providing information; discussing/revising the plan of care; verbally summarize and document the plan of care; supporting/coaching on challenges identified (e.g., Anderson et al., 2017)
	Structured (1) By including checklists	Presenting the patient; discussing the important events, observing the abnormal laboratory marks; checking the problems and treatments; to review the 'FASTCHUGSBID' (feeding, analgesia, sedation, thromboprophylaxis, CAM-ICU, head of bed 30°, ulcer prophylaxis, glucose control, SBT/SAT, bowel regimen, in-dwelling catheters, de-escalation of antibiotics), daily goals, and plan (Brown et al., 2020)
	(2) By indicating the questions to formulate	To review the past one-day events; to present ABCDEF (Assess, prevent, and manage pain; Both spontaneous awakening trials and spontaneous breathing trials; Choice of analgesia and sedation; Delirium: assess, prevent, and manage; Early mobility and exercise; Family engagement and empowerment) Bundle checklist which centres on management of pain, agitation and delirium; To control all systems; To develop a plan of care by all team members; To review the missing checklist items (Chapman et al., 2021) Is there anything else I can do for you? Is there anything else you need me to do for you before I leave? (Al-Danaf et al., 2017)
	(3) By describing the roles and the time	The nurse initiates the visit by reviewing the purpose, introductions, 24-h summary of events, and safety checklist. The physician continues with a clinical update, plan for the day, and discharge plan, inviting input from all members of the team, including the patient and family. If a question requires a detailed response, a team member offers to follow up with the patient/family at a later time to maintain the goal of 5 min per patient visit (Malec et al., 2017)
(4) By describing the work processes/priorities	Before morning rounds, the overnight resident will write a predetermined sequential order of rounds on the patient census whiteboard which is located in a centralized location in each unit (nursing input, patient acuity, and new patient status) to allow all team members to plan their morning accordingly based on the rounding order to increase the chances that all necessary team members would be present for their patient's rounding discussion. While nursing input is encouraged at any time, there will be a designated 'hard stop' at the end of the patient presentation and before the patient examination, at which time the nurse will be asked if she or he has any concerns or information to add. At the conclusion of the plan, the presenting clinician will briefly and succinctly summarize the major actionable items for the day (O'Brien et al., 2018)	
Who provided		
Intervention provider (e.g. psychologist, nursing assistant), describe their expertise, background and any specific training given	Monodisciplinary;	Nursing staff (Archald-Pannone et al., 2021)
	Multidisciplinary Clinicians, Managers	Nurse and surgeon (Moyses et al., 2021) Consultants, Clinical nurse consultant or delegate (Tobiano et al., 2019), Nurse managers, Directors of nursing and Chief Nursing Officer (Blake et al., 2020)
	Internal/External unit	Nurse researcher (Thomas, 2017), Clinical librarian together (Thomas, 2017), Nursing student (Zheng et al., 2021)
How		
Modes of delivery (e.g., face to face or by some other mechanism, as Internet) of the intervention and whether it was provided individually or in a group	Face to face or mediated	Through instant messages and phone calls (Bonaconsa et al., 2021) By e-mail (Archald et al., 2021) Telemedicine consultation requests (Archald et al., 2021)
	Individually or in a group	Case presentations, discussions and clinical examination (Gross et al., 2022) Individual presentations (Haigh et al., 2016)

TABLE 3 (Continued)

