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Feature

Rounding, work intensification and new public management

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In this study, we argue that contemporary nursing care has been overtaken by new public management strategies aimed at curtailing budgets in the public hospital sector in Australia. Drawing on qualitative interviews with 15 nurses from one public acute hospital with supporting documentary evidence, we demonstrate what happens to nursing work when management imposes *rounding* as a risk reduction strategy. In the case study outlined rounding was introduced across all wards in response to missed care, which in turn arose as a result of work intensification produced by efficiency, productivity, effectiveness and accountability demands. Rounding is a commercially sponsored practice consistent with new public management. Our study illustrates the impact that new public management strategies such as rounding have on how nurses work, both in terms of work intensity and in who controls their labour.

Key words: accountability, effectiveness, efficiency, new public management, nursing care, productivity, risk, rounding, work intensification.

In this study, we argue that contemporary nursing is driven by the dictates of new public management (NPM), rather than patient-centred care. In making our arguments, we draw on research conducted in South Australia, specifically data on missed care, and illustrate how nurse managers in one public hospital have responded to this through mandating rounding. The study begins with a brief overview of rounding and then proceeds to outline the major tenets of NPM as it has rolled out in the Australian public health sector. Following an overview of the methodology used for this study, we detail the way nurses experience rounding at the ward level. In the final section, we argue that rounding as a NPM strategy reduces nursing to a time and task set of activities that impact negatively on the nurse–patient relationship.

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Rounding: risk and patient satisfaction

Hourly or intentional rounding has gained prominence in the past few years in the nursing literature as a result of being introduced into a number of hospitals, first in the United States, then the UK and more recently in Australia (NSW Health 2012). In the UK, rounding was proposed as one response to the 'lack of care' identified in the Francis Report (2013) and a host of subsequent inquires on the state of care in the NHS (Royal College of Nursing 2013). Presented as a strategy that places the patient at the centre of the ward routine by taking care back to the patient, rounding involves nurses carrying out regular and standardized checks, on all patients at set intervals to assess and manage their fundamental care needs (Dix 2012). It is an auditing mechanism

to purposefully keep patients safe and comfortable and constitutes 'a bundle of interventions' that meets the Nursing Intervention Classification (NIC) criteria of definitions for nursing care work (Halm 2009). The purported benefits of rounding are 'an opportunity [for nurses] to involve patients in their care, and [to] show care and concern for patient well-being and healing' (Tea, Ellison and Feghali 2008, p. 327–8). As a practice, rounding ensures the nurse touches base with the patient at regular intervals and it is viewed as a means of reducing the use of call bells and patient falls (Halm 2009; Krepper et al. 2012) and as a consequence reduces the demand on nursing time (Snelling 2013). Rounding centres on four or six elements of patient surveillance, however, it is the 4Ps that dominate rounding practices reported in the literature (Halm 2009; Dix 2012; Snelling 2013). In the United States, the 4P's cover – *pain, position, potty [elimination] and possessions* (Studer Group 2007), while in the UK, the 4Ps are understood as *positioning, personal needs, pain and placement* (King's College London 2012; Snelling 2013). In the Australian context, rounding may include *personal, pain, position and proximity*, or variants of this such as *pain, position, possessions, pan and plugs* (NSW Health 2012).

Rounding is located within wider context of safety and quality in healthcare delivery with patient or consumer satisfaction paramount (Studer Group 2007; Woodward 2009). A number of commentators attribute rounding to the work of Quint Studer and the Studer Group (Blakely, Kroth and Gregson 2011). However, the first formalized, managerially imposed approach to rounding is reported by Seedy (1989). In this study, hostesses were employed to respond in a timely and friendly manner to patient call bells and address all non-medical or non-nursing requests. Intentional rounding in the United States was introduced as a way for hospitals to improve patient experience scores required as part of funding eligibility (Blakely et al. 2013). The Studer Group advanced this concept by tying it to the Medicare and Medicaid standardized patient satisfaction survey H-CAHPS (Hospital Consumer Assessment of Health Providers and Systems). In 2007, H-CAHPS became mandatory for all hospitals in receipt of Prospective Payment System funding for publicly funded Medicare and Medicaid patients as part of the deficit reduction strategy. More recently under the provisions of the Patient Protection and Affordable Care Act (often referred to in the critical public press in the United States as Obamacare), survey results are one of the criteria for access to incentive-based funding (Centre for Medicare and Medicaid 2015). The contribution of the Studer Group was to develop two tools that worked hand in glove; these were the rounding and the H-CAHPS toolkits (Studer Group 2015a).

