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Ethical and professional concerns in research utilisation: Intentional rounding in the United Kingdom

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Abstract

Intentional rounding, a process involving the performance of regular checks on all patients following a standardised protocol, is being introduced widely in the United Kingdom. The process has been promoted by the Prime Minister and publicised by the Chief Nursing Officer at the Department of Health as well as by influential think tanks and individual National Health Service organisations. An evidence base is offered in justification. This article subjects the evidence base to critical scrutiny concluding that it consists of poor quality studies and serial misreporting of findings and a failure to consider wider concerns, including transference of evidence to differing health-care systems, and the conflation of perception and quality of care. Political promotion and wide implementation of intentional rounding despite the flimsy and questionable evidence base raise questions about the use of evidence in ethical nursing practice and the status of nursing as an autonomous profession.

Keywords

Intentional rounding, politics, professional autonomy, research utilisation, Studer Group

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Introduction

Intentional rounding is not a new nursing initiative but it has gained renewed prominence in the United Kingdom (UK) over the last few years partly as a response to a number of high profile scandals involving poor nursing care¹. Whilst currently falling just short of being presented as formal government policy, the practice has been heavily promoted through press releases, government officers and even the Prime Minister. Evidence in the form of published studies and local audits is cited in support of implementation, reporting in many cases claims of notable improvements in care. Many National Health Service (NHS) organisations are implementing the process². This paper begins by tracing the political activity promoting intentional rounding in the UK, before highlighting three sets of ethical and professional concerns about its implementation. First, the evidence base that is presented in support of intentional rounding is discussed and evaluated and found to be of poor quality. Second, largely because of the poor quality of the evidence and its origin from the US, it is argued that the evidential claims have been misused because of difficulties in transatlantic transferability and a failure fully to consider the nature and aim of the intervention, and third the politically driven implementation of the practice highlights some important tensions which threaten nursing's ability to practice according to its Code of Ethics.

It should be clear at the outset that it is not argued that there is anything necessarily unethical about intentional rounding *per se* (though there might be). This is not a paper about the ethics of intentional rounding, but rather a paper about the ethics of the implementation of intentional rounding. It is argued that the manner in which the practice has been introduced is unethical and unprofessional; not because there is deception or fraud or anything dishonest with the papers or the intentions of those responsible for implementation, but because standards of competence about evidence utilisation and the rationale for professional practice, articulated by regulatory standards, have not been met. This makes the issue of the process and rationale of implementation a matter for ethical and professional interest, of wider concern than its clinical effectiveness, and as worthy of analysis in an ethical journal as a clinical one.

Political promotion of intentional rounding

On 6th February 2012, the Prime Minister, David Cameron, accompanied by the then Secretary of State for Health, Andrew Lansley, visited Salford Royal Hospital. The British Broadcasting Corporation (BBC) website reported that 'Mr Cameron [...] said he wanted nurses to carry out hourly ward rounds to check on patients at their bedside'³ a process known as intentional rounding. A press release by the Salford Royal NHS Foundation Trust⁴ claimed that 'The Trust also puts nursing at the heart of several of its quality improvement initiatives, which has lead to:

- 92 percent of patients harm free as measured by the safety thermometer
- 78 percent reduction in *C. difficile*
- 71 percent reduction in cardiac arrests
- 56 percent reduction in pressure ulcers
- 17 percent reduction in falls.

These impressive figures were the subject of a piece in the Chief Nursing Officer's (CNO) newsletter⁵ which reproduced these numerical claims but prefaced them by stating that;

‘Piloted in April 2011, intentional rounding is a structured process where nursing staff carry out regular checks on patients at set intervals, typically hourly. The hourly check follows a prescriptive format using the 4Ps system and crucially, should finish with the closing key words: “Is there anything else I can do for you?”

- *Pain (“How is your pain?”)*
- *Personal needs (“Would you like help getting to the bathroom?”)*
- *Position (“Are you comfortable?”)*
- *Possessions (Help with drink, moving items to within reach)*

The initiative has been tested and refined by frontline nursing staff in partnership with patients and and (sic) became an organisational policy in November 2011.

