A systematic approach to rounding can improve patients’ experience of care and build their trust, ensure that care is safe and reliable, and alleviate pressure on nurses

**Intentional rounding: its role in supporting essential care**

**In this article...**
- What is intentional rounding?
- Benefits of this approach
- Steps to implementing rounding

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The King’s Fund Point of Care (POC) programme aims to identify and test interventions that can improve patients’ experiences of care.

“Intentional rounding” is one such intervention, which is being trialled by some of the teams working with the King’s Fund on the POC programme.

This article explains the principles of intentional rounding and how nurses can use it to ensure patients’ essential care needs are met.

There is increasing awareness of the importance of patients’ experiences as a fundamental aspect of the quality of healthcare, alongside safety and clinical effectiveness. There is also a recognition of the interrelationships between these three factors. At the same time, an increasingly frenetic and industrial scale of healthcare delivery can lead toward the institutionalisation of care in which “human touch” can get lost, and this mitigates against health professionals delivering care that is caring and compassionate.

**What is intentional rounding?**

Intentional rounding is a structured process where nurses on wards in acute and community hospitals and care home staff carry out regular checks with individual patients at set intervals, typically hourly. During these checks, they carry out scheduled or required tasks.

Rounding helps frontline teams to organise ward workload to ensure all patients receive attention on a regular basis.

In 2006, Tucker and Spear suggested nurses tended to work around problems rather than identifying new ways of organising their work.

However, ways are being sought to make the ward a calmer, less chaotic environment for health professionals and patients alike, and to release time to care. Interventions such as the Productive Series have been designed specifically with this in mind (NHS Institute for Innovation and Improvement, 2011).

On the King’s Fund Point of Care (POC) programme, we aim to identify and test interventions that can improve patients’ experiences of care (Firth-Cozens and Cornwell, 2009). Essential to this are health professionals’ experiences of delivering care.

“Intentional rounding” is an intervention that targets both issues, and is being trialled by some of the teams working with us on the POC programme.

**Why is intentional rounding needed?**

A number of high-profile reports have drawn attention to examples of poor standards of what is often called “basic nursing care” – attending to patients’ needs for support with feeding, positioning, personal hygiene and skin integrity (Parliamentary and Health Services Ombudsman, 2011; Department of Health, 2010).

At the same time, there is a growing body of evidence that suggests more nursing time per patient results in better patient outcomes (Cheung et al, 2008; Aiken et al, 2002; Kovner et al, 2002).

In the current healthcare environment, spending more time with patients is challenging. Patients report busy staff who “don’t have time”, and many are reluctant to ask for help. Health professionals on wards say there is never enough time to do everything, and that they are too busy to have time to care.

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Rounding helps frontline teams to organise ward workload to ensure all patients receive attention on a regular basis.

What is critical to this approach is reliability. The consistency of care brings with it the confidence of staff and patients alike.

Rounding requires health professionals to adopt certain behaviours.
Keywords: Intentional rounding/ Essential care/ Time to care

This article has been double-blind peer reviewed

5 key points

1. Concerns about essential nursing care have drawn attention to ensuring fundamental care is delivered reliably.
2. Intentional rounding involves health professionals carrying out regular checks with individual patients at set intervals.
3. The approach helps nurses focus on clear, measurable aims for undertaking the round.
4. It also helps frontline teams to organise workloads on the ward.
5. Rounding can reduce adverse incidents, offer patients greater comfort, and ease their anxiety.

The round begins with opening words, in which carers introduce themselves and explain why they are there. This “connection” is designed to build patients’ trust and confidence. The staff follow this up by: carrying out scheduled tasks or observations with patients; addressing patients’ pain, positioning and toilet needs; assessing and attending to the patient’s comfort; and checking the environment for any risks to the patient’s comfort or safety.

The round also includes closing key words – typically: “Is there anything else I can do for you – I have time.” This addresses the frequently reported issue that patients do not like to ask for support because they can see how busy staff are.

Closing words include, critically, when patients can expect carers (or others) to return. Finally, rounds are documented, which fulfils audit requirements.

Where did the idea come from?
The idea of systematically rounding to ensure patients’ essential care needs are met is not new.

CASE STUDY 1. NORTHUMBRIA HEALTHCARE

Northumbria Healthcare Foundation Trust has been trialling nurse rounding in a number of wards across the trust. Matron Emma Dawes described her experience on a medical assessment unit. She said there were misgivings about the approach before it started. There was a sense among staff that it would not work on a short-stay, rapid turnover medical assessment unit.

Implementation was staggered, with the number of patients included in the care round gradually increased over three weeks. During this period, staff felt patients who were not included in rounding were “missing out”. They also noticed how much easier it was to provide meals, as there were not constant interruptions to meet patients’ other needs.

There were some initial reductions in the use of call buzzers, particularly from patients requesting the toilet, but the fast turnover of patients and pace of the ward has made this difficult to sustain. Work is ongoing with the nursing team to try different ways of incorporating care rounds into everyday practice on a busy admissions unit.

What has been particularly surprising was that, on one ward, rounding was most successful in the mornings - the busiest time on the ward.

Since care rounds have become embedded into practice on this ward, real-time capture of patient experience data has shown improvement across all domains of care that matter most to patients.