The key to understanding the flaw in rounding as an approach to care is the Studer toolkit. Both the H-CAHPS and rounding toolkits work off standardized verbal texts, actions and procedures. For example, a recommended text reads: 'Our goal is to provide you with very good care which includes rounding on you each hour to manage your pain, assure you are comfortable and offer assistance to the bathroom. How well are we doing?' and the various lanyards, posters, charts and thank-you notes used to act as prompts or strict guides to report completion of tasks (Studer Group 2015b). The second difficulty for nurses is that these practices are performed in response to managerial fears about adverse events, or failure to meet productivity targets. We suggest that as a consequence, these rote-like practices lack the genuineness and integrity seen as core to total patient–nurse care interactions.

Rounding as a new public management strategy in the Australian context

In this study, we suggest rounding is a contemporary technique of NPM. Within the Australian context, NPM is understood to have its origins in economic rationalism and public choice theory (Willis 2009). While the influence of the UK Thatcher-led reforms, particularly those of the NHS, are highly significant, Pusey suggests that for Australia, the major influence was free market US economic theory which draws on rational choice theory (people always act in their own interest) and laissez-faire economics (Pusey 1991). While economic rationalism does not eschew equality of access as the first principle of welfare and government services, it positions economic considerations as the more rational and scientific approach to achieving equitable political outcomes. Essentially, Pusey argued that the federal bureaucracy was dominated by young conservative economists who had more trust in the market and the science of economics, than in building the nation-state. In the view of conservative economists, the current system gave too much power to organized labour through the union movement, legal restrictions on working conditions and restraints on business. A highly rule bound public sector, and a political system that imposed severe restrictions on economic activity meant services such as hospitals, schools, electricity, transport and water utilities were inefficient. Solutions included privatization or the introduction of market-like practices into the public sector (Gruening 2001; Ferlie, Hartley and Martin 2003).

Pusey (1991) argued that the conservative economists in the federal administration had significant influence on both the coalition and labour governments in deregulating the Australian labour market and the economy. In transferring

these ideas into the public sector and the management of the welfare state, such as the public hospital system, they took up a number of ideas then in vogue in large corporations, arguing that reform of the welfare and nation-state could be achieved if the bureaucratic system operated like the private sector with its focus on competition as the driver of innovation, high productivity and efficiency (Ferlie et al. 2003).

Proponents of NPM claimed that competition generated high levels of efficiency and productivity through continuous quality improvement and innovation – all necessary to maintain market share or in the case of the public sector, reduce the budget. Simulating these mechanisms within the public sector, particularly hospitals, enabled them to become more productive and to respond to innovation and efficiency reforms without long lag times common to large public government-run hospital bureaucracies (Bejerot and Hasselbladh 2013). There were of course other factors impacting on the move to curtail public welfare state spending; the most glaring being its massive growth in welfare spending in the postwar period and a series of recessions, and as Gruening (2001) notes, a wave of movements focused on reforming public sector administration.

