The effect of intentional rounding on essential care

In this article...

- Why intentional rounding is being introduced
- How it has affected patient outcomes
- Challenges faced in implementation

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Abstract

Intentional rounding (IR) is a structured regime to proactively manage care needs and communicate care delivery between health professionals. Much of the evidence around its effectiveness comes from the US; this has shown IR improves patient experience, specifically around call bell activity, satisfaction, complaints, pressure area care and falls reduction (Dix et al, 2012; Bartley, 2011; Halm, 2009; Culley, 2008; Tea et al, 2008; Meade and Bursell, 2006).

Rounding is generally performed every two hours, but more frequently for the most vulnerable patients. It aims to replace presumed care with documented evidence that can be used to prioritise care in future rounds. The IR tool focuses on fundamental aspects of care, which have been identified as lacking in many care reports (Francis, 2013; 2010), specifically dignity, pain, nutrition, hydration, continence, falls and pressure ulcer prevention. IR will also help to keep care consistent through the use of a checklist to ensure potentially less obvious aspects of care are considered and managed at every round.

The two-hourly regime is flexible enough to capture most patient activity that occurs in and around these periods. For patients who have not needed attention in the previous two hours or where no care is planned in the near future, a formal round at the designated time is required. Rounding should feel like a quick conversation focused on identifying any problems relating to fundamental care.

Audits of testing showed that patients rarely needed additional care and, when problems were identified, they could usually be resolved quickly. IR should help prevent quieter patients from being missed or the same patient being checked more frequently than necessary.

Pilot study
Before implementing IR widely at Musgrove Park Hospital it was tested on one patient in one bed and was subject to PDSA cycles of improvement (Plan, Do, Study, Act), recommended by the NHS Institute for Innovation and Improvement (tinyurl.com/NHSI-PDSA). After several developments, the tool was implemented on an eight-bed bay in the medical assessment unit, where staff were given one-to-one instruction on how to provide IR.

The pilot led to some significant improvements (Table 1). The MAU sister reported a “significant increase in the number of thank-you cards and positive comments on the exit cards”. Within two months of the whole MAU conducting IR,
“Don’t be afraid to speak out about what you believe in”

Cheryll Adams p24

TABLE 1. IMPACT OF IR ON THE MAU

<table>
<thead>
<tr>
<th>Aspect of care</th>
<th>Jan to June 2011</th>
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</thead>
<tbody>
<tr>
<td>Number of call bells/hour</td>
<td>78% reduction</td>
</tr>
<tr>
<td>Patient complaints</td>
<td>73% reduction</td>
</tr>
<tr>
<td>Average duration of call bell ring time</td>
<td>54% reduction</td>
</tr>
<tr>
<td>Patient concerns</td>
<td>37% reduction</td>
</tr>
<tr>
<td>Reported falls incidents</td>
<td>32% reduction</td>
</tr>
<tr>
<td>Community-acquired pressure ulcers (all grades)</td>
<td>10-fold increase in detection</td>
</tr>
<tr>
<td>Staff perception of care rated</td>
<td>Increased from 6/10 to 7/10</td>
</tr>
</tbody>
</table>

FIG 1. LOW CONSEQUENCE FALLS
Incidents trust-wide

Source: Ulysses incident database

FIG 2. FORMAL NURSING CARE COMPLAINTS
PALS incidents trust-wide

Source: Musgrave Pals Complaints Department

FIG 3. COMMUNITY-ACQUIRED PRESSURE ULCERS
Reported trust-wide

It had become the most improved ward on the trust’s ward assurance monitoring system (Dix et al, 2012).

Dissemination
An IR dissemination plan was developed in response to interest from ward managers and matrons. After staff heard about its impact on the MAU, 11 further wards agreed to implement rounding in May 2011. The IR team attended ward meetings and informal drop-in sessions on the wards before introduction.

Following a review of the use of IR on these 11 wards, implementation was adapted, resulting in smaller cohorts of 2-3 wards and repeat training for the previous wards already performing IR. At this point, each ward received two weeks of training (10 hours in total), followed by 10 weeks of receiving an hour a week of auditing and feedback of practices, before monthly auditing. In addition, Annette Bartley of the King’s Fund was a guest speaker to an audience of HCAs on a trust HCAs’ development day and spoke about the benefits of IR.

