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

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***RCN International Research Conference April 5<sup>th</sup> 2017, Oxford, UK***  
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# Intentional rounding in hospital wards: What works, for whom and in what circumstances?

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This project was funded by the National Institute for Health Research Health Services & Delivery Research (NIHR HS&DR) Programme as part of their 'After Francis' call (project number 13/07/87). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR HS&DR Programme, NHS or the Department of Health.

**Please note that these are confidential preliminary findings of the study and are not for wider circulation.**

# What is Intentional Rounding?



**P**ain   **P**osition   **P**otty   **p**ossessions

# 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
<b>Intentional rounds completed by:</b> (place initials in box indicating time of rounds, check all items below that apply for that time)																				
<b>3 P-s</b>																				
Pain Assessment																				
Toileting (potty) - assist patient to restroom																				
Positioning																				
<b>Environmental scan</b>																				
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																				
<b>Prior to leaving room</b>																				
Ask, "Is there anything else I can do for you? I have the time."																				
Remind the patient that a staff member ( <b>let them know who</b> ) will be back in about an hour to round on them again.																				
<b>Document the round on the patient's chart.</b>																				

Signature/Initials: \_\_\_\_\_

Signature/Initials: \_\_\_\_\_

Signature/Initials: \_\_\_\_\_

Signature/Initials: \_\_\_\_\_

Signature/Initials: \_\_\_\_\_

Signature/Initials: \_\_\_\_\_

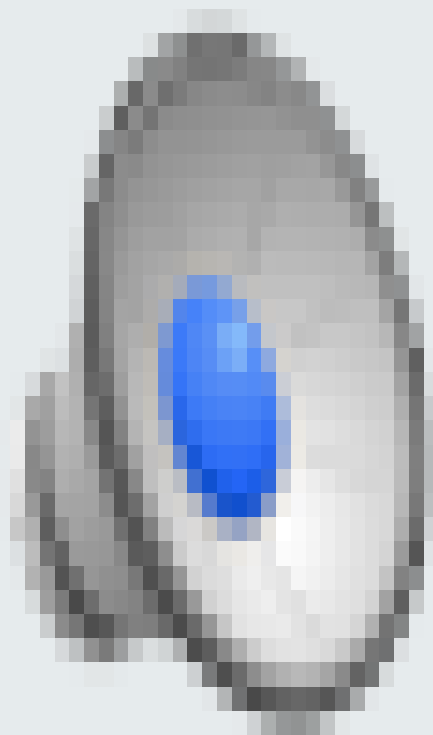
Patient Label



Report of  
the Mid Staffordshire  
NHS Foundation Trust  
Public Inquiry  
Volume 1:  
Analysis of evidence and  
lessons learned (part 1)



*"... regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds" (Francis Report, Vol 111, Recommendation 238, p1610)*



# So what's the evidence?

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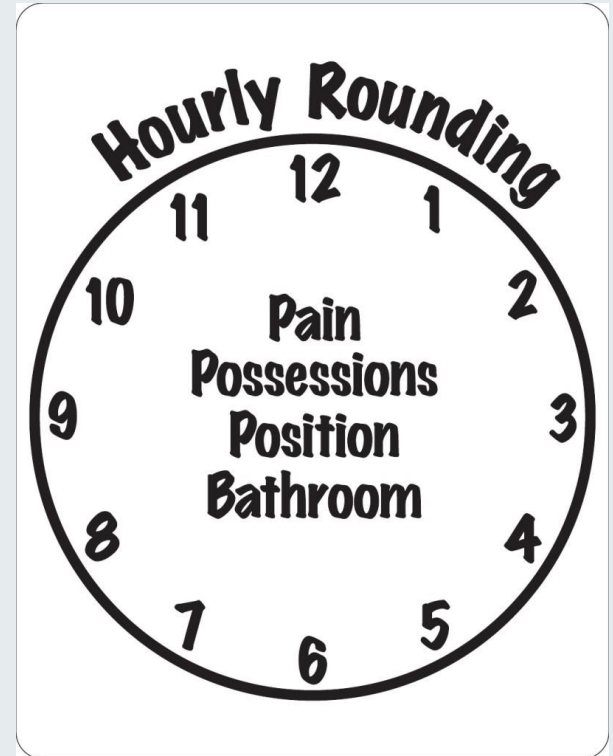




