

The impact of pre-round meetings on quality of care: A qualitative study

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Abstract

Aim: This study's aim was to improve our understanding of the impact of pre-round meetings before ward rounds on hospital wards.

Design: Qualitative study.

Method: Focus group interviews were conducted with nurses and doctors.

Results: Participants reported that pre-round meetings provide opportunities for interdisciplinary cooperation and have a positive impact on the quality of treatment and care. These meetings offer a forum for health professionals to develop a shared understanding and to convey congruent information to the patient. However, there may be reasons for omitting the pre-round meetings before ward rounds on wards with acute admissions and high patient turnover. Continuity of those attending the meetings and attendance by consultants are needed for timely decision-making and hence, successful pre-round meetings. If health trusts establish systems promoting successful pre-round meetings, the quality of treatment received by patients has potential for improvement.

KEYWORDS

focus groups, interdisciplinary cooperation, pre-round meeting, qualitative study, quality of care, ward rounds

1 | INTRODUCTION

Pre-round meetings are conducted in conjunction with ward rounds at many hospitals. Ward rounds are complex clinical activities that are hard to define, require many different skills and have varying goals (Royal College of Physicians & Royal College of Nursing, 2012; Walton, Hogden, Johnson, & Greenfield, 2016; Willemann, Svendsen, Ankjær-Jensen, & Petersen, 2006; Wolfel et al., 2016). They are organised and implemented in different ways, but the literature describes a basic structure consisting of preparations, including the pre-round meeting, the ward round itself and activities arising from the ward round (Lees, 2013; Willemann et al., 2006).

In the 18th century, ward rounds were the sole preserve of the doctor and their main purpose was to teach students and junior doctors. From the end of the 19th century onwards, nurses started to participate in ward rounds, which began to serve a wider purpose (Willemann et al., 2006). Today, the purpose of ward rounds—and hence, pre-round meetings—encompasses several patient-oriented areas, including assessments related to diagnosis, treatment, prognosis and discharge (Flink & Ekstedt, 2017; O'Hare, 2008), as well as the traditional functions of learning and cooperation (Stanley, 1998). This is often the only time during the day when nurses, doctors and patients are all able to exchange information about diagnosis and treatment and patients consider ward rounds to be important (Cohn, 2013; Wolfel et al., 2016). Both doctors and nurses view nurses as important

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participants in ward rounds because they have specific, vital knowledge about the patients (Wolfel et al., 2016). Despite the key role of ward rounds in patient care and their long history worldwide, they have not received much attention in the research or educational literature; they are rarely referred to in the curricula or textbooks of medical and nursing degree programs (O'Hare, 2008; Wolfel et al., 2016).

2 | BACKGROUND

The pre-round meeting is an integral part of the preparations for ward rounds and is thus, an important component of their overall framework. It is where doctors, nurses and other experts exchange information about patients and receive an overview before beginning the ward round (Stanley, 1998; Willemann et al., 2006). Nurses provide the doctors with information to supplement medical histories and test results, thereby enhancing their overall understanding of the individual patients, which contributes to the discussions and decisions related to patients' appropriate care and treatment (Willemann et al., 2006). The pre-round meeting is also a time for planning and coordinating discharge and follow-up after a patient's hospital stay (Flink & Ekstedt, 2017).

As such, the pre-round meeting is a forum for discussing different aspects related to the patient's hospital stay and an opportunity to exchange ideas in clinical practice. Although some wards do not use the term "pre-round meeting," they do hold meetings with a similar function (Cooper & Meara, 2002; Foster, 2017; McBeth, Durbin-Johnson, & Siegel, 2017). Regular meetings to discuss patients, involving nurses and doctors, can be useful, partly because they offer both professions greater insight into each other's professional perspectives (Aston, Shi, Bullot, Galway, & Crisp, 2005).

However, hospital wards may face practical challenges with respect to implementing pre-round meetings, such as a lack of continuity of staff and inadequate time for preparation (Årdal, 2017; Olsvold, 2010), having negative effects on the quality of treatment received by patients. Nevertheless, as far as we know, the amount of research published on the impact of pre-round meetings on patient treatment and care is small in relation to its widespread practice. It is, therefore, important to gain a better understanding of this by learning about nurses' and doctors' experiences with pre-round meetings.

The aim of this study was to gain a better understanding of the impact of pre-round meetings on the quality of treatment and care received by patients on hospital wards. With that in mind, the following research questions were formulated.