In Australia processes for simulating, markets within the public hospital system began in earnest in the mid-1990s in response to the Federal Labor National Health Reform led by Jenny Macklin (Stanton, Willis and Young 2005). This resulted in extensive budget cuts, the shift from historical to outcomes and casemix funding, and the introduction in 1996 of localized or enterprise bargaining based on what the employer said they could pay, rather than centralized wages fixation. These agreements bound workers to increased productivity and efficiency as part of what was traded off in lieu of wage increases. New public management also included excessive contracting out of public services to the private sector, and in some cases, privatization of what came to be known as non-essential hospital services such as cleaning, catering, pathology, and radiology, and increasing attempts to shift the costs to the consumer through user pays or co-payment increases as is the case with the Pharmaceutical Benefits Scheme and recent GP co-payments proposed by the current Federal Coalition. The classic phrase was that governments would steer now, rather than row (Barlow and Röber 1996). This often translated to contracting out the service to a private provider, while maintaining tight control over productivity. To ensure equity of services that were still publically owned, governments were forced to introduce high levels of regulation. The establishment of quasi-government agencies regulating outsourced or privatized services such as gas, water and electricity, or supposedly setting the fair price for a surgical procedure or aged care bed has been exponential in the last 20 years, so much so that some commentators question the savings or the efficiencies (Willis and King 2011).

The various casemix tools employed to fund public sector health services required shorter length of stay, which in turn meant higher patient acuity during their episode of care. Clinicians responded to this through a series of innovations, or redesigned models of care sometimes based on new technologies and medical procedures that enhanced efficiency, but also on increased productivity. Increases in work productivity led to work intensification (Duffield, Gardner and Catling-Paull 2008; Alameddine et al. 2014). Work intensification may include numerical flexibility where working hours are adjusted to suit the needs of the industry, are casualized or split. It also includes increases in the hours of work, or in the intensity or speed or work effort (Mather and Worrell 2005). Nurses now found themselves working longer hours and at a faster pace to meet productivity and efficiency demands. There is little debate that these changes resulted in work intensification for nurses and other clinicians. Copious research, campaigns and industrial agreements have illustrated the impact of NPM strategies on nursing and other clinicians within the public health sector in Australia and elsewhere (Dent 2005; Duffield et al. 2008).

Post-New Public Management: effectiveness, accountability and risk

There is considerable debate about whether or not NPM has run its course to the point that it is now referred to a *post-NPM* (Waring 2005; Morris and Farrell 2007). We suggest a more accurate analysis in the early 21st century is that NPM has taken on the new digital technologies that allow for sophisticated monitoring and audit, along with a heightened preoccupation with risk. Importantly, we argue that NPM mechanisms for controlling labour and state funding of welfare services such as that of nurses working in the public sector have not been replaced by quality assurance, but rather strategies of risk management and increasing audit have joined forces with NPM to create new forms of work intensity, and we argue, harsher working conditions (Morris and Farrell 2007). The introduction by nursing management of rounding is but one example of a 21st-century NPM technology. We outline this trajectory below.

The move from NPM technologies where the guiding principles were to increase productivity and efficiency in order to secure market share (or in the case of governments, to reduce the cost burden on the welfare state), to include the management of risk and risk-related policy, is a natural

progression in regimes of control, particularly in health care, and for nurses whose role is careful monitoring of the patient's illness condition. Missing from the early NPM mantra of *efficiency* and *productivity* was *effectiveness and accountability* – absolute necessities in health care. It is not sufficient to increase productivity or to be more efficient. What is required is effective treatment and accountability. These are both ethical and cost control issues (Waring 2005). While patient safety has always been a concern of the health professions, central to their sense of autonomy and part of professional regulation, under NPM control of patient safety has undergone a seismic shift. It is now more fully under the control of centralized governments at both Federal and State level through the processes of mandatory risk reduction strategies, regulation, accreditation and serial restructures purported to achieve the desired budget reductions (Commonwealth of Australia 2012). As a result, at the local-level hospital, managers now organize clinicians' work through endless attempts to redesign care and patient flow in an attempt to meet productivity, and efficiency targets, as well as achieve effective and accountable outcomes (Flinders Medical Centre 2007). Productivity and efficiency demand cost control within the organization, usually through set budgets and specific targets that must be reached to receive incentive funding. Both demands run the risk of poor patient outcomes, given that they are often achieved through reduced staffing levels, outsourcing, early discharge of patients and the outsourcing of non-essential services. This is countered by a renewed focus on quality assurance mechanisms that make the individual health professional accountable for effectiveness and make the performance of the hospital a matter of public record (National Health Performance Authority 2015).