# Intentional rounding in hospital wards: What works, for whom and in what circumstances?

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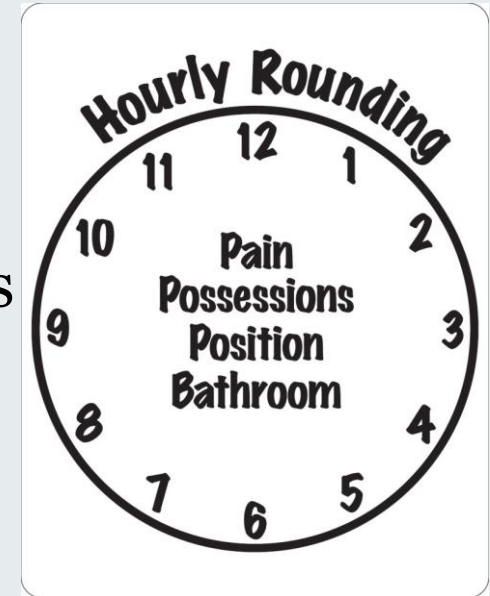
- **Phase 1:** Realist synthesis
- **Phase 2:** National survey of all NHS acute trusts in England
- **Phase 3:** Case studies
- **Phase 4:** Accumulative data analysis



# Realist synthesis

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- **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 theories of intentional rounding

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

# 1. Allocated time to care

## THINGS THEY'RE TOO BUSY FOR

Comforting/talking to patients ..... **78%**

Promoting mobility and self care ..... **59%**

Oral hygiene ..... **48%**

Falls prevention ..... **45%**

Sufficient change of patient's position ..... **41%**

Keeping patients and families informed ..... **38%**

Helping patients with food and drink ..... **34%**

Helping patients use toilet or manage incontinence ..... **33%**

Prepare patients and families for discharge ..... **30%**

Skin care ..... **30%**

Pain management ..... **19%**

Care for dying patients ..... **17%**

## 2. Visibility of nurses

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### 3. Nurse-patient communication and relationships

#### About a Nurse



*"Let's go over this one more time, when you call me, it should be for medical purposes only. We don't have HBO, and you can't get free pay-per-view movies."*



## 4. Consistency and comprehensiveness



# 5. Accountability

## *Savage Chickens*

by Doug Savage



## 6. Anticipation of needs

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ANTICIPATE

KNOWING WHAT CUSTOMERS NEED BEFORE THEY DO

## 7. Staff communication



**TEAMWORK  
MAKES THE  
DREAM WORK**

## 8. Patient empowerment





# Findings

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44 papers reviewed....

- peer reviewed journals (n=18),
  - professional press (n=21),
  - four study reports
  - a doctoral thesis.
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- USA (n=25)
  - UK (n=12)
  - Australia (n=5),
  - Canada and Iran (1 paper each).





# Mechanism 1: Consistency and comprehensiveness (n=21)

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- IR helped staff remember to conduct all aspects of care on every round and identify tasks that might otherwise be missed.
- Helped guide junior/unqualified staff and staff less familiar with the patient.
- Enabled staff to regularly speak to all patients, not just those identified as higher risk.