Initially, a significant number of staff were sceptical about IR, with many describing it as a paper exercise and something they already did. As the roll-out continued, they began to see it as a good idea, but doubted it was achievable or adaptable to their area. Two years on, resistance to IR is waning and there have been some remarkable improvements across the trust.

On reflection, our implementation was done in a “spray and pray” approach that stretched the implementation team; there was also false optimism that, because wards volunteered for IR, implementing it would be relatively straightforward.

Results
Falls
Within one month of IR being rolled out, the monthly average of low-consequence injury falls dropped from 84 to 54 (Fig 1).

Complaints
Formal complaints also dropped in the first month, from an average of 4.5 to 1.5. There have been further improvements, with four of the five months to September 2012 having no formal complaints. However, the PALS department changed the way it manages complaints during this period, so the reduction may not be wholly attributed to IR (Fig 2).

Pressure area care
Two trends were analysed: how IR has influenced the detection of community-acquired
pressure ulcers; and how it has affected the development of hospital-acquired pressure ulcers (Figs 3 and 4).

From the beginning to the end of implementation, the average number of community-acquired pressure ulcers reported rose from 17 to 74 per month.

Fig 4 shows the incidence of hospital-acquired pressure ulcers was increasing before the main introduction of IR in May 2011. Between September 2011 and January 2012, there was evidence of improvements. However, in February, the tissue viability service provided training and awareness raising, and changed the definitions of pressure ulcer grading in line with the European Pressure Ulcer Advisory Panel updated grading (2009).

Call bells
The impact of IR on call bell use was assessed on 10 of the 19 wards. There was no overall improvement in the number of calls – three wards showed an improvement, four did not change and three became worse. The duration call bells rang for improved on nine wards, with large reductions on four of them. In 14 wards, call bells were consistently answered within 60 seconds after IR was introduced. While it was too time-consuming to continue data collection after September 2012, anecdotal feedback from staff suggests improvement has continued.

Evaluation
The Patients Association (PA) was invited to review and report on how Musgrove Park conducted IR, and interviewed 27 patients from five wards in October 2011. Its report noted that: “There were many positive experiences with the majority of patients and carers/relatives very complimentary about the care provided. Staff were seen as highly valued and visible on the ward but very busy.” However, it highlighted inconsistency in the delivery of IR by some staff on the wards (Eardley, 2012).

The PA report corroborated work conducted at Whipp Cross University Hospital in 2009, which showed there were several benefits to IR on two orthopaedic wards, but noted great variation IR activity among staff (Lucas et al, 2010).

Discussion
Despite outcome measures supporting its use, some staff are still opposed to IR. Many still see it as a paper exercise and some report having witnessed IR being performed with little intention by others, and poor activity not routinely challenged. Some report difficulty in reconciling their experiences of IR with the improvements in care since its introduction.

Rounding does, however, appear to make staff more visible. This is probably because the IR form is kept at the foot of the bed, rather than a result of proactive patient management. It may also explain why the use of call bells has not reduced as expected (Studer Group, 2007; Meade and Bursell, 2006). The closer proximity of staff could explain why the duration of call bell rings has reduced as they are able to respond more quickly.

We are aware of the risk of IR being used as a tick-box exercise and have worked hard to prevent this through monthly audit. Auditors engage with staff to discuss performance and audit results, and to reiterate the values underpinning IR. Valley (2012), commenting that a tick-box culture is not a result of nurses not caring about patients but is more likely to be due to management emphasis on targets and cost-cutting, said: “The nurse who does the job and forgets to tick the box is disciplined: the one who ticks without doing it is rewarded, unless a catastrophe finds them out.”

Another criticism is the perceived increase in unnecessary paperwork. However, in legal terms, if an intervention is not documented it did not happen. IR provides a means to record care quickly and enables colleagues to review documentation.

Conclusion
Musgrove Park Hospital is committed to using IR as the basis to coordinate and manage fundamental aspects of patient care. Since the pilot, there have been many significant challenges and, despite evidence of its effectiveness, it has not been possible to engage all staff. The emphasis during implementation of IR was on the underpinning principle that care is universal, regardless of patients’ acuity.

With increasing demands on staff to do more with less, it is not surprising that the NHS is witnessing failings in care (Francis, 2013; 2010). Delivering care without regularly checking which patients require what interventions, will ensure that these failings continue. NT

References