Previously, the problem of professional control of patient safety was defined as either one of ethics or lack to nursing knowledge. Professional control is now understood as managerial control where managers take the lead. The shift arises partly as a result of the capacity of digital technologies to aggregate the data on errors and adverse events and estimate the costs, but also because of developing sophistication in the field of risk management. Identifying the root cause of adverse events requires first, detailed and standardized reporting of errors and incidents, and second, highly detailed process analysis. It also calls for solutions. Solutions provide managers with insight and some control over the very organization of nurse clinician's work and give them access to domains once thought the preserve of the profession of nurses. Rounding, with its precise and detailed verbal scripts, procedures, posters and lanyards, fits this neatly as we illustrate in the case study below.

METHOD

Data for this study come from a larger research project examining missed nursing care. The first part of the study was an electronic survey conducted through the Australian Nursing and Midwifery Federation South Australian Branch (ANMFSA) portal using a modified version of the Bernice Kalisch's MISSCARE tool (Kalisch and Williams 2009; Blackman et al. 2015). In the second phase, we sought permission from the directors of nursing in two public hospitals to conduct qualitative interviews. In all, 21 interviews were conducted, although we only report on 15 from one hospital in this study. We placed advertisements in all wards requesting nurses interested in participating to contact us directly for a confidential interview. The call for participants clearly linked our study to the concept of missed care, but also made special mention of our interest in talking to nurses in middle management who worked non-standard shifts.

Our interview questions were aimed at eliciting from these nurses descriptions of their everyday work experiences, with the starting point being the concept of missed or rationed care related specifically to shift times and the nurse's role. The survey results gave us data on what care nurses thought was missed and why, but it did not spell out in detail how this occurred. By commencing interviews with a focus on missed care respondents reflected on the issues as they experienced them. It was during these interviews that we became aware that the hospital had recently instigated rounding across all wards. From these descriptions, we were able to identify policies and procedures and to hear nurses describe how they adhered to or navigated around them. The questions also elicited stories of nurses' actions when risk management policies conflicted with the needs of their patients. As a consequence of discovering rounding had been introduced, we gathered relevant policy documents, charts and notes used in the hospital at that time and other publically available data on the hospital that outlined resources or performance. Six of the documents gathered in this study related to rounding. These were a survey completed in November 2012 evaluating the rounding trial, two sets of data on compliance: one for July and October 2012, an additional chart recording compliance by ward or unit, the nurse's observational chart, a patient information sheet on rounding and the briefing sheet provided to nurses. These documents are used as supporting evidence where applicable.

The fifteen nurses interviewed were experienced registered nurses. All except three had nursed for over 10 years, with the three having 2 to 5 years' experience. The majority worked after hours, either as senior managers, clinical nurse consultants or hospital-wide intravenous nurse specialists, after-hour bed coordinators, or in specialized units. All interviews occurred outside their working hours. The second author conducted all interviews. Interviews were audio-taped, transcribed and put onto the shared drive for team members to read and analyse. The analysis followed a thematic approach, although it needs to be stated that not all interviewees devoted the same time to the concept of rounding or elaborated on the concept, so quotes are limited to those who expounded on its benefits or flaws at length. As we became aware of rounding, we directed interviews towards understanding how it operated. Initially, we isolated all the comments on rounding and then organized them according to themes in order to understand how nurses viewed this practice. This thematic analysis was driven by an overall view that nurses' work was increasingly intensified. Hence, our analysis sought to uncover how rounding contributed to work intensification either in a positive or negative manner.

Ethics approval was gained from both the Flinders University Social and Behavioral Research Ethics Committee and the South Australian Health (SA Health) Human Research Ethics Committee.