Element and description (TIDieR)	Approaches emerged according to the studies included in this rapid review	Examples as extracted from studies included in this rapid review
Where		
Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features	Away from patients	In the hallway (Gross et al., 2022); outside of the patient's room (Huang et al., 2017); at nurses' stations (Borges et al., 2020; Chau et al., 2017; Lahiri et al., 2021; Ryan et al., 2017; Thomas, 2017)
	Close to patients/families	In any patient rooms (e.g. Thomas, 2017); at the bedside (e.g. Bodi et al., 2017; Dalmaso et al., 2015)
When/How Much		
Describe the number of times the intervention was delivered and over what period including the number of sessions, their schedule, and their duration, intensity or dose.	At the unit level	More frequent in special units such as ICUs (Al-Danaf et al., 2017)
	At the month/week	Monthly (Koerner et al., 2021; Ong et al., 2020)
		At least once per week (Blake et al., 2020; Heip et al., 2020; Thomas, 2017; Winter & Tjong, 2015)
	At the daily/shift levels	From Monday through to Friday (Borges et al., 2020)
		Daily (Al-Danaf et al., 2017; Amaral et al., 2018; Archald et al., 2021; Borges et al., 2020; Case, 2020; Chapman et al., 2020; Chau et al., 2017; Cody & Reed, 2018; Dunn et al., 2017; Fisher et al., 2016; Garvey et al., 2019; Heip et al., 2020; Hillmann et al., 2021; Hudson-Covolo et al., 2018; Kolikonda et al., 2022)
	At the patient level	Twice daily (Chau et al., 2017; Ndie et al., 2015; Winter & Tjong, 2015)
		Twice daily for ≥3 days (Ayaad et al., 2019)
	At the rounding level	9 rounds/per day (Case, 2020)
		On day shifts (Dalmaso et al., 2015)
	Combined times according to different levels	Every shift (Al-Danaf et al., 2017; Blake et al., 2020)
		More often before noon (Heip et al., 2020)
	Rounding duration	Morning (Archald et al., 2021; Hillmann et al., 2021; Kolikonda et al., 2022; Shirreff et al., 2018)
Mid-morning (Ryan et al., 2017)		
Dose at the patient/nurse level	Day and night (Willis et al., 2016)	
	Every patient seen at least once during their hospitalization (Al-Danaf et al., 2017)	
From highly prescriptive to low	Two patients/day (Al-Danaf et al., 2017)	
	10 patients/week (Al-Danaf et al., 2017)	
From highly prescriptive to low	With a maximum of 12 patients on each side (Chau et al., 2017)	
	At least 50% of the inpatient/each day (Littleton et al., 2019)	
From highly prescriptive to low	At least 90% of patients cared (Cody & Reed, 2018)	
	At the standardized start/ fixed time (Brown et al., 2020; Heip et al., 2020)	
From highly prescriptive to low	Prearranged time (Moyses et al., 2021)	
	At a stipulated time during awake hours (Daniels, 2016)	
From highly prescriptive to low	Regular (Al-Danaf et al., 2017; Fabry, 2015; Kirk & Kane, 2016; Morgan et al., 2016)	
	No specific time (Ndie et al., 2015)	
From highly prescriptive to low	At 10.00 a.m. (Dunn et al., 2017; Merriman & Freeth, 2021)	
	From 1 p.m. to 2 p.m. (Haigh et al., 2016; Winter & Tjong, 2015)	
From highly prescriptive to low	At least 4 h per unit per month (Anderson et al., 2017)	
	In each of the 10 target ICUs for a mean of 3 h per unit per month (range, 0–9) (Anderson et al., 2017)	
From highly prescriptive to low	Hourly during waking hours (Johnson & Bryant, 2020)	
	Every hour between 6 a.m. to 10 p.m. (Brosey & March, 2015; Fabry, 2015; Goldsack et al., 2015; Sai Ram et al., 2019)	
From highly prescriptive to low	Every 2 h during sleeping hours (Johnson & Bryant, 2020)	
	Mean duration 60 min (Hillmann et al., 2021; Koerner et al., 2021; Ong et al., 2020; Ryan et al., 2017; Tobiano et al., 2019)	
From highly prescriptive to low	Between 20 and 60 min (Haigh et al., 2016)	
	For a minimum of 1 h (Blake et al., 2020)	
From highly prescriptive to low	5 min per patient (Ayaad et al., 2019; Cody & Reed, 2018)	
	Each nurse approximately 15 min (Schwartz et al., 2021)	
From highly prescriptive to low	Every 2 h from 8 p.m. to 6 a.m. (Al-Danaf et al., 2017)	
	Just before the start of the day (7.35–7.45 a.m.) (Shirreff et al., 2018)	
From highly prescriptive to low	3–4-min-long structured (Schwartz et al., 2021)	
	No specific time (Ndie et al., 2015)	

Abbreviations: 4 Ps, Pain, Position, Potty, Possessions; TIDieR, Template for Intervention Description and Replication checklist.