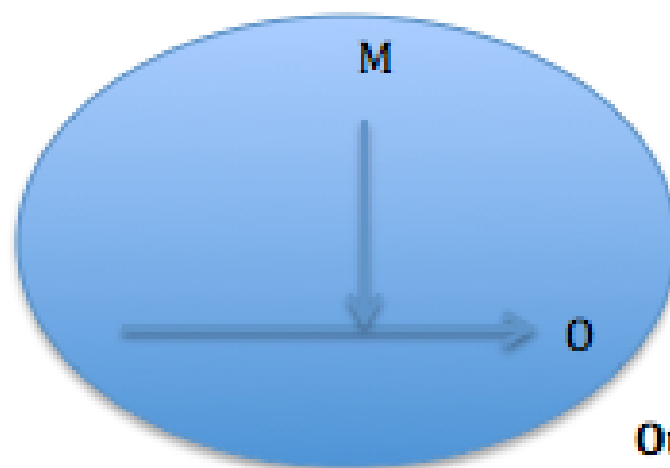
## *Context*

- Strategies in place to reinforce adherence to process (e.g. education, observations)
- Suitability of IR documentation

## *Outcome*

- Reassuring to staff, patients and carers
- Evidence not clear about clinical outcomes, incidence of call bells

**Context** of **patient need**, un(suitable) education strategies, (un)suitable IR documentation, setting of ward, individual staff characteristics, lack of clarity about round delivery, lack of time/low staffing/conflicting priorities



**Outcomes:** Reassuring to staff, patients and carers, some evidence about clinical outcomes, incidence of call bells, staff feel 'silly' or uncomfortable, patients refuse to participate in rounding

# However....

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- Rounds not consistently carried out by all nurses or for all patients or nurses not conducting IR according to the recommended protocol.
- Nurses used clinical judgement and professional autonomy to modify rounding process, assessing patients on an individual basis and making informed choices about how frequently to conduct rounds and what questions to ask.

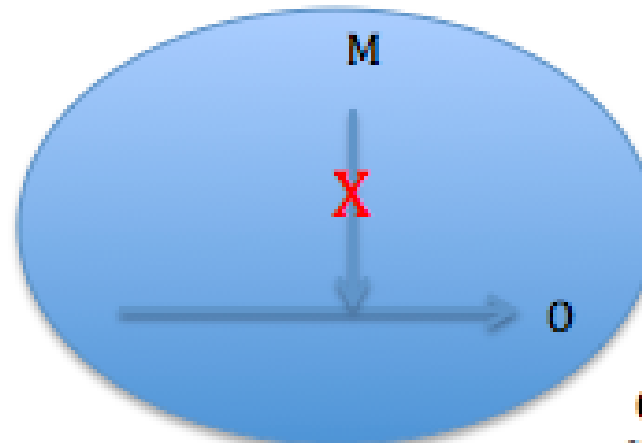
## *Context*

- Ward setting
- Individual staff characteristics
- Lack of clarity around when/by whom rounds should be delivered
- Lack of time/low staffing/conflicting priorities

## *Outcomes*

- Staff feel 'silly'/uncomfortable
- Patients refuse to participate in rounding

Context of **patient need**, **un**(suitable) education strategies, (un)suitable IR documentation, setting of ward, individual staff characteristics, lack of clarity about round delivery, lack of time/low staffing/conflicting priorities



**Outcomes:** Reassuring to staff, patients and carers, some evidence about clinical outcomes, incidence of call bells, **staff feel 'silly' /uncomfortable**, patients refuse to participate in rounding

# Mechanism 2: Accountability (n=19)

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- Original definition of mechanism partially supported by empirical evidence, with accountability perceived as underpinning IR in some studies
- However, staff accountability for rounding seemed to focus upon the **completion of IR documentation** rather than upon the ability to carry out high quality IR
- No evidence that increased personal accountability led to the delivery of **higher standards of care**.
- IR may be more a means of **offering assurance** to key stakeholders (eg. patients, relatives, nurses, managers) about the care being delivered

## Example of a CMO configuration associated with the *presence* of the accountability mechanism

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Qualitative research study comprised of 3 focus groups (9 nurses and 6 nursing and midwifery managers/educators working in either aged care or maternity units in one Australian hospital):

- **Context:** Confused patient unable to recall receiving care.
- **Accountability mechanism present:** IR documentation is recalled and used to demonstrate that care had been provided.
- **Outcome:** Family members feel reassured.