RESULTS

Setting the context: New Public Management in the South Australian context

The introduction of rounding into the case study hospital was motivated by a range of external events. A major factor was budget constraint. In 2012, the state government concerned that it would not be able to fund the public hospital system, given the shortage of funds from the Commonwealth, engaged KPMG (2012) and Deloitte Touche Tohmatsu (2012) in a Budget Performance and Remediation Review. The Deloitte's assessment of nursing resource utilization costs for the public sector for 2012 to 2015 included the major public acute hospital that formed part of our study. The Deloitte analysis estimated a deficit of $37 million over the period 2009 to 2012. The report is indicative of new public management text in identifying the following problematic issues in nurse staffing; a failure to use the prescribed union negotiated enrolled nurse to RN ratios (30/70), overly generous handover times of 2.5 hours a result of 10-hour shifts that do not accord with peer hospitals in other states, lack of control of overtime costs, higher nurse staffing levels in comparison with peer hospitals in other states, a decline in nursing productivity since the last workplace agreement, an increase in flexible work practices, including part-time staff which increases the numbers entitled to non-productive professional development time and other entitlements, higher levels of sick leave among nursing staff and longer patient length of stay in comparison with interstate peer hospitals (Deloitte Touche Tohmatsu 2012). A secondary factor influencing the introduction of rounding was a growing awareness that nurses were rationing care as a result of work intensification, despite the fact that the recently appointed director of nursing had made considerable improvements in nurse–patient staffing levels (pers comm director of nursing).

Managing nursing work: Introducing rounding

Rounding was introduced across the hospital site in 2012, 6–7 months prior to our interviews, and was an established practice when the majority of the interviews occurred. In later interviews, it is evident that the hospital's rounding mandate was occurring more sporadically as a new model of (re)embracing 'fundamentals of care' was promulgated. Rounding at this site was an hourly practice entrenched in a 'rounding chart' or log. The chart focused on the 4Ps: personal which relates to toileting, pain, positioning and proximity, and required that nurses ask patients hourly, day and night, whether they wanted to go to the toilet or had pain. Nurses were provided with a lanyard or badge to wear that illustrated the 4Ps. This lanyard was a memory prompt reminding nurses to note the patient's positioning within the bed (e.g. which side the patient is lying, right or left) and to record that all items such as the call bell, and tissues were within patient reach.

We examined the six documents that related to rounding for what they told us about the practice. A 'Patient Information Sheet' was provided to all patients on admission, suggesting that rounding would enable them to leave all queries about their care and progress to these hourly visits. The success of rounding was evaluated in-house through pre- and post-implementation patient satisfaction surveys conducted between May and November 2012. Patients were asked to rate their satisfaction with nursing care on a five-point Likert scale. Nurse courtesy showed only a 3% improvement, while the question directed towards measuring increases in nurse responsiveness to patient demands indicated a decline of 5% for *very good* and an increase of 8% for those who thought nurse responses were *good*. Conversely, when patients were asked whether nurses were caring, there was a 4% increase over the 6-month period for *very good*, but a decrease of 5% for *good*. Similar results were obtained for questions dealing

with patient's satisfaction with health professional–patient communication. Pre- and post-test results showed minimum improvements, with fewer patients rating communication *very good* post rounding (58–55%). In response to the question asking patients if they had had adequate responses to questions about their illness, there was a 10% increase for those who thought this was *good*. There was a 9% increase in patients who felt pain management was v*ery good*, but a 6% decline in those who reported nurses responded promptly to call bells, and a 4% decrease in those who felt they were in easy reach of their personal items. In a similar manner, there was a 2% decrease in those who felt their mobility needs were met in a manner that could be rated as *very good*. Nurse compliance with rounding logs slipped from 89.4 to 85.7 between May and October with 13 of the 26 wards/units recording lower compliance rates at the end of the period.

Rounding as risk management

Rounding was introduced at this site as a means of reducing risk for the patient and the organization through preventing critical incidents but also as a means of improving the quality of care and patient satisfaction through ensuring that basic nursing care was attended to. One senior nurse in commenting on the introduction of rounding identified it as a response to a perception by the director of nursing (DoN) that falls were occurring when patients were not toileted regularly.