2.1 | Research questions

- How may cooperation between nurses and doctors at pre-round meetings contribute to the quality of treatment and care received by patients?
- What are the prerequisites for a successful pre-round meeting?

TABLE 1 Overview of the study participants

Focus group	Participant and gender (f/m)	Position	Current field of work
A	1 f	Team nurse	Department of general medicine
	2 m	Nurse	Observation unit
	3 f	Cancer nurse	Cancer ward
	4 f	Lead nurse	Medicine and surgery
	5 f	Assistant ward nurse	Surgical ward
	6 f	Assistant ward nurse	Surgical ward
	7 f	Nurse	Department of general medicine
B	1 m	Consultant	Children's ward
	2 m	Consultant	Neurology ward
	3 m	Consultant	Neurology ward
	4 m	Doctor, specialist in anaesthesia	Intensive care/anaesthesia/operating theatre
C	1 f	Nurse	Neurology ward
	2 f	Nurse	Neurology ward
	3 f	Nurse	Surgical ward
	4 f	Critical care nurse	Intensive care unit
	5 f	Nurse	Orthopaedic ward
	6 f	Nurse	Children's ward
D	1 f	Consultant	Department of general medicine
	2 m	Registrar	Orthopaedic ward
	3 m	Senior consultant	Orthopaedic ward
	4 f	Registrar	Surgical ward
	5 m	Registrar	Department of general medicine

Abbreviations: f, female; m, male.

3 | THE STUDY

3.1 | Design

We chose a qualitative approach to evaluate pre-round meetings by obtaining knowledge about the participants' experiences with these meetings. Phenomenology and hermeneutics were the central philosophical bases and methodologies used for the analyses. A qualitative design is more suitable than a quantitative approach when the purpose is to obtain an in-depth understanding of different participants' experiences (Hammarberg, Kirkman, & de Lacey, 2016; Patton, 2015). We wanted to gather information from different perspectives (from nurses and doctors). We obtained data through focus group interviews with nurses and doctors engaged in clinical practice in the specialist health service. This approach, which allows

the collection of information based on participants' perceptions and experiences, is highly suited to studies with the aim of learning more about environments where many people cooperate (Carey, 1995; Malterud, 2011). Discussions between focus group members are used to generate data, and the group's interaction processes are considered part of the methodology (Kitzinger, 1995).

3.2 | Method

3.2.1 | Study participants

Thirteen nurses and nine doctors in clinical practice from two different parts of Norway (Table 1) were distributed across four focus groups. The participants were recruited by contacting the administration of the department of health trust in each of the two geographic regions. The nurses (twelve women and one man) and the doctors (two women and seven men) were interviewed in separate focus groups. The nurses had 0.5–30 years of nursing experience, while the doctors had 2–40 years of medical experience. None of the recruited participants dropped out of the study.

3.2.2 | Data collection

Focus group interviews conducted from 2013–2014 were led by a moderator and an assistant moderator (Lerdal & Karlsson, 2008). Two of the focus group interviews (A and B) were conducted 15 April 2013. The other two (C and D) were conducted 19 June 2014. The same researcher (LK) moderated all four focus group interviews, while two other researchers (IS and OTK) served as assistant moderators at two interviews each. All of the researchers (two males and one female) were educators at a bachelor's program in nursing during the study period. Two of the focus group interviews were conducted at the hospital where the participants worked. The other two were held at a university college. The duration of the interviews was between 1–2 hr. The interviews were based on guidelines from a thematic interview guide (Malterud, 2011, 2012). Each interview began with participants telling us about their own professional backgrounds and organisations and describing how pre-round meetings were conducted at their workplace. After that, the researchers followed the interview guide containing four main topics:

- (i) The impact of pre-round meetings on the quality of patient treatment and care.
- (ii) Pre-round meetings as a forum for cooperation.
- (iii) Pre-round meetings as an opportunity for learning.
- (iv) Potential to improve pre-round meetings.

This study is mainly based on data related to topics i, ii and iv.