The initiatives above have led to the following improvements: [same as above]

The newsletter article from the DH, but not the press release from the Trust suggests that the initiative has become organizational policy, but this is not publically available from the Trust’s website, and it is implied that the benefits were the result of rounding alone. Data from the pilot or audits are similarly not available and their veracity and methodologies cannot be scrutinized. A further Prime Ministerial visit to Blackpool the same month was also mentioned in the CNO newsletter⁶ promoting intentional rounding. The initial report of the Nursing and Care Quality Forum, established by the Prime Minister to identify and share best nursing practice recommended that;

we want to accelerate the implementation of person centred approaches such as ‘rounding with intention to care’ – where every individual receiving care knows they will have at least hourly contact with staff (p.8)⁷

A press release by the Prime Minister (4th January 2013) states that:

Nine in ten hospitals have introduced hour by hour care rounds. We want to go further and detailed action plans for Compassion in Practice to be published in the spring will urge the remaining hospitals to do so within a year.’²

A search of the Department of Health website (4th January 2013) using the term ‘intentional rounding’ finds no documents such that its implementation can be described as a formal government policy. However, promotion of the practice through the Chief Nursing Officer’s webpage highlighting implementation, direct intervention by the Prime Minister and recommendation by the Nursing Care and Quality forum implies what might be considered as *de facto* policy.

Also in the UK, intentional rounding features in the Hospital Pathways Programme, a project run by the King’s Fund, an influential healthcare think-tank. A PowerPoint presentation with commentary⁸ available on their website presents the evidence base for intentional rounding as being from a study undertaken by the Studer Group⁹ in the US which found in a ‘controlled trial’;

- *38% reduction in call lights*
- *12 point mean increase in patient satisfaction*
- *50% reduction in patient falls*

- *14% reduction in pressure ulcers*

It is admitted in the presentation that there were ‘some flaws in the study’ but the commentary insists that organisations ‘talked about the difference it made to patients’. The study is neither referenced in this presentation nor a similar one given at a Royal College of Nursing conference¹⁰ which repeated these findings. It is significant that care is taken to root justification in evidential claims, from audits or from published literature (and see for example a video from University Health Board in Wales¹¹). The next section of the paper offers a critical evaluation of these claims.

(1) Concerns about the quality of evidence and its citation.

Though more studies are reviewed here than in available published reviews^{12,13} this discussion paper does not offer a systematic review of the research evidence for intentional rounding, though one is probably needed elsewhere. Papers discussed have been identified by limited database searching but mainly by using citation tracking, because the aim is not comprehensively to evaluate the evidence base, but rather the manner in which evidence has been utilised and presented, and this principally requires engagement with the papers presented or cited. Evidential claims made for intentional rounding as presented in the UK rely heavily on Meade *et al.*⁹ Google scholar (4th January 2013) reports that it has been cited 114 times. This partial review begins with a critique of this paper.

Critical evaluation of Meade et al.

The study was a multi-centre quasi-experimental non-equivalent groups design undertaken in 27 units in 14 hospitals in the United States. Following two weeks of baseline measurements, units were assigned either to control, one hourly or two hourly rounding groups. Rounding was undertaken during the four week test period by various grades of nursing staff following a standard 12 point protocol. Outcome variables were the number of call lights measured either by existing systems of electronic monitoring or by dedicated staff, patient satisfaction scores collected by a number of different Likert type questionnaires with a single common statement, and hospital fall records. Originally 46 units in 22 hospitals were recruited but data from units where more than 5% of data elements were missing from rounding logs were excluded from the final analysis because it was assumed that nursing staff had not consistently performed rounding. The paper claims that reductions in call bell use, falls and increased patient satisfaction occurred in both rounding groups, with a larger effect noted in the hourly rounding group compared with baseline. Percentages are not given in the paper, but these are calculated as a reduction in call bell use of 37% for hourly rounding, a 12 point increase in patient satisfaction from 79.9 to 91.9 on a 100 point scale, and a 52% reduction in falls from 25 to 12 for compared four week periods.

These are, at face value, impressive results. However, a number of methodological critiques can be made about the study, some of which are acknowledged. There was no randomisation of the units into the arms of the study. Allocation was undertaken by the hospitals themselves in consultation with the principal investigator who attempted to arrange a stratified sample, and it is acknowledged that hospitals may have arranged inclusion in an arm which suited them, raising the possibility of recruitment bias. The researchers did not have access to raw data for patient satisfaction and falls, relying instead on data supplied to them by the participating hospitals. Patient satisfaction scores were derived from a single question on

different survey instruments and the inferential analysis translated ordinal into interval data.¹⁴ The paper acknowledges that the Hawthorne effect may have affected the behaviours of participating nurses. A great deal of data was excluded from the final analysis. The results are not presented clearly, and headline percentages are not given. One graph presents aggregate results for both experimental groups, and another presents data from two control groups while elsewhere the paper states that there was only one (see Vest and Gamm¹⁵ for further critique of the evidence for intentional rounding and other transformation strategies in healthcare).