> I know that [the DoN] was quite appalled that this sort of stuff wasn't actually going on or she perceived it not to be going on, and this was actually contributing to the amount of falls that were happening in the hospital. . .she felt that if they were doing regular rounding then there would be more efficient use of nursing time
>
> (Interview #7)

The association of rounding with risk prevention was also evident in the manner in which a senior manager who was instrumental in the introduction of rounding described its purpose:

> . . . it's just about containing complications, or trying to sort of don't make them bigger than what they can – just sort of you know, pre-empting conditions and stuff.
>
> (Interview #8)

Nurses also suggested that rounding and the accompanying documentation provided legal evidence that care was delivered. There appeared to be some confusion as to whether the rounding chart was a legal document as it was not assigned a record number for inclusion in the patient medical record. The manager cited previously viewed the rounding chart as a legal document carrying similar weight to a statutory declaration.

> [It is a] stat dec that the nurse has actually seen that patient and when they've seen it they've signed it, and so with safety and quality with some of the incidents now, they can say well that patient was seen at 1.15, and that that patient was okay
>
> (Interview #8)

Another senior nurse argued against retention of the rounding chart in the medical record as it documents care that should already be occurring. She stated:

> . . . it's basic nursing care, toileting, pain relief, fluids, comfort, is basic nursing care, to what point do we need to document this . . . this is what I do as a job
>
> (Interview #7).

As such, the rounding chart may be of questionable legal value.

Rounding as a means of promoting 'patient-centred' nursing care

A second purpose of the rounding chart is to promote quality patient care through ensuring basic care needs are met. Meeting basic care needs is at the centre of current nursing policy in South Australia. The Nursing and Midwifery Strategic Framework 2013–2015 prioritizes 'caring with kindness' which places patient-centred, fundamental care delivered at the bedside at the centre of nursing practice. Rounding is viewed by ward nurses as a response that ensures patient centredness. A nurse notes that the director of nursing promotes the concept of patient centredness and as a consequence 'everything you do has to be patient focussed – everything you say has to be patient focussed' (Interview #3). However, it does not require direct personal contact with patients, only regular observations. As noted by the one nurse, the predetermined scripts strip them of authenticity; 'the early rounding was designed to set a culture of ensuring your patients were checked at numerous times during the shift' (Interview #16). This approach is reflected in the manner in which the nursing manager who was instrumental in introducing rounding talks about it. She stated:

> I mean from a safety and quality thing for the patient, being with the patients – we want people to have toileting regimes and we want people to have pain relief – because a lot of patients when you talk to them – that they see the nurse is busy and they don't want to press the bell, but if you go and ask them what would you like, well then, they are more likely to respond. Oh yes, that's good, well now it's my time or my turn

(Interview #8)

Ward nurses, however, questioned whether rounding was patient-focused. One nurse argued that it resulted in treating 'every patient the same' (Interview #7), while another noted that it can be intrusive, particularly for younger patients to be approached hourly.

> ..it's hard with [our] patients because they're usually nocturnal, so if you're doing an early they'll tell you to "#*@# off" if you bang on the door every hour, and so we're documenting 'refusing rounding'
>
> (Interview #15).

Rounding as an efficiency measure

Rounding is also presented by senior nurses as a means of increasing efficiency via reducing demands on nursing time through being 'proactive in the care rather than reactive' (Interview #8) and meeting patient needs before they escalate. Another senior nurse stated that rounding ensures that

> . . . everybody is okay, and they have got their call bell and they don't need to go to the toilet and they're not in pain – and if you pre-empt things then your workload decreases and if you have made sure everybody has got their pain relief and made sure they have got up and gone to the toilet then you're not changing a wet bed and you're not picking someone up because they have fallen over
>
> (Interview #3).

Conversely, it is viewed by ward nurses as time-consuming with nurses arguing that it created rather than reduced nursing workload. Participants identified both the time taken to complete and document a round and the timing of rounds as problematic. One nurse stated that

> . . ..we have too many pieces of paper, and you just don't have time to fill in 25 bits of paper for 1 patient, when you've got 9 of them. It becomes, a nonsense
>
> (Interview #11).