^aThe Why, Tailoring and How Well and Modifications elements of the TIDieR approach (Hoffmann et al., 2014) were not assessed according to the aims of the rapid review.

weeks (e.g. Blake et al., 2020), daily/shift (e.g. Al-Danaf et al., 2017), patient (e.g. Chau et al., 2017) and at rounding levels (e.g. Daniels, 2016). There are also rounding interventions expressed in a combined fashion, including more than one of the above-mentioned levels (e.g. Johnson & Bryant, 2020). In addition, the duration may be expressed in variables terms at the rounding level (as averages, ranges, minimum time, e.g. Blake et al., 2020) and the patient/nurse level as the time that each patient should be exposed to the rounding (e.g. Ayaad et al., 2019; Schwartz et al., 2021).

Above all, the intervention might be delivered at specific moments of the day, and repeated for a given duration, as precisely structured and prescribed (e.g. "Every 2h from 8 p.m. to 6 a.m.", Al-Danaf et al., 2017), or left free according to the judgement of the health-care professionals (e.g. "No specific time"; Ndie et al., 2015).

4 | DISCUSSION

4.1 | Discussion of the methodologies used

We performed a rapid review, a knowledge synthesis tool in which components of the systematic review process are simplified to summarize information in a short period of time (Tricco et al., 2015). The overall intent was to summarize the knowledge and contribute to conceptual clarity in the research context of rounding. Given the emerging impetus in this field of research, a review method allowing a rapid summary of the literature produced to date was preferred; there were considered the previous reviews in the field of conceptual clarification (Hutchinson et al., 2017; Walton et al., 2016) by also following their methods. By considering the several methodological steps of reviews, we decided against performing a qualitative evaluation of the studies as the finding of each study were not described in detail.

However, instead of describing the major results by performing a simple descriptive summary (Tricco et al., 2015), we combined different methods of data analysis, from those purely inductive (e.g. the textual description, the content analysis, and the thematic synthesis), to the deductive (the framework analysis). This complex data analysis process was different to that performed by the two reviews available in the field, where a limited number of studies with substantial similarities in the round features were included (Hutchinson et al., 2017; Walton et al., 2016). The sequential data analysis approach (Hong et al., 2017) that we adopted has generated three different frameworks regarding the terminologies used, the purposes, and the features of the rounding intervention, which might be useful in designing and implementing intervention studies, reviews, educational toolkits, and to shape daily practice. The multiple data analyses required a particular commitment by the researchers, using an inductive to a deductive approach, progressing from one method to another to maximize the analysis richness.

In performing the whole project from the rapid review to the multiple data analysis, three main methodological challenges were undertaken

1. The rapid review was performed by including a short period, established according to the time frame of reviews available and including studies up to April 13th, 2022: on the one hand, we used a purposeful approach (Walker, 2014, p. 329) by selecting a sample of studies published only recently; on the other, the number of studies that emerged (=72) was huge and difficult to analyse due to their great variability. Our approach, which appears to be paradoxical because it is selective in the time frame but ample in the study inclusion, was aimed at rendering available a rich and inclusive approach to graft a rich data for the following data analysis. In fact, our intention was to reach a broader representation of the variances in terminologies, purposes and intervention features; in the future, a rapid review based on a theoretical sampling, by including only some studies (e.g. reviews) on the basis of the emerging data might be more effective.
2. Given that our interest was in terminologies, purposes and main features that are usually described in some parts of the papers, the data analysis was performed by the substantial use of the introduction/background and the methods sections of the included studies. Therefore, different studies were combined regardless of their different research methodologies; consequently, context data were not analysed, such as how the intervention was applied in the real world, shaped and implemented. Therefore, while our attempt was mainly aimed at increasing the conceptual clarity in this field, the same research exercise might be performed in the findings section of the included studies to discover context-rich knowledge regarding the real implementation of the intervention according to the health service research frameworks (Walker, 2014).
3. By combining different studies, those designed as quality improvement projects or professional investigations, thus practical-based, have been combined with research studies thus aimed at expanding the conceptual knowledge in the field. At the overall level, the first may have contributed less and the second more; however, we tried to embody the "buck the trend" approach (Walker, 2014, page 330), thus including all studies to ensure inclusiveness and considering all as valuable in generating the theory. A pure approach, by including only those respecting some criteria (e.g. describing the intervention in a detailed fashion, or with a certain quality criteria) might have prevented an inclusive approach.