As important as the methodological critiques, issues about the funding arrangements of the paper indicate at least the potential for conflict of interests. Acknowledged in the paper, two of the three authors of the paper are directly connected to the funders of the study, the Studer Group, a management consultancy, and the paper is available full text via its website. An instructional DVD in the techniques of patient rounding is also available for \$1495¹⁶ as well as participant guides and pocket cards at \$60 for 25. Results are not presented in a disinterested manner; the paper contains a boxed feature detailing a conversation with a nurse manager extolling the virtues of intentional rounding and offering further anecdotal evidence for the success of the intervention.

It is not suggested that there is anything necessarily wrong with the funding arrangements of the study, but it is suggested, despite the acknowledgements, that the funders of the study have a financial interest in the findings of the paper, and that there are on its web page a number of additional and unsubstantiated claims including that hospitals see a reduction in hospital acquired decubiti. An 'hourly rounding supplement'¹⁷ reports that Hospital-acquired pressure ulcers were reduced by 56% (exactly the same figure as in the CNO's newsletter story) but there is neither data nor citation in support. Only a sample of this document is available on the Studer group website with the full version being available as part of the DVD package for sale. The full version referenced in this paper is available (10th January 2013) via the website of Vanderbilt University.

A replication study has recently been published¹⁸, using a unit chosen because of 'the nurse manager's strong desire to be used.' The findings can be summarised as followed (all p.25): The fall rate reduced by 23 per cent, but 'while this was not significant statistically (p=0.672), the 23% reduction in falls was significant clinically.' A statistically significant call-light usage occurred during the first week of intervention (sic) but there was a statistically significant rise in call bell usage for the following two weeks caused by a single delirious patient, and the final week showed no statistically significant change. No figures are given. Finally, 'no statistically significant differences (p=0.383) occurred in patient satisfaction'. However 'anecdotal evidence from the nurse leaders' rounds showed increased patient satisfaction.' Despite these figures showing no statistically significant effect, (except presumably for the first week reduction in call light usage) the discussion section of the paper starts by claiming that, 'Study findings suggest hourly rounding by nursing personnel positively impacts the three variables studied.' This is simply not true, replicating at least the biased reporting of the original study.

Other published evidence

In the US, intentional rounding is presented as being an example of a new evidence based-practice¹⁹ and there are a number of studies which support this claim. Halm¹² retrieved eleven reports, including Meade *et al.*⁹ The studies were evaluated using an adaptation of the American Heart Association's introduction to the international guidelines for CPR and

ECC²⁰. This paper evaluates interventions rather than individual papers, and details about how the evaluations were performed are not given, but despite this and the methodological concerns discussed earlier, Meade *et al.*⁹ alone was rated as level IIa (good to very good evidence) with the other studies evaluated as IIb (nine – fair to good evidence) or III (one – not acceptable or useful). With the exception of Meade *et al.*⁹, the studies cited were ‘quality improvement designs [which] lacked rigorous analysis on which to base conclusions... (p.581)’.¹² More recent studies add to the amount of weak evidence. For example Sherrod *et al.*²¹ report a pilot in a 36 bed medical surgical unit claiming an increase in patient satisfaction and no significant reduction in falls or pressure sores.

As the published reviews make clear nearly all the studies cited are of weak design, of a design which cannot be generalised. However, it is also the case that some of the studies, notably Meade *et al.*⁹, Saleh *et al.*²² and Olrich *et al.*¹⁸ present concerns about funding, data analysis or presentation which should lead to sceptical interpretation of the results. This has not been done, and Meade *et al.*⁹ in particular has been wrongly presented as a significant study, worthy of wide generalisation.

(2) Concerns about the way the evidence has been utilised.