For another nurse

> . . .sometimes it's really hard to physically get around and do those hourly rounding's, just because, it takes an hour and a half to do a dressing, well they're an hour and a half, you're not going to get around again
>
> (Interview #10).

Despite the time taken to undertake rounding, it is not factored into workload as it is considered fundamental nursing care. The nursing manager who introduced rounding notes that attempts to factor rounding into staffing numbers through the hospital's patient classification system (Excelcare) were unsuccessful potentially increasing nursing workload.

> It did go to the Union about it, because they said that we didn't do timings on Excelcare for rounding, because it's basic nursing care, and that, was what they should be doing anyway. . . So it's a basic nursing; it's under that umbrella of basic care, and should be incorporated in that, not extra
>
> (Interview #8).

As a consequence, nurses admitted that rounding was either omitted or the documentation completed at the end of the shift. An experienced nurse who had recently retired describes her experience in completing rounding documentation

> . . .. I'd go around and I'd forget so I'd lie about which way they [patient] were facing quite honestly . . . it's not a legal document, there's no time in it, . . . I just didn't do it
>
> (interview #1)

Rounding as regulating nursing practice

For many ward nurses, rounding is also viewed as a means of regulating nursing practice. A nurse describes rounding as being about 'checking that the nurses are checking the patient' (Interview #1). Senior nurses objected to the documentation of rounding arguing that regular observation of patients has always been an element of good nursing care. One ward nurse stated that

> I think people get frustrated with it [rounding]. . .I think that most nurses that were very good nurses anyway did it without thinking, and that element is in their nursing care anyway
>
> (Interview #10).

For other nurses, the practice of rounding devalues nursing work through focussing upon processes rather than professional judgement. A senior nurse stated 'I don't think nursing is about performing a process I think it actually downgrades what we do, I think it doesn't acknowledge that we are able to critically think' (Interview #7). For this nurse, rounding is 'very policy driven [and] detracts from what we are actually trained to do' (Interview #7).

DISCUSSION

Rounding has been identified in the nursing literature as a means of ensuring high-quality patient-centred care that

occurs through focusing upon the basics or 'fundamentals of care' (Studer Group 2007). We argue that rounding needs to be understood in the context of NPM and maintenance of care standards in the light of work intensification. Rounding as a standardized risk management practice entrenches the practice of continuous patient audits, but it also requires the nurse to audit their own practice. For Hillman et al. (2013, p. 951), the introduction of these practices seeks to manage the 'secondary risks' of litigation: failure to meet performance targets and reputational risk. The introduction of rounding in this study is explicitly associated with management of risks to the patient and to the organization arising through tasks not being undertaken. Thus, one respondent identifies rounding as a response to the risk of falls occurring when patients are not toileted regularly. The auditing of the performance of tasks identified as 'basic nursing care' implies that these tasks are viewed as not occurring regularly, a perspective which is confirmed by a senior nurse who argues that rounding was introduced to develop the practice of viewing patients regularly. The use of rounding as a tool to manage risk to the organization is evident in the manner in which the rounding chart is viewed as a legal document even though it is not part of the medical record but also in the conduct of pre- and post-implementation patient satisfaction surveys. What is not explored is why nurses are missing these essential nursing tasks.

In short, rounding reproduces the problems it set out to solve: that of missed care arising from work intensification. The focus on rounding as a risk assessment practice suggests managers are aware that nurses ration care in response to work intensification. This is not new, nurses have always prioritized the tasks they need to do for patients, omitting some, delaying others to be taken up by the next shift or modifying protocols to get the work done in a timely fashion (Harvey et al. 2014). As Campbell and Rankin (2006) note, rationing care is 'a professionally sanctioned method of nursing decision-making'. Making the judgement about what care can be omitted or delayed requires expert knowledge of the patient's illness. It is a key competency novice nurses are expected to develop (Gillespie and Paterson 2007). However, as we argue, rationing care has moved to *missed care* understood as care that is missed because the work intensity does not allow time for the task to be completed (Willis et al. 2015). Managers respond to this by tightening the various forms of audit and control.