Consistent with recommended practices, we did not simply adhere to the original interview guide (Malterud, 2011); we also asked follow-up and supplementary questions whenever we saw the need

TABLE 2 Overview of the main categories and subcategories

Organisation and practical implementation of pre-round meetings
Importance for quality
How do pre-round meetings contribute to the quality of patient treatment and care?
Factors affecting the quality of pre-round meetings
Create flow and efficiency on the ward
Importance of participation for flow and efficiency on the ward
Factors increasing or reducing the efficiency of pre-round meetings
A forum for cooperation and communication
Benefits of cooperation
Nurses and doctors' perceptions of pre-round meetings
Improvements in pre-round meetings

to do so. Audio recordings of the interviews were subsequently transcribed by one of the researchers (LK).

3.3 | Analysis

Transcripts of the interviews were analysed thematically using systematic text condensation, as described by Malterud (2011, 2012). All authors participated in the process of analysis. Based on our overall impression of the content, we outlined the topics covered in the interviews. These topics formed the basis for coding groups (categories), into which the units of meaning from the text were sorted. Table 2 shows the main categories and subcategories highlighted in this study. Then, the contents of the units of meaning in each code group were reduced to condensates in the first-person statements ("artificial quotes"), in accordance with the description of the method (Malterud, 2011, 2012). We also selected genuine quotes from the transcripts. Based on the first-person statements and the selected genuine quotes, the analytic text for each code group was synthesised (Malterud, 2011, 2012). The presentation of the results was based on the analytical text. To ensure that the results reflected the original text, we also reviewed the original transcript of the focus group interviews and the texts from the previous stages of the analysis, as recommended by Malterud (2011, 2012). This study complies with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong, Sainsbury, & Craig, 2007).

3.4 | Ethics

The study was approved by the Data Protection Officer for Research at the Norwegian Centre for Research Data (NSD, no. 33036). The regional ethics committee judged that the study could be conducted without its approval. The study participants were informed about the project in writing and the signed consent forms. The information letter also made it clear that it was possible to withdraw from the project at any time without needing to give

any reason. To protect the anonymity of the participants, their names were not used in the audio recordings. Instead, each participant was given a number that was also used for the purposes of transcription.

4 | RESULTS

4.1 | A forum for interdisciplinary cooperation may improve the quality of treatment received by patients

Both the doctors and nurses emphasised that they approach patients from different backgrounds and perspectives and stressed the importance of pre-round meetings as a forum for interdisciplinary cooperation. Various nurses and doctors also emphasised the importance of pre-round meetings for the delivery of high-quality treatment and care to patients. One experienced doctor in the department of general medicine shared the following opinions:

...the nurses have observed the patients overnight; perhaps some family members have come and had a chat. The fact that you've sort of done a bit of research on the patient before meeting him or her, that enhances quality.

(D1)

Several nurses described the pre-round meeting as an arena where doctors and nurses can learn to understand each other's perspectives and ways of thinking, as one nurse on an observational unit stated:

...you have to learn how other occupational groups think. I often think nurses have their problems that we focus on. The doctors have their problems and the solution is something in the middle. Having an understanding there, without the pre-round meeting, I think, would have made it much more difficult to figure out what we needed to focus on.

(A2)

A doctor on an orthopaedic ward emphasised the importance of pre-round meetings for consensus between professions, with all members of the team communicating the same information to the patient:

....you get as much consensus as possible and then the patient has one regimen to follow.

(D2)

Though most participants in the study expressed a need for team communication before visiting the patient on the ward round, there were some differences based on their experiences, as to the extent pre-round meetings were perceived as being necessary for their ward.

A highly experienced nurse on an intensive care unit expressed it in the following way:

I think that it [the pre-round meeting] is absolutely vital for the quality of nursing... We interact very closely with patients around the clock. We are the ones who observe, who see any changes....

(C4)

A doctor, who was a specialist in anaesthesia, working at an intensive care unit in another hospital, had a similar opinion about the importance of the pre-round meeting:

...and it is very important for us, at least to have a time of day when everyone can discuss such difficult things. It [the pre-round meeting] is really important for that.

(B4)

In contrast to the other participants in the study, one highly experienced consultant on a neurological ward for the treatment of acute patients had stopped conducting pre-round meetings many years ago, but continued with the ward round. This was related to the fact that he worked on a ward with high patient turnover:

We go straight to see patients and the reason for that is that we're dealing with acute patients. So it's an acute situation. I don't see much point in sitting down to discuss it before we've seen the patients ... so much can change between a discussion before seeing the patient and when you actually see the patient on the ward round....

(B3)

He also argued that going directly to the ward round was necessary for dealing with an increasing number of admissions to the ward:

...that means we get started with the ward round right away. We need high turnover for our patients because there are many admissions.