4.2 | Discussion of the findings

4.2.1 | Study characteristics

To the best of our knowledge this is the first rapid review performed by using a systematic approach in this field. The previous investigations were based on a bibliometric analysis (Hutchinson et al., 2017) or as regulating the entire intervention (such as its roles times, priorities)/and on a narrative review (Walton

et al., 2016) summarizing the evidence published up to 2015 and 2014, respectively. Although reviews were slightly different in their aims, we based our review on both with the intent of valuing the advancements already established (Hutchinson et al., 2017; Walton et al., 2016) and as a form of “evidence surveillance”, thus monitoring the evidence produced recently and updating or re-shaping the previous evidence (Thomas et al., 2020). More than 11 primary studies/year have been published from 2015 to date, while in the previous reviews around 2.5 studies/year were retrieved (Hutchinson et al., 2017; Walton et al., 2016), indicating an increased interest in the field. Moreover, although the majority have been produced in US and in Australia/UK, a worldwide interest in this field of research in the last seven years is visible, with international studies included. In addition, near to half of the studies that emerged (=34/72) were based on experimental (=3) or quasi-experimental studies (=31) assessing the effectiveness of the rounds as intervention studies. All these elements confirm the need to establish a conceptual clarity in this research field given its global research interest and impetus, and its attempt to establish the effectiveness of rounds to accumulate strong and easily evaluable evidence and to disseminate it in the practice.

4.2.2 | The rounding terms

Researchers use from two to five words to name the rounding intervention: the lack of a common language is not uniquely a nursing challenge—this has also been identified recently with regard to other health science disciplines on surgical ward rounds (Morris et al., 2022). However, the rich number of terms used suggests three lines of interpretation.

First, the word “round” alone seems to be insufficient to communicate and describe the intervention, suggesting that this field of research is entering a complex intervention (Clark, 2013) where the qualification of the different components is important to indicate which elements contribute or are essential for its effectiveness (Craig et al., 2008). By expressing the intervention with a series of interrelated terms, the researchers are implicitly affirming the ontological nature of the intervention with respect to the components of which it is composed and to their relationship: naming the intervention as simply “rounding” (e.g. Willis et al., 2016) or as “real-time random safety audits/safety rounds” (Bodi et al., 2017) expresses a clarity of the intervention investigated and may ease the conducting of systematic reviews as well as the evidence search by clinicians.

Secondly, by analysing the terms used, it is possible to understand which are superfluous (Craig et al., 2008) and which, on the other hand, are relevant to describe the intervention: according to the categorization performed, the qualifications of the actors involved, the setting, and the format in their main properties seem to be of higher importance as compared to the time/frequency or the focus of the intervention. In other words, the context (where) and how to implement the rounding intervention (how to deliver and by whom) seems to be important in this field of research. However,

some parts might be nested, thus not explicitly stated in the terms used to express the rounding intervention that is reported not in its components (Clark, 2013). Therefore, two lines of perspective seem to emerge in this field of research: those who considered the rounding as a whole and undifferentiated intervention (nursing round, Tobiano et al., 2019), and those who considered rounding as differentiated and thus needing to be named in its discrete (Clark, 2013) parts (e.g. structured interdisciplinary bedside round, Basic et al., 2018). There is also a third possible line, comprising those studies who describe the discrete parts of the intervention in the methods of the studies, without embodying these parts in the name of the intervention. Given the ample range of terms used to date, as well as the different interventions that they might mean, including the discrete parts or components in the terms might be useful for practical purposes because it can facilitate the dissemination of the intervention by making it explicit with respect to what to do and how to do it to ensure effectiveness.

Thirdly, according to the frequency of the components of discrete parts included in the rounding term, a sort of hierarchy seems to emerge: at the overall level, indicating who performs the rounding in a mono- or multidisciplinary context, seems to be of higher importance compared, for example, to the focus, such as on issues of the nursing care or the patient. These often-labelled elements may express clarity in the main features of the rounding and which are the higher-powered components capable of affecting the outcomes.