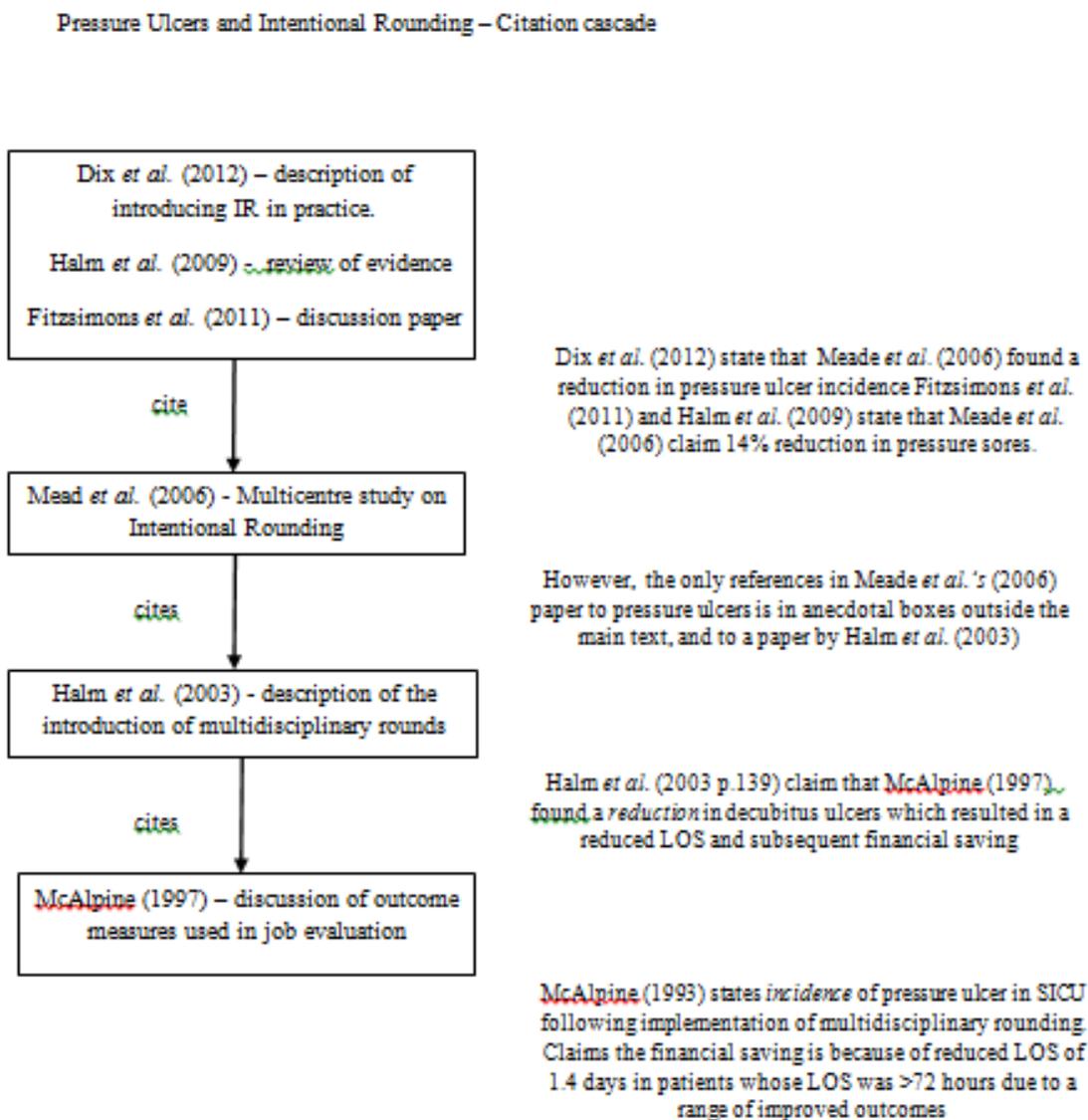
The evidence for intentional rounding is presented as unproblematic. At the very least this indicates a failure to evaluate the papers cited, but this extends to a series of incorrect citations and misattributed findings. Further concerns with the way the evidence base is presented include failure to consider contrary evidence, and contextual difficulties in application including transferability, staffing levels, and the aim of the intervention.

