

Intentional rounding in hospital wards: What works, for whom and in what circumstances?

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Nurses to make hourly rounds under Cameron plans

Prime minister wants hospital nurses to concentrate on 'patients not paperwork' to drive up standards



▲ Nurses will make regular rounds to talk to patients under plans to be put forward by David Cameron. Photograph: Getty Images

Nurses will be told to undertake hourly ward rounds while members of the public will be allowed to inspect hospitals, the prime minister has announced on a visit to a hospital in Salford.

David Cameron said most patients were happy with NHS care but there had been well publicised cases of patients not getting good basic treatment or being treated with respect.

Alexandra Topping and agencies

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David Cameron: There is a real problem with nursing in our hospitals

There is a "real problem" with the standard of nursing in British hospitals, David Cameron has said, as he today calls on nurses to make hourly rounds to ensure patients are comfortable.



NEWS



Nurses to make hourly rounds to improve patient care

Nurses will be told to carry out hourly ward rounds under government plans to improve hospital care standards in England.

Patients will also be encouraged to lead inspections in a series of measures to be announced by David Cameron to help tackle a "real problem" with patient care.

The prime minister says he believes nurses have too much paperwork and he wants them to spend more time with patients.

Jane Hughes reports.

🕒 06 Jan 2012



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“.... regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds” (Francis Report, Vol III, Recommendation 238, p1610)

What is Intentional Rounding?

Intentional Rounding Checklist

Rounding occurs on all patients

Schedule: Nurses round approx. every 2 hours on odd hours; NA/PMC round approx. every 2 hours on even hours

Date:	12am	2 am	4am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9 pm	10pm	
Intentional rounds completed by: (place initials in box indicating time of rounds, check all items below that apply for that time)																					
3 P-s																					
Pain Assessment																					
Toileting (potty) - assist patient to restroom																					
Positioning																					
Environmental scan																					
Fall risk hazards: bed in low position, cords are secured																					
Phone, water, tissue, urinal, bedside table, trashcan, and call light are within reach																					
Temperature of room, blankets, pillows																					
Prior to leaving room																					
Ask, "Is there anything else I can do for you? I have the time."																					
Remind the patient that a staff member (let them know who) will be back in about an hour to round on them again.																					
Document the round on the patient's chart.																					

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

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Patient Label



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Intentional rounding in hospital wards: What works, for whom and in what circumstances?

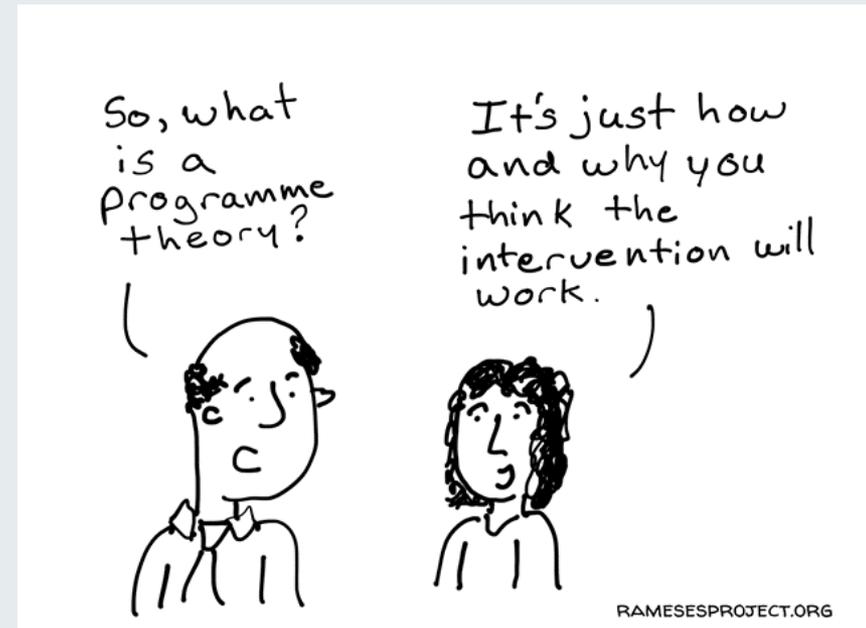
The overall aim of the study was to investigate the impact and effectiveness of IR in hospital wards in England on the organisation, delivery and experience of care from the perspective of patients, their family carers and staff.

- **Phase 1:** Realist synthesis
- **Phase 2:** National survey of all NHS acute trusts in England
- **Phase 3:** Case studies
- **Phase 4:** Accumulative data analysis

Phase 1: Realist synthesis

Stage 1: Identify *theories* or *assumptions* about why/how intentional rounding works or is expected to work. **89** documents included. **8** programme theories identified.

Stage 2: Identify *empirical research* to support/refute theories identified in stage 1 or identify any new ones. **44** documents included.



8 preliminary theories of intentional rounding

- Allocated time to care
- Visibility of nurses
- **Nurse-patient communication***
- Consistency and comprehensiveness
- **Accountability***
- Anticipation of needs
- Staff communication
- Patient empowerment

Preliminary theory - Nurse–patient communication

When workload and nursing staffing levels permit, more frequent nurse-patient contact improves relationships, communication and increases awareness of patient comfort and safety needs

Preliminary theory - Accountability

Documenting IR checks increases accountability and raises standards of fundamental care

Phase 2: National survey (n=108, 70% RR)

- **97%** of NHS acute trusts in England had implemented IR in some way, (although considerable variation in implementation).
- **89%** of Trusts had a mixture of registered and unregistered nursing staff conducting IR.
- **81%** of Trusts had a structured protocol, script or procedure in place for IR.
- Documentation of IR took place in **96%** of Trusts.
- **64%** of Trusts had implemented IR on all wards
- **80%** of Trusts reported that, on the wards where IR had been implemented, it occurred for all patients.