4.2.3 | The purposes of the rounding

A range of aims have been reported across studies, indicating that the purposes of the rounding might vary. At the overall level, rounding has been described as pursuing three main purposes, namely, “Preparing the care by ensuring an effective care plan, team and environment”, “Delivering tailored and timely nursing care” and “Promoting the quality of care”, with a series of specific aims, emphasizing one aspect among others, such as sharing data among professionals, providing fundamental care, ensuring safety, or promoting research, respectively. In other words, the rounding is intended to prepare, deliver, or ameliorate the care. The findings suggest three main reflections:

- regarding the setting, the round may be performed away from the patient whereas other required rounding should be applied at the point of care; others aimed at promoting research for example, may be implemented away or at the bedside, in all settings.
- regarding the time, those roundings “ensuring an effective care plan, team and environment” are performed before the delivery of the care, to set some structural and processes prerequisite to ensuring quality, such as sharing information, preparing the team, deciding the plan care, thus making the whole environment safe and effective (Kurhila et al., 2020). Those rounds aimed at “delivering tailored and timely nursing care” are performed instead when the care is delivered, as a care intervention itself, to check

needs, safety issues, to implement the multidisciplinary approach or to involve patients. The third round "Promoting the quality of care" can be applied before, during as well as after the care delivery in a more flexible approach in terms of the time.

- regarding the processes involved, those roundings performed before the delivery of care require mainly cognitive processes aimed at preparing and at making decisions regarding the care, according to the patients' needs; those delivered at the bedside require, in addition, observable behaviours (e.g. going to the bedside, providing care) and are also in this case focused on patients and family carers; in contrast, those roundings aimed at ensuring the expected outcomes involve cognitive processes and behaviours focused on a mix of targets from patients (e.g. assessing their satisfaction) to professionals (e.g. supervising the care delivered), organization (e.g. achieving the expected outcomes regarding satisfaction) and students/residents (e.g. ensuring learning).

Previously, Hutchinson et al. (2017) identified specific aims, such as assessing patient comfort, unmet needs or required care regarding comfort, safety or satisfaction; targeting specific preventive or early detection activities; monitoring appropriate care delivery; and leading/supporting nurses or the interprofessional team in the care delivery. Walton et al. (2016) also identified eight different rounds achieving specific aims, such as, for example, in the case of ward round, mostly represented in the literature, the aim is to plan the care alone or combined with teaching. By comparing our findings with previous findings, the round purposes have been enriched in recent years with direct and indirect implications for patients, staff and organization.

4.2.4 | Intervention features

According to the TIDieR Checklist (Hoffmann et al., 2014), we provided a categorization of the main intervention features to map the options investigated to date in available studies. At the overall level, the intervention may have different features, in each item of the TIDieR checklist, starting from the materials required, that might be limited as paper or electronic, thus in addition or not to those resources routinely devoted to the nursing care. The degree of freedom that emerged across studies regarding the rounding procedures is highly variable from ample to very limited, and this might introduce issues while evaluating the effectiveness of the intervention. Apart from the dichotomy between unstructured and structured approaches, in those structured, different aspects might be disciplined: that embodied in the intervention itself (e.g., applying a checklist or requiring some questions to be formulated at the bedside), or other elements affecting the whole intervention regulating its roles, time, and priorities. This suggests that while comparing the effectiveness of the intervention, those aspects that have been regulated in structured interventions should be assessed to prevent heterogeneity. On the other hand, the main elements influencing the structured intervention have emerged, might be used as a source to describe rounding in future studies.

In the case of who provides the intervention, the options are really ample, not only from the more classical approach including one or more professionals (e.g. mono or multiprofessional rounding), but also imply that providers can be clinicians or managers, variable healthcare professionals working inside or outside of the unit. These different combinations of roles reflect not only the different rounding purposes but also the underlying philosophy of care, based, for example, on multidisciplinary processes; the full involvement of managers in the clinical care processes; the value given to students, and to researchers. In contrast, how (face to face vs mediated) and where (away from patients/closer) the rounding is delivered seems to have binary options to date.