(B3)

A nurse, working in an observation unit, also dealing with acute admissions and high patient turnover, shared different experiences. There was a high turnover of doctors in his department, with new doctors approximately twice a year. The pre-round meetings usually lasted approximately 2 hr and focused on logistics, as patients' length of stay in the observation unit was <24 hr:

...often we are more concerned with logistics, "what's next, what's next?" and "what's important to do there and then?" That's what the discussion is about.

(A2)

4.2 | Continuity, experience and structure are important prerequisites for successful pre-round meetings

Members of both professions stated that continuity of attendance by the doctors and nurses is the cornerstone of successful and efficient pre-round meetings. This requirement was met on several wards, but there was inadequate continuity on others. One nurse on an orthopaedic ward recounted her experience of a lack of continuity:

On my ward, I would almost say that the nurse leads it [the meeting]. It's the nurse who sets the agenda... That's because there's no continuity, but obviously it depends a bit on the people—which consultants are there or the other doctors. But if you're there as an experienced nurse with a house doctor in their first week, it goes without saying that the nurse leads it.

(C5)

Some of the nurses mentioned that doctors who do not have ultimate responsibility for patients are more reluctant to make decisions and that a lack of continuity can delay decisions about the treatment given to patients. The doctors reported experiences of being assigned to a new team with patients they did not know. One doctor in the department of general medicine stated the importance of continuity at a time when patient stays are becoming shorter:

I agree that continuity is extremely important because our modern health service has incredibly high turnover.

(D1)

There was broad agreement amongst the nurses that it is particularly important for consultants to attend pre-round meetings. Several nurses expressed concern about logistics, which are not dealt with adequately if a consultant does not attend the meetings. The pre-round meeting takes longer and decisions are more likely to be delayed, which can result in the patient spending a longer time on the ward. This situation is exacerbated if the nurse is inexperienced. A nurse working on a cancer ward expressed the importance of the doctor's experience:

At the moment, sometimes I don't really see the point of a pre-round meeting without a consultant and if it's a registrar who isn't very experienced, I don't always see the point of a pre-round meeting.

(A3)

A nurse working on a neurological ward stated:

One of the consultants attends most ward rounds during the week, but if this consultant is absent, patients' length

of stay might increase because decisions have not been made....

(C1)

A doctor from a department of general medicine also commented on this issue:

So, I think more decisions get made if a consultant is present...yes.

(D1)

Both nurses and doctors stressed the importance of having a structured pre-round meeting with a fixed schedule, where everyone comes prepared, respects each other and meets deadlines. However, many of the participants, including the doctors and nurses, said that in practice, this was often not the case.

Nurses from different wards reported that pre-round meetings were often disrupted by doctors having to come and go. If a doctor had an operation or had to prioritise treating outpatients over the pre-round meeting, the house doctor or registrar assumed responsibility. This led to decisions being delayed, which could have affected the treatment received by the patients and disrupted the logistics of the ward. One nurse on an orthopaedic ward saw it like this:

...when you have a pre-round meeting with a registrar or a house doctor, there are loads of things that don't get decided, which the consultant needs to decide, but they're performing an operation. So things don't get decided until much, much later in the day, instead of being decided upon first thing in the morning. That's a problem; it really is.

(C5)

Several doctors agreed that pre-round meetings suffer when outpatient work is waiting and that it is distracting to be on call with a pager during a pre-round meeting. In those cases, the pre-round meeting is often deprioritised, which can affect the quality of treatment received by patients. One doctor on an orthopaedic ward shared the following opinion about how pre-round meetings and inpatients are prioritised in practice:

In spite of us emphasising how important it is, they're the first things to be ditched if you're in a hurry. Then you run off to handle more urgent matters and the ward has to wait.

(D2)

Doctors on a department of general medicine (D5 and D1) and an orthopaedic ward (D2) argued that it was necessary to establish a system to guarantee the structure of the pre-round meeting and a smooth workflow on the ward. They emphasised that hospital finances and the quality of treatment would benefit from this. A registrar at one of the departments of general medicine stated:

I think that it is very important to establish a system that allows things to be done in the right way. In other words, you need rotas and work schedules that enable the right people to attend the pre-round meeting... the ward must have a work culture where everyone turns up on time and does what they're supposed to do and then you can finish when you've covered everything or at the set time, ensuring a smooth workflow.