Incorrect citations

Meade *et al.*⁹ has been incorrectly cited especially in respect of a finding misattributed to it; that there was a 14% reduction in pressure sore development during the study. This finding is reported in the two UK presentations cited earlier and also in the UK publication Fitzsimons *et al.*²³ and elsewhere, including the review paper by Halm¹². Meade²⁴ and Dix *et al.*²⁵ report a reduction in pressure ulcers without stating a percentage. The problem is that this finding of a reduction in pressure ulcers does not feature at all in Meade *et al.*'s⁹ study. The only textual reference to pressure ulcers in the paper concerns interdisciplinary rounding (a different process from intentional rounding) and a finding from a paper²⁶ that this rounding resulted in a reduced incidence of pressure ulcers among patients who stay in the ICU for more than 72 hours. This paper discusses interdisciplinary rounds but the specific finding was referenced to a further discussion paper by McAlpine²⁷ about process and outcomes measures evaluating the performance of a Clinical Nurse Specialist. This paper does not demonstrate a *reduction* in decubitus ulcers, stating only the *incidence* of <1% for the SICU population and 3% for patients whose length of stay exceeds 72 hours. The citational confusion has travelled through the years illustrated in figure 1 (page 9). The claim that intentional rounding reduces the incidence of pressure ulcers appears to have become orthodox without support from a single cited peer-reviewed study. A paper²² published in the International Journal of Nursing Practice (since retracted) claimed in the abstract to have found a reduction of 50% in pressure sore incidence, based on a reduction from just two sores to one following implementation.

Figure 1. Pressure ulcers and intentional rounding – citation cascade

LOS: length of stay; SICU: surgical intensive-care unit; IR: intentional rounding.



Contrary evidence

In an Australian study, Gardner *et al.*²⁸ note that the practice of hourly rounding has not been adequately tested and report a pilot study which tested a more robust method to measure patient satisfaction using a nine statement instrument which assesses patient views of both specific nursing behaviours and general nursing care. Good reliability of the instrument is claimed. Rounding was provided only on weekday evenings for the duration of the study. Limited data is presented but it is stated there was no difference between the intervention and control groups for patient satisfaction, but there was significant differences in three of five subscales (including quality of care) of the Practice Environment Scale administered to nursing staff. Though the findings in this pilot were incompletely reported and inconclusive, the study extended the evidence base in that it developed and tested a robust instrument rather

than using commercially developed tools, used a control group, and was published in an established peer reviewed academic journal.

In a more robust US study, Tucker *et al.*²⁹ assessed the introduction of structured nursing rounds interventions (SNRIs) on two orthopaedic inpatient units, hypothesising that fall rates would be lower during SNRI. Though the number of falls declined during the intervention period it was not statistically significant ($p=0.088$), and the rate of falls drifted back towards baseline after a year. The rate of undertaking and documenting the rounds was variable, indicating problems with implementation, confirmed by focus groups. The rate of completion of documentation was 22 – 60%, that is a long way short of the criterion for excluding clinical areas in Meade *et al.*'s (2006) study, which would have discarded all of these data even though they represent real life implementation of rounding. One nurse stated (p.25);²⁹

...that prompt [toileting] may be relevant for an elderly or confused patient yet not for some of our patients. So, I did not ask that question to all of my patients. It felt silly – out of place – to keep asking a healthy individual if they needed to use the bathroom.

Difficulty in translation

From a UK perspective there are some ethical concerns about the possibility of conflict of interests in undertaking research within predominantly commercial and competitive health care systems. Whilst there is wide commonality between nurse values and professional ethics between nations, there are also differences. To dismiss the findings of research conducted in the US by nurses acting in the US healthcare system and practicing under US regulation as *necessarily* tainted would be to impose different ethical values to different systems, what might be regarded as ethical imperialism. However, concerns relating not directly to the production of evidence but rather its transfer and utilisation are of more immediate local concern. Translation of research findings to other countries is a recognised problem in health literature³⁰ but there are some specific problems in transferring findings from US studies on intentional rounding to the UK.

Staffing levels

Some US states³¹ have implemented legally binding minimum staffing levels, a policy that has been also discussed in the UK³². Meade *et al.*⁹ report hours of direct patient care that would be highly unusual in NHS hospitals, over 8 hours per patient day spent in direct patient care. A RCN survey^{33,34} calculates staffing differently but reports approximately 5.4 nurses per 24 bed ward during the day and 3.9 at night. Shift patterns vary, but as an illustration two day shifts at 7.5 hours and a night shift at 11 hours, equates to a little over 5 hours per patient per day not all of which will be spent in direct patient care. There is a wealth of evidence to show that quality of care improves with increased staffing levels³⁵ but despite recent advances in the NHS, staffing appears to have peaked and is now in decline³⁶. Intentional rounding may work better where there are good staffing levels, and the chance that nurses leaving more important work to undertake rounds is slim. Alternatively intentional rounding could produce more beneficial effects where staffing levels are poorer.