*Confused patient unable to recall receiving care [C] → IR documentation recalled and used to demonstrate care provided [M present] → Family members reassured [O+]*

*As highlighted in Flowers (2016)*



# Mechanism 3: Nurse-patient communication/ relationships

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- Original definition partially supported by empirical evidence:
- Widely reported that IR did increase the **frequency** of communication between nurses, patients and family members but less evidence that it **improved** communication.
- Staff believed that increased communication was welcomed by patients and family, making them feel more involved in care, more likely to voice concerns and less likely to feel ignored/neglected.
- However, for some patients, it was the **quality** and **meaningfulness** of their interactions with staff that were important and IR did not always facilitate this:

*“I just want them to speak friendly, not ask questions about my pain and drinks” (Patient. Kenny, 2015, p18)*

*“We don’t have conversations, we just answer questions” (Patient. Kenny, 2015, p18)*

## **Example of a MCO configuration associated with the *presence* of the nurse-patient communication/relationships mechanism**

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Two-stage pilot project with participatory methods undertaken to introduce IR as a service improvement initiative in nursing and midwifery at 2 general hospitals within 1 NHS Healthcare Trust in England. Findings were based upon the results of a staff evaluation questionnaire sent to clinical managers and matrons.

- **Context:** Outpatient area with unavoidable delayed waiting times.
- **Communication mechanism present:** IR offers opportunity for patients to be advised every hour about delays and waiting times, enabling them to feel able to go and get refreshments whilst they wait.
- **Outcomes:** Patient complaints are reduced.

***Outpatient setting with unavoidable delayed waiting times [C] → Patients are informed every hour about delays and waiting times so that they feel able to go and get refreshments whilst they wait [M present] → Less patient complaints about waiting times [O+]***

*As highlighted in Dewing and O'Meara (2012).*

# Discussion and conclusions – what aspects of IR work, for whom and in what circumstances

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- **What aspects of IR work?**
  - Frequent, structured approach to delivering fundamental care is reassuring for *some* patients
  - **For whom?** – patients who need more help, are quieter or are reassured simply by seeing nurses regularly
  - **In what context?** – when there are sufficient nurses to conduct IR / workload is manageable

***BUT what does not work?***

# Discussion and conclusions – what aspects of IR work, for whom and in what circumstances

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- **What aspects of IR work?**
  - Having to sign IR documentation after each round makes *some* nurses feel more personally accountable
  - **For whom?** – nurses who understand the purpose of the IR process and have ‘bought in’ to the concept
  - **In what context?** – when there are sufficient nurses to conduct IR / workload is manageable , IR documentation is fit for purpose and at easy reach at the patient bedside

***BUT what does not work?***

# Discussion and conclusions – what aspects of IR work, for whom and in what circumstances

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- **What aspects of IR work?**
  - Completed IR documentation can monitor what care has been delivered ... or *documented*
  - **For whom?** – nurse managers who need to demonstrate that care has been delivered
  - **In what context?** – in response to patient relative query, complaint or untoward incident

***BUT what does not work?***

# Discussion and conclusions - outstanding questions in refining the explanatory theory

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- **Flexibility of approach**

**Should the implementation of IR be delivered in structured, standardised manner to all patients or targeted at particular patients depending on their need?**

- *If a flexible approach to IR is undertaken:*
  - *For which patients, in what circumstances and how does IR demonstrate greatest success?*
  - *Whom is best suited to determine patients' suitability for IR?*
- *How flexible can the approach to the delivery of IR be before it can no longer be considered IR?*
- *If a more structured, systematic approach is undertaken:*
  - *How does approach that 'treats all patients the same' encourage individualised and compassionate care?*



# Discussion and conclusions - outstanding questions in refining the explanatory theory

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## Nurse-patient interactions

- Is IR proposed as a tool for increasing the *frequency* of nurse-patient communication, improving the *quality/meaningfulness* of nurse-patient interactions or both?
- Whilst it is clear to see how ensuring that a nurse speaks hourly with every patient would increase the frequency of nurse-patient communications, can such a structured and prescriptive approach ever facilitate more meaningful interactions?

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