(D5)

5 | DISCUSSION

The aim of this study was to gain a better understanding of the impact of pre-round meetings on the quality of treatment and care received by patients on hospital wards.

5.1 | How cooperation at pre-round meetings may contribute to quality of care

Most doctors and nurses in our study stated that pre-round meetings have an important impact on the quality of patient care and stressed the importance of reporting patient observations. We found that most participants from different wards considered holding a meeting before visiting patients on the ward round to be an important opportunity for doctors and nurses to meet and acquire a fuller picture of the patient's situation. This finding is consistent with those of previous studies (Årdal, 2017; Aston et al., 2005; Willemann et al., 2006).

Our study shows that this cooperation between nurses and doctors during pre-round meetings contributes to quality of care by giving health professionals a better understanding of each other's roles and ways of thinking and thereby, a shared understanding. Participants also stated that is vital for all members of the team to convey the same information to the patient, which was emphasised in different ways by representatives from the different wards.

Doctors and nurses may have different perspectives on clinical situations, so an understanding of each other's roles is important for optimising the treatment received by patients (McKay & Narasimhan, 2012; Walton et al., 2016; Willemann et al., 2006). A United States report showed that communication failure is involved in 30% of medical malpractice cases and that 44% of miscommunications leading to medical errors occur in inpatient settings (CricoStrategies, 2015). Consequently, good cooperation on the ward is essential for providing high-quality treatment and care, and our study shows that pre-round meetings may enhance this cooperation by contributing to the understanding of other professionals' perspectives.

Nevertheless, the meaning of good cooperation may differ amongst health professionals. For doctors, implementing medical decisions effectively is an important measure of good cooperation.

To nurses, on the other hand, good cooperation means to be appreciated for their contributions to the patient's overall situation and coping (Krogstad, Hofoss, & Hjortdahl, 2004), indicating that doctors and nurses' perceptions of cooperation during pre-round meetings may differ. With that in mind, understanding each other's perspectives and ways of thinking is an important contribution to the quality of treatment and care received by patients.

Although this study clearly indicates that pre-round meetings enhance the quality of treatment and patient care, the need for such meetings may vary between wards. As with previous studies, there were differences in how pre-round meetings were conducted (Årdal, 2017; McBeth et al., 2017; Stanley, 1998), specifically in both the structure and duration of the meetings, which might have reflected the ward size, ward structure or patient group (Årdal, 2017; Hougaard, 2014). The aims of the ward round might also be a factor (Walton et al., 2016). One of the wards where the pre-round meeting seemed most essential was the intensive care unit. The reason why both representatives (one doctor and one nurse) from the intensive care units emphasised the importance of pre-round meetings might have been related to the complexity of the clinical situations requiring thorough discussion amongst the doctors and nurses from the ward, as well as participants from other departments of the hospital.

Nevertheless, there might be reasons for not holding pre-round meetings, as described in one of the study's examples. Although decisions about treatment and care are often made at pre-round meetings, they may be revised after the doctors have seen the patients during the ward round (Hougaard, 2014; Willemann et al., 2006). This is more common on wards with many acute cases and a high turnover of patients. On those wards, it is more likely that decisions will need to be changed because doctors might not know many of the patients until after the ward round. This may explain why one highly experienced consultant in our study had stopped conducting pre-round meetings.

On the other hand, our study also described an acute ward, which was an observational unit, where pre-round meetings lasted approximately 2 hr. One reason for having a pre-round meeting on this ward was most likely the high turnover of doctors, with new doctors approximately twice a year. This may indicate that a high level of experience and continuity of doctors and nurses is needed to go directly to the ward round without attending a pre-round meeting.

5.2 | Prerequisites for successful pre-round meetings

Both the doctors and nurses were adamant that their continuity of attendance was vital to the success and efficiency of pre-round meetings. This corresponds with the findings of earlier studies showing that the continuity and stability of staffing have a large impact on cooperation and inpatient care (Årdal, 2017; Krogstad, 2006; Southey, Mishra, Nevill, Aktuerk, & Luckraz, 2014).

Several factors may reduce continuity, including the absence of the consultant due to outpatient work or scheduled operations. As operations is one of the factors, surgical/orthopaedic units might be more vulnerable. In our study, continuity seemed slightly more challenging in units where doctors had to operate. However, there were examples of both adequate continuity and inadequate continuity of attendance at pre-round meetings, both in these departments and in other departments. The study is too small to state if certain types of units have greater challenges than others regarding continuity at pre-round meetings.