The number of times the intervention is delivered is established at different levels, from macro (unit) to the micro (at the rounding) levels, suggesting that this intervention should be embodied in the whole process of care delivered. For example, the need to express the time from monthly to weekly and daily/shift may express the different intensity of the intervention according to the peculiarities of the setting (e.g. long-term care vs acute care). However, two main tendencies emerged: first, the decision regarding when and how much the rounding should be delivered is left to the person responsible for the rounding, while in other studies these are precisely prescribed it (e.g. every hour between 6 a.m. and 10 p.m., e.g. Brosey & March, 2015). Second, the metrics used are really variable (from describing the duration of the intervention, the dose to each patient or at the nurse level), suggesting that this should be standardized to increase clarity and reproducibility.

4.2.5 | Limitations

This rapid review should consider several limitations. Firstly, we approached two databases and the grey literature by excluding PsycINFO and by accessing only studies published in English suggesting that future studies should consider multiple databases and languages. Furthermore, only primary studies published in the given time frame were eligible, in line with the review considered as a basis of the work (Hutchinson et al., 2017). Secondly, the quality assessment of the studies was not performed according to the aims of the rapid review. In updating the reviews, researchers should also consider the opportunity to assess the quality of the primary studies produced in the field. Third, in performing the framework synthesis (Booth & Carroll, 2015), the underlying rationale/mechanism (Why) of the intervention was not analysed across the included studies: understanding the mechanism justifying the effectiveness of the intervention merits consideration (e.g. Harris et al., 2019), suggesting that future investigations may develop knowledge in this field. Fourth, the findings that emerged may have been influenced by the background of the researchers (all nurses) engaged in the different data analysis process performed, suggesting that future reviews should be encouraged to validate the frameworks that emerged. Fifth, although the keywords used in the rapid review were aimed at investigating the nursing rounding, different profiles of rounding

emerged that were not only related to the nursing care. Therefore, while on the one hand this might have affected the preciseness of the findings to the nursing care, on the other the findings might also be useful for other health-care professionals.

5 | CONCLUSIONS

This rapid review was performed to increase conceptual clarity regarding the terms, purposes, and main features of rounding.

According to the findings, how to name the rounding intervention and the number of terms to include has not been decided to date. The word 'round' alone seems to be insufficient to communicate and describe the intervention, suggesting that this field of research is entering a complex intervention. A minimal or rich descriptive approach in the terminologies used may increase the differentiation and the clarity across the different rounds and may affect transparency, which might be important for research, practice, managerial and for educational purposes. Also regarding the purposes of the rounding, as rich variety has emerged: the different purposes may affect the setting, the time, and the same processes of rounding delivery. The specific aims identified inside of the three main umbrella purposes that emerged, might help researchers to identify and classify the possible aims of their intervention, to refine reviews in this sector by including only certain studies according to the aims of the interventions; but also may inform the decisions of educators regarding when and how to educate nurses regarding rounding according to the specific aims, as well as possibly engaging clinical nurses in identifying additional rounding purposes as delivered in practice and not emerged in available studies.

The intervention features of the intervention may range from simple to very complex descriptions. At the overall level, two polarities seem to emerge in all features: rounding may be described from highly structured/prescriptive to low structured/prescriptive approaches. While the degree of preciseness in all aspects might satisfy the research purposes when intervention is investigated for its effectiveness, on the other hand, describing all features of the intervention might prevent the variability required in daily practice when the clinical judgement of the nurses may inform the interventions shaping them according to the needs of the patients. However, establishing the minimal features required while describing rounding for research purposes, as well as the metrics to use in defining its duration and dose is strongly suggested to increase the likelihood of accumulating evidence in this field.

All frameworks emerged as continuously accumulated and validated, might help in establishing standards through naming the rounding, thus establishing their purposes and describing their main features.

AUTHOR CONTRIBUTIONS

Conceptualization: Aysun Bayram, Alvisa Palese and Stefania Chiappinotto. Data curation: All authors. Formal Analysis: All authors. Methodology: Aysun Bayram and Alvisa Palese. Project

administration: Alvisa Palese. Supervision: Alvisa Palese. Writing – original draft: Aysun Bayram, Stefania Chiappinotto and Alvisa Palese. Writing – review & editing: Aysun Bayram, Stefania Chiappinotto and Alvisa Palese.

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No conflict of interest has been declared by the authors.

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