The aim of the intervention (1). Should we aim to reduce the number of call bells?

The stated rationale of many studies in intentional rounding is to reduce call bell usage (p.59)⁹:

...rigorous assessment of patient-care management systems is needed to determine the best ways to reduce call light use and burnout and fatigue amongst hospital personnel as well as increase patient satisfaction and safety.

The use of call bell response as a measure of patient satisfaction is not supported by research³⁷. In Meade *et al.*'s⁹ study (p.62), 72% of the hospitals had 'existing internal checks and balances to verify the accuracy of the call light records' or staff whose primary function was to act upon call light requests. Unlike the US, call bell analysis is not routinely measured in the UK. Tzeng and Yin³⁸ (2009) found that *increased* calls for assistance correlated to less fall related patient harm leading them to conclude that rather than regarding lowering call rates as indicative of good quality care, unit managers should 'routinely monitor the trend of call light use rate per patient-day and ensure that this use rate is maintained at least above the mean rate (p.3340).'³⁸ A care environment which seeks to reduce the number of call bell use may actually increase harm, even while improving patient satisfaction.

The aim of the intervention (2). Satisfaction versus quality of care

Patient focused outcome measures are important in the US where, as Tea *et al.* (p.233)³⁹ note, 'customer service and patient satisfaction have become increasingly important in the healthcare industry.' Rozzell *et al.* (p.69)³⁷ begin their paper by stating that, 'a growing body of evidence indicates that patient satisfaction is a key component of quality of care.' At least two issues can be derived from these quotations. First the notion of increasing patient satisfaction as essentially a commercial tool presented by institutions as marketing material reinforces the potential bias in these sorts of studies. Meade *et al.* also reported their study in the journal *Marketing Health Service*²⁴. Second the conflation^{40,41} of patient satisfaction and quality of care presents more fundamental concerns. It is possible that patients are satisfied with poor quality of care⁴² especially if carers are highly visible, for example during rounding. In the UK, these concerns have led to the National Institute for Health and Clinical Excellence (p.10)⁴³ to state that:

The concept of satisfaction has been explored in various formats over the last two decades within the NHS; it is now widely acknowledged that it is a poor indicator for evaluating quality from a patient experience perspective.

Despite this unambiguous statement from the official UK organisation whose purpose is to develop evidence-based guidelines, the promotion of intentional rounding has been justified on the basis of weak evidence largely from other countries undertaken principally to evaluate an intervention designed to increase an acknowledged poor indicator of quality of care. The measurement of patient satisfaction is central to UK policy, with the imminent implementation of the Friends and Family Test⁴⁴ which requires all NHS acute services to ask patients the same question: 'How likely are you to recommend our wards to friends and family if they need similar care or treatment?'

There is no evidence that those implementing intentional rounding in UK hospitals have considered any of the problems discussed above. In everyday moral life, this offends the

epistemic duty⁴⁵ which, broadly stated, requires moral agents to seek evidence on which to base beliefs. Where this is challenged for example by Levy (p.64)⁴⁶ it is on the grounds that ‘there is no point in non-experts becoming involved in debates which turn on matters of special expertise.’ It can be confidently stated that the Prime Minister is not an expert in the profession of nursing, but this cannot be said of managers who require the implementation of intentional rounding and the individual nurses who undertake it. To say that these individuals are experts in the evaluation and application of research is no aspirational bluster; it is a regulatory requirement necessary for initial registration and continued practice. The epistemic duty can be seen in professional codes which require professional autonomy and personal accountability, because patient care must be justified on an evidence-base. Clearly this does not apply fully where there is no available evidence, and in this case non-evidential justification is needed including a requirement for open-mindedness⁴⁷ and consideration of likely rather than demonstrated benefits and pitfalls. Trials or local implementation with specific indications could be justified on these grounds in the absence of evidence. However, wide implementation is in need of a different order of justification, and the fact that it has not been provided threatens the claims and requirements of professional practice relating to evidence utilisation. These threats constitute the third set of ethical concerns with the implementation of intentional rounding.