Rounding represents a formalized workplace strategy of NPM of the 21st century. Initially, managers moved to implement efficiency and productivity gains through trimming available resources, be it services or staff. There is adequate evidence that this led to work intensification, rationed and missed care and in some instances adverse events (Royal College of Nursing 2013). In response to these unpredicted outcomes of NPM, accountability and effectiveness were introduced as two further goals or targets to balance out the negative impacts of productivity and efficiency regimes which had intensified the labour through shorter length of stay and in some instances reduced the quality of care through omission of care. Rounding represents a practice to ensure effectiveness and accountability that resides with the nurse. It is usually a managerially imposed practice, has a strong focus on prescribed and standardized approaches and practices to the work, is highly audited and reduces the work to a set of routine tasks (Blakely 2011).

Rounding is also viewed by management as an efficiency measure which will reduce nursing workload through preempting patient needs. Indeed, the literature suggests that rounding may be a means not only to reducing critical incidents but also the use of call bells (Studer Group 2007; Halm 2009; Krepper et al. 2012). In practice, rather than being an efficiency measure, rounding is viewed by ward staff as increasing work intensification by enforcing hourly rounds. Rounds are not factored into nurses' workloads as they are designated by managers as 'fundamental care'. The hospitals own evaluation of the rounding, conducted independently of our research confirmed these findings. Rounding did not reduce call bells. The timing of rounding is also problematic as it requires nurses to organize their work around the completion of hourly rounds, shifting the control of nursing time from the nurse to the manager. Rounding charts, like handover sheets, are a textual tool that order the activities of nurses, by nurses, '(pre) organizing' their work from moment to moment, hour by hour, shift by shift and indeed from 1 day to the next leading to nurses 'nursing' hours (Toffoli 2011, p. 255).

Further, the introduction of standardized risk management practices potentially reduces the discretion of nurses through systems which focus upon quantifiable aspects of care over tacit and intuitive knowledge (Hillman et al. 2013). The process of auditing makes visible those aspects of care which can be quantified in the process, both individualizing accountability for the quality of services but also decreasing trust in the practitioners who deliver that care (Nettleton, Burrows and Watt 2008). These strategies erode professional autonomy through subjecting professions to targets established by funding agencies external to the profession (Dent and Whitehead 2002). They are rationalized by arguing they add value to patient care.

Many experienced nurses in this study, while not objecting to rounding per se, view the documentation of this prac-

tice as insulting and as undermining their professional judgement. As a consequence, the paperwork is often poorly done with compliance with rounding falling off over the period of its implementation. Poor completion of the documentation demonstrates 'the development of what Power (1997, p. 12) describes as 'new motivational structures' [that] develop to cope with being audited'. In this case, these strategies effectively negate the purpose of introducing rounding.

A focus upon task performance also potentially impacts on nurse–patient relationships. Hillman et al. (2013) argue that nursing practices that focus on the auditing of risk potentially dehumanize that care leading to defensive practice. Rounding is presented in the literature and by the nursing management in this hospital as promoting patient-centred care (Meade, Bursell and Ketelsen 2006; Blakely et al. 2011). But we would argue that it routinizes nurse–patient contact. In this hospital, for example, patients are advised on admission to save their concerns for the hourly rounds. Data from the patient satisfaction surveys suggest that this strategy has resulted in declining satisfaction with many aspects of care including prompt answering of call bells. The process of standardization of practice also presumes that all patients have the same needs. This is challenged by nurses in this study who argue that it can be an intrusive practice for those who do not require regular pain relief or assistance with toileting.

Our evidence suggests rounding is an initiative created and implemented by hospital managers, including nurse managers, in an effort to respond to economic pressures and the way funding is tied to performance incentives in the public sector (Tiedeman and Lookinland 2004). As a consequence, rounding reduces the nursing to a set of productivity and efficiency measures, coupled with accountability to achieve effectiveness. It is both an approach to NPM and part of the fallout.

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