

Intentional Rounding: What is the evidence?

In January 2011 the British Prime Minister called for changes in the way nurses deliver care. Following a number of critical reports, concern had been expressed about the need to ensure essential aspects of nursing care are consistently delivered. One of the Prime Minister's recommendations is for NHS hospitals to implement hourly nursing rounds, to check on patients and ensure their fundamental care needs are met – an approach related to 'intentional rounding' in the United States. Within the United Kingdom some organisations refer to this type of nursing activity as "care rounds" or "comfort rounds". In this Policy Plus we examine different approaches to intentional rounding and review available evidence.

How has intentional rounding evolved?

For many years nurses working in NHS hospitals undertook task based rounds e.g., two hourly back rounds to check on the position of patients, prevent pressure sores, or monitor mouth care or toileting needs. Many nurses felt regularly checking on patients helped them to feel reassured and cared for [1].

Intentional Rounding has been developed as an evidence-based structured process in the United States (US) by the Studer Group [2]. Over 400 international healthcare systems hospitals and medical groups have made use of their methodology and scripted tools, which include a documentation log, an hourly reporting dashboard, competency checklist and scheduled meetings between shift leaders and nursing staff to review rounding behaviours [2]. In the United Kingdom (UK) intentional rounding methods or Proactive Patient Rounds have been introduced as part of larger quality improvement initiatives, such as the Hospital Pathways Project [3], or the NHS 'Harm Free' care campaign (www.harmfreecare.org).

What are the key elements of intentional rounding?

In acute settings key aspects that are usually checked during intentional rounds include the "Four P's" [2,3]:

- Positioning: Making sure the patient is comfortable and assessing the risk of pressure ulcers
- Personal needs: Scheduling patient trips to the bathroom to avoid risk of falls
- Pain: Asking patients to describe their pain level on a scale of 0 - 10
- Placement: Making sure the items a patient needs are within easy reach

During each round the following behaviours (which may be summarised on a prompt card) are undertaken by the nurse [3,4]:

- use an opening phrase to introduce themselves and put the patient at ease
- perform scheduled tasks
- ask about the "Four P's" (described above)
- assess the care environment (e.g. fall hazards, temperature of the room)
- use closing key words e.g. 'is there anything else I can do for you before I go?'
- explain when the patient will be checked on again
- document the round

Structured methods of intentional rounding are underpinned by leadership support, e.g. regular staff meetings to review activities and progress. Staff training and accountability structures are used to 'hardwire' the required behaviours and competencies into routine practice [2].

How does intentional rounding vary?

In some US hospitals the whole team (qualified nurses, healthcare support staff, physicians, allied health professionals, etc.) take part in rounding [4]. In the UK the focus has been on registered nurses undertaking rounds, with the support of healthcare assistants. In some hospitals registered nurses and healthcare assistants may undertake rounds alternately each hour [4], elsewhere the whole interdisciplinary team are involved [3].

How frequently rounds are undertaken also varies between hospitals and wards. For example, patients who are acutely ill or people with dementia may need more frequent checks [5]. Where implemented in the UK, rounds are typically undertaken every hour or two hours during the day and night depending on the patient's clinical condition or level of need [3,4].

Which patients are included also varies. Some hospitals in the US consider that all patients should receive intentional rounding because they have a right for their fundamental care needs to be identified and met promptly [2]. However, in some hospitals, only patients at risk of falling or skin damage, or people requiring emergency or critical care are included [4].

What is the evidence of impact?

- The majority of information on intentional rounding comes from development and testing in US hospitals in the last 10 years [4]. The evidence focuses on 'before and after' measures of call bell usage, falls and pressure sore incidence, but the scale of improvement can be small on already well performing wards [4].
- In the UK a range of outcomes for patients and staff have been reported in the literature but the quality of the evidence is limited because the small number of studies that do exist are descriptive rather than using comparative or controlled methods [3,5,6].
- Reported improvements in clinical outcomes include: pain management [3,4], decrease in falls [2,4,7-11] and pressure ulcers [2,6].
- Patient reported outcomes include: better patient experience [3,4] and satisfaction [5], reduction in patient complaints [2,4,6,8,9], reduction in the frequency of call bell usage and the length of time patients wait to have their call bells answered [2,4,6,8,10].
- There is little evidence about the impact on staff time. It has been suggested that time taken to carry out rounds is offset against time savings from improved patient management [4,5].
- Research has not explored the cost effectiveness of intentional rounding.

Conclusions and implications

- The available evidence suggests that intentional rounding can help staff to organise their workload and provide more systematic reliable care. However, nurse leadership, staff training and accountability structures are essential to ensure intentional rounding supports improved patient outcomes and experiences of care.
- Patients are reported to generally like intentional rounding because they feel less isolated and know they will be checked on regularly.
- Currently there is no evidence evaluating intentional rounding against other interventions to promote patient-centred care.
- Key questions remain in relation to intentional rounding, such as: Who does it, how often, and for which patients? What are the implications for skill mix and nurse staffing? What are the costs associated with different models?

Key points for policy

- Intentional rounding takes many different forms. The available evidence suggests that in general it can achieve improved outcomes for patients.
- As with any new quality improvement initiative, success and sustainability depend in part on adequate preparation, ongoing support, and a readiness to change.
- Further evaluation of intentional rounding is needed to determine the evidence of its effectiveness and cost implications within the UK.
- Essential to determine the evidence of its effectiveness and cost implications within the UK.

References and information

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