(3) Concerns about professional practice.

The paper thus far has taken a critical line against the quality of the evidence on intentional rounding and the way it has been used in its promotion. It is worth repeating that it is not argued that the practice of intentional rounding is necessarily unethical in itself. The data suggest that rounding is popular with patients and relatives, albeit that patient satisfaction is not a good measure of quality of care. It is plausible, though no more than that, that the practice, variously implemented, may also improve quality in addition to perception of quality of care. It is to be hoped that a number of high quality research studies will answer questions on the effectiveness and cost-effectiveness of various manifestations of the practice. However, whilst remaining open-minded about the practice of intentional rounding, the manner in which it has been promoted illustrates tensions within the very idea of professional ethical practice.

What evidence is required?

As far as the literature for intentional rounding is concerned, it appears, *prime facie*, that articles originating in professional and managerial journals, like the ones referred to in Halm’s¹² review present evidence in support whilst the fewer but more considered papers published in academic journals are more reticent. This might be explained to some extent by the different imperatives for action. Managers seek pragmatic solutions to identified problems and especially where political and/or commercial activity is involved, this can require speedy action resulting in evaluation processes which are not as thorough as they might be. As Meade *et al.*⁹ noted it is possible that the Hawthorne effect influences results in the short term, enabling political or managerial capital to be realised. Even where evaluations are thorough and robust they are rarely reported in a way which allows critical scrutiny.

Intentional rounding has been discussed in the UK literature for at least a decade⁴⁸ and so it could be suggested that time has been available to undertake robust research prior to adoption, but it is clearly the case that it is unavailable now as momentum for large scale implementation proceeds. The gap between several small scale, management driven service evaluation studies and the desirability of larger scale studies of the sort recognised in

systematic reviews is easily identified, even where an intervention appears not to involve the risk of harm to patients. However, the apparent low cost of intentional rounding can be challenged; seconds saved from many performances of routine tasks formed a significant part of the ‘releasing time to care’⁴⁹ initiatives promoted by the Department of Health, and similarly, routinely asking all patients regardless of assessed need about their comfort and toileting needs comes with an opportunity cost unconsidered in the weak studies that form the evidence base thus far.

Evidence, Ethics and Professional Autonomy.

In the UK, Nursing claims to be an evidence based profession, consistent with the requirement that student nurses study research methods and methodology in pre-registration studies, such that they can meet the competency contained within the NMC Standards for Pre-registration Nursing Education (p.14)⁵⁰ that:

All nurses must appreciate the value of evidence in practice be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.

This document also states that ‘All practice should be informed by the best available evidence and comply with local and national guidelines’ (p.17)⁵⁰ Though these statements are presented as competencies, they do not set out what skills student nurses require to be permitted to register. Rather they are written as authoritarian Standards for Practice, starting with the declamatory: ‘All nurses must...’, as are Standards from *The code: Standards of conduct, performance and ethics for nurses and midwives*.⁵¹ The nature of the education standards are demonstrated by brief textual analysis; the section on adult competencies is just over 2600 words long. The word ‘must’ is used 103 times, that is on average once every 25 words. In contrast, the word ‘should’ is used just once, in the sentence ‘all practice *should* be informed by the best available evidence and comply with local and national guidelines’. It is possible that it is a simple textual curiosity that the single area of competence regulated by the normative, discursive ‘should’ in place of the directive ‘must’ is evidence based practice. The equivalent statement in *The code* uses the word ‘must’. Nevertheless it is worthy of note. Ambiguity in this sentence extends to the use of the word ‘and’ which appears to cause problems where local and national guidelines are not informed by the best available evidence. Intentional rounding falls into this category.

Initial analysis at these regulatory Standards may suggest that they represent an orthodox view of nursing as nursing as a profession based on a fully appraised evidence base. However, closer examination reveals that they can also be read to illustrate tensions reflected in the story of the implementation of intentional rounding. The definition of best practice is open to wide interpretation as is the type and quantity of evidence required. As far as intentional rounding is concerned, the available evidence might suggest some benefit in perception of care, but the problems identified earlier relating to transferability, staffing, desirability of promoting a reduction in call bell use and the conflation of perception and quality of care should be sufficient to question wide top down management implementation. The few articles describing implementation give no indication that the quality of the studies cited has been appraised or other factors even considered, and this makes it difficult to defend a view that ethical practice, based on the Code, is being promoted. Where intentional rounding is introduced by organisations via local policy or guidelines which do not engage with the quality of the evidence supporting them, fulfilling both of the potentially competing

parts of the competence Standard appears problematic. Individual students seeking to meet this competence, as well as nurses practising direct nursing care may find this especially challenging when applying regulatory requirement to their individual practice.