Phase 3: Case Studies - methods

- **One-to-one interviews** were conducted with **17** senior nurse managers, **33** frontline nursing staff, **26** non-nursing healthcare professionals, **34** patients and **28** family carers.
- **188 hours** of direct care delivery was observed by four research staff over day and night shifts. **39** nursing staff also ‘shadowed’.
- Safety thermometer data
- Cost analysis

Nurse-patient communication

Interview data

- Whilst some nursing professionals believed IR increased the *frequency* of nurse-patient communication, very few believed it improved the *quality*.
“... *the contact becomes transactional rather than enriching, so you’re not having a conversation with that patient*” (Senior Nurse)
- Patients and family carers valued the *relational* elements of their interactions with nursing staff. They wanted care *when they needed it* and were less concerned about the precise regularity or structure of rounding.
- Some patients disagreed with a structured, scripted approach to communication and preferred nursing staff to use their “*initiative and sensitivity*”.
“*I don’t think that’s very people friendly really.*” (Carer)

Nurse-patient communication

Observation data

- Nursing staff and patients were observed to talk to each other often, although the majority of interactions were not observed to be part of an IR.
- On average, patients had a direct interaction with a member of nursing staff (e.g. registered nurse (RN), healthcare assistant, student nurse) every **17.52 to 21.8 minutes**.
- On average, patients had a direct interaction with a member of registered nursing staff every **36.29 to 38.92 minutes**.

Accountability

Interviews

- Frontline nursing staff and managers worried the main focus of IR was in completing the documentation rather than in the conversation with the patient.
“... the task had become the documentation not the actual conversation or the care”
(Senior Nurse)
- Nursing staff viewed IR documentation primarily as a means of protecting themselves, rather than patients, by providing written evidence that they had provided care should incident or complaint arise.
Interviewer: “Do you think if you didn’t have to sign it, you might not go in [to a patient’s room to do IR]?”
Staff Nurse: “Oh, no, I think I would go in but I think it’s a good way of showing that I’ve gone in” (Staff Nurse, Band 5)
- Concerns raised that IR documentation was not always accurate, which could lead to a false sense of security for nursing managers and incorrect information provided to family carers .
“...from what I see on an audit, it literally is a tick, tick, tick, tick, tick, tick, tick, tick, tick. Now, for me, that doesn't necessarily mean it was done...” (Senior Nurse)

Accountability

Observation data

- Frontline nursing staff were very busy and carried out a wide range of tasks. IR was usually combined with other activities and staff were frequently interrupted when undertaking IR. Staff were therefore often observed to document IR *retrospectively*.
- On occasion, staff delivered what looked like IR but *did not complete* IR documentation.
- IR was also observed to be completed *prospectively*.

Accountability

Fidelity to the original IR intervention

- **240** IRs were observed within 188 hours of care delivery observation. Whilst 86% of all IR interactions were observed to be documented, fidelity to the original intervention (i.e. Studer Group protocol) was generally low. For example:
- ‘Positioning’, ‘personal needs’, ‘pain’ and ‘placement of items’ questions were observed to be asked in **27%**, **26%**, **26%** and **23%** of rounds, respectively.

Revised theory - Accountability

- **Some evidence** that when documented ‘authentically’, IR provided nurses, ward and senior nursing managers with reassurance and evidence that basic, fundamental patient care had been delivered. When the accountability mechanism was activated, this contributed to the following outcome:
 - Nurses said they could use IR documentation to provide evidence that they had delivered basic, fundamental patient care to a minimum standard.
- **No evidence** that IR increased personal accountability, as nurses said they already felt a professional accountability for the care they delivered.

Revised theory - Nurse–patient communication

- **No evidence** that IR was a vehicle for meaningful *nurse-patient conversations*, even if nurses deviated from script/set questions and developed their own style of doing IR. No outcomes were associated with this mechanism.
- Mechanism not activated.

Conclusions

- IR reduces the scope of nursing practice, privileging a transactional and prescriptive approach over relational nursing care.
- Intentional rounding is used by nursing staff as a defence/safety net
- IR protocol as defined by the Studer Group in United States is not sufficient in England
- IR adds to the tension inherent in the delivery of systematised care vs. individual patient care
- IR is not visible to patients and carers
- IR does not contribute to multidisciplinary care
- This study shows the effectiveness of IR, as implemented and adapted in England, is weak.

Recommendations

- “Well, if I were you, I wouldn’t start from here”.
- We suggest that there is a need for a national discussion/debate among nursing managers and leaders about whether IR is the best way to support the delivery of fundamental nursing care to patients.
 - De-implementation - or “*stopping practices that are not evidence-based*” or “*to abandon care that wastes resources or delivers no benefit to patients*”
 - Significantly revise IR to address weaknesses identified in this research.



“... we don’t have these professional conversations... we don’t have those types of forums because we’re so caught up just trying to keep it safe at the moment in most organisations...” (Senior nursing manager)

Thank you

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