In our study, participants made it clear that holding pre-round meetings without the consultant resulted in delayed decisions, potentially extending patient stays, which is consistent with the findings of other studies (Hougaard, 2014; Soliman et al., 2013). This impact is exacerbated if the nurse is inexperienced. Hence, if patient stays are extended, the number of patients on the ward may increase and thereby alter the quality of treatment and care. Other relevant factors that might have the same undesired effect include having the ward's doctor on call at the same time as the pre-round meeting or the ward nurses not knowing all the patients. If circumstances such as these mean that pre-round meetings are deprioritised, the participants' desire for structured pre-round meetings with a fixed schedule will not be fulfilled.

To deal with these challenges, the doctors, in particular, proposed that the health trusts establish a system to provide structure for pre-round meetings and facilitate a smooth workflow on the ward. This suggestion is consistent with Cohn (2013), who recommended that ward rounds be prioritised by hospitals (Cohn, 2013). In practice, this means creating rotas and shift patterns that allow continuity and ensure that participants at pre-round meetings have the necessary expertise and do not have other obligations that might interfere with their participation. Several conditions must, therefore, be met for pre-round meetings to work according to plan and to improve the quality of treatment received by patients (Table 3).

It was argued that health trusts would see benefits in terms of hospital finances and quality of treatment if they facilitate successful pre-round meetings. One important reason for this is that regular meetings of doctors and nurses can enhance their insight into and understanding of the functions of both professions, thereby improving the quality of treatment for patients (Aston et al., 2005). Looking after inpatients should be a priority task (Cohn, 2013) and on many hospital wards pre-round meetings are the most important forum for cooperation between doctors and nurses (Willemann et al., 2006). The quality of treatment received by patients is, therefore, dependent on having successful and properly structured pre-round meetings.

5.3 | Limitations

One limitation concerns the generalisability of the study. We collected information from a limited number of wards; therefore, the

TABLE 3 Factors that may contribute to a successful pre-round meeting

Establish a system that allows pre-round meetings to work smoothly
Continuity of participants
Consultant attends the pre-round meeting every day
Consider it a priority task and avoid assigning participants other concurrent responsibilities
Fixed schedule and structured framework

study's results are not necessarily transferable to the types of wards that were not represented in the study. A broader range of ward types could have led to better saturation of the data.

Another limitation is the gender distribution of the participants. There was a clear majority of women amongst the nurses and of men amongst the doctors. This does not necessarily reflect the gender distribution of doctors and nurses at Norwegian hospitals.

In only a few cases, the doctors and nurses from the same ward participated in the study. Given the limited number of participants, this had the advantage of providing information about pre-round meetings on a larger number of wards. However, one disadvantage was that in most cases, we were unable to compare opinions about pre-round meetings of doctors and nurses from the same ward.

Finally, we interviewed only nurses and doctors. Perhaps involving allied health professionals to share their perceptions would have been interesting and might have provided additional information about the value of pre-round meetings.

6 | CONCLUSIONS

The nurses and most doctors reported that pre-round meetings improved the quality of treatment and care and that this was achieved because the meetings offer a forum for health professionals to gain better insight into each other's roles and ways of thinking. Shared understanding and the communication of congruent information to the patient by all members of the team are essential for high quality of patient care.

However, the need for pre-round meetings varied between wards. There might be reasons for not holding pre-round meetings on wards with acute admissions and high patient turnover. This seems to imply continuity and experience of the ward's doctors and nurses.

For pre-round meetings to work as intended and raise the quality of treatment and care received by patients, continuity of attendance by doctors, nurses and consultants is necessary for making decisions in a timely manner. Pre-round meetings must be structured properly, and participants should not have other concurrent tasks. This study's results suggest that health trusts may benefit from improvements in patient care if the overall system facilitates successful pre-round meetings.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

AUTHOR CONTRIBUTIONS

All authors contributed in design of the study. LK was the moderator at all four focus group interviews, while IS and OTK acted as assistant moderator at two interviews each. Data analysis and interpretation of the data was accomplished by LK, OTK and IS. LK and OTK drafted the manuscript. IS read the manuscript and provided feedback. All authors agreed upon the final version of the manuscript.

PATIENT CONSENT STATEMENT

We did not need to seek patient consent (Patients were not included in the study).

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