The notion of professional practice which is purportedly based on evidence which is less certain than presented or is not supportive of political imperatives is well known to nurses and others. For example, Professor David Nutt, the UK government's chairman of the Advisory Council on the Misuse of Drugs was dismissed for suggesting that scientific evidence did not support drug policy⁵² and the current and ambiguously worded advice on alcohol consumption promoted by nurses is based on evidence nearly 20 years old⁵³. However, practicing within a political and managerial environment does not require nurses to condone its acknowledged imperfections and fallacies.

Autonomous practice is one of the defining features of what it is to be a professional⁵⁴ recognised elsewhere within the Standards for Education; 'All nurses must practice autonomously...(p.17).⁵⁰ Regardless of the amount and quality of evidence for the interventions discussed in this paper, the tension between the application of evidence for personal professional practice and the larger institutional practice of employers, which may or may not be based on evidence is not fully represented in the simplistic view that a literal reading of these regulatory standards suggests. Commercial pressures in the US, and political pressures in the UK will inevitably remain features of healthcare environments. It would be absurd and naïve to argue that this is not the case or should not be the case. However, the examples discussed in this paper illustrate some points which should focus the attention of nurses, managers, politicians and regulators to the question of what professional nursing practice is. Professional autonomy cannot justify individual nurses always acting alone or solely for their patients independent of other patients and the system providing the care. However, neither can the very idea of autonomous professional practice, not least that promulgated by regulators, be sustained in a political and managerial culture which seeks to impose practice, especially insofar as this applies to all patients regardless of assessed need, justified on the flimsiest of evidence uncritically presented.

Guidance from National Institute of Health and Clinical Excellence⁵⁵ states that all healthcare professionals should assess pain and provide nutritional support, something that is ingrained in professional nursing practice, but this document also notes that patients value individualised care, 'tailored to the patient's needs and circumstances'(p.11).⁵⁵ More recent literature from the US⁵⁶ recommends the abandonment of routinisation in intentional rounding, and some UK NHS organisations⁵⁷ are implementing rounding only for patients assessed as requiring it. However, the manner in which intentional rounding has been advocated and introduced thus far speaks against individualised patient care which has hitherto characterised the notion of professional nursing practice.

Conclusion

From a UK context, this paper suggests some ways in which political and managerial imperatives impact upon professional ethical nursing practice. The discussion has indicated a number of tensions and dissonances⁵⁸ within nursing which are probably under acknowledged in official documentation. These tensions result in politically driven practice developments being presented as though based upon on a sound evidence base. However, when challenged, the evidence base for intentional rounding is found to consist almost exclusively of weak studies, serial errors in reporting and failure to question basic

assumptions about outcomes. It could well be that intentional rounding is an effective intervention and though further evidence and more nuanced application is required, it seems unlikely to be provided in an environment in which professional considerations yield apparently uncomplainingly to political and managerial imperatives.

Recent concerns about the quality of care in UK hospitals¹ has apparently justified attempted political micromanagement in nursing practice, (as opposed to regulation), despite the stated policy of empowering health care professionals⁵⁹. That government recognises the need to placate the notion of professional nursing practice is implied by the attempt at evidentiary justification as discussed in this paper. That nursing managers appear to have so readily adopted the interventions in the absence of robust justifying evidence speaks loudly of nursing's insecurity as an autonomous profession. And wide and uncritical introduction of the practice may place an unenviable burden on practicing nurses caught between a managerial culture and a desire to follow ethical codes of practice relating to research appraisal and application. The conclusion of this paper can be presented simply; If nursing is going to use evidence, including research, to justify wide implementation of practice development then it is unprofessional not to do it properly. If, on the other hand, nursing is not going to use evidence in this way then it is unethical to claim that it is.

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Declaration of conflicting interests

The Author declares that there is no conflict of interest

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