There appears to have been step-like improvements in the relationship between nurses and patients and information received around medication. One patient on ward 8 at Wansbeck General Hospital reported: “From the domestics up to the sisters and the consultant, they have been absolutely brilliant. Everything is explained to me with care and compassion. I cannot fault them in any way. They always come back around when they say they will and sit and chat to me when they can. If I have been upset, they have been there for me and they have listened to my concerns. They are a very friendly team; nothing is a problem to them.”
For many years, nurses carried out “back” rounds, where particular attention was paid to patients’ skin to avoid skin breakdown. While aspects of these were evidence based, anecdotally staff believed patients felt more comfortable after the round and it provided an opportunity to build relationships between nurses and patients.

With the advent of the holistic nursing care approach and the requirement for more technical skills, nurses began to move farther away from the bedside and began to view such task-oriented processes as archaic, preferring to focus on the provision of “individualised” care.

However, concerns about essential nursing care have refocused attention on the need to ensure fundamental aspects of care are delivered reliably, alongside individualised care.

The origins of the approach lie in the US, where the Studer Group and the Alliance for Health Care Research identified that rounding had the potential to increase patient satisfaction as well as impacting on other aspects of care (Studer Group, 2007). Their results highlighted significant improvements in patients’ experience of care and clinical outcomes.

Owensboro Medical Health Care System in Kentucky coined the term “intentional rounding” or rounding with intent, placing a focus on nurses having some clear aims for undertaking the round, and a measurement process in place to ensure they monitor progress against their aim. This differentiates the intentional round from the old back round.

While there has been some criticism about aspects of the design of the Studer study, its results have been replicated elsewhere. The evidence base is sparse but, intuitively and anecdotally, rounding makes sense. The question is: why would we not do it when we know patients like it and it has benefits for all?

In 2006, Annette Bartley – one of this study’s authors – came across intentional rounding while undertaking a Health Foundation fellowship in the US at the Institute for Healthcare Improvement (IHI). It formed part of a Robert Wood Johnson/IHI initiative called Transforming Care at the Bedside (TCAB).

This initiative was designed to address nursing shortages by seeking ways to transform frontline care for the benefit of patients and staff using simple tools and techniques. Rounding was being tested at a number of TCAB hospital sites at the time.

On returning to the UK, Ms Bartley brought the TCAB programme to Wales where it formed part of the 1,000 Lives NPSA campaign. Positive results were seen, particularly in relation to reductions in falls and pressure ulcers, and improved patient experiences. Over the last couple of years, rounding has spread across the UK with similar results seen where it has been introduced effectively.

**Benefits of rounding**

The theoretical basis for nurse rounding is the idea that patients will be more comfortable, and find greater confidence and reassurance in a calmer and more orderly ward environment.

They will have fewer ad hoc needs for help and support, knowing their carer will be back soon. Equally, patients who are anxious or who feel ill informed are likely to generate even greater demands for information or support than those who feel better supported.

Greater reliability of scheduled tasks is aimed at reducing pressure ulcers and falls. And, of course, a calmer ward environment benefits staff too – for example...
Research by the Alliance for Health Care Research reported a 38% reduction in call buzzer use, a 12-point mean increase in patient satisfaction, a 50% reduction in patient falls and a 14% reduction in pressure ulcers after the introduction of intentional rounding (Meade et al, 2006).

Rounding can be used in a number of ways. But it is critical that it is conducted with the intention of achieving an outcome for patients – it must have a clear aim and associated measures so it is possible to judge its effects objectively. Some of the teams we are working with have focused, for example, on reducing social isolation in patients with dementia, on improving nutrition and hydration, or on reducing falls and pressure ulcers.

Rounding as an approach is flexible, and can be adapted to local circumstances. For example, although the original studies focused on hourly rounding by nurses, some hospitals have adapted this to involve nurses and healthcare assistants doing alternate rounds, so patients are still seen hourly but alternately by nurses and other staff. Rounding is centred on patients, can capture all scheduled nursing tasks and provides a quality assurance framework for care. It can provide robust evidence on what nurses do and demonstrate the impact of care interventions.

What its detractors say
To some nurses, rounding harks back to the dark ages of task-oriented nursing, moving away from treating patients as individuals. They ask whether nurses really need to be told to do this. Others see it as an add-on, for which there is not enough time: a further example of a checklist mentality, which takes them away from holistic nursing.

However, there is a difference between a systematic, reliable care process and task orientation. Rounding hourly does not mean you suddenly stop treating patients as individuals, but it will ensure the care is delivered in a safe and reliable manner; the need for this has been demonstrated to devastating effect by the Francis inquiry and the Ombudsman’s report (Parliamentary and Health Services Ombudsman, 2011; Francis 2010).

There is extensive literature on the emotional cost of caring for others (Firth-Cozens, 2003; Wall, 1997; Caplan, 1994). It is possible that rounding may prove challenging for staff, because it leads them to encounter directly and personally some individuals’ painful circumstances via immediate, regular contact with patients as people.

The patient’s perspective
Clearly, if we can replicate the experience of the Alliance for Health Care research, rounding can bring with it improved patient experiences through fewer adverse incidents, greater comfort, a greater sense of needs being met and less social isolation and anxiety (Meade et al, 2006).

Already, the teams we are working with are noticing significant reductions in call buzzer use. In addition, patient experience measures are showing highly positive and improving patient experience – although clearly this depends on multiple factors. Qualitative feedback from patients is beginning to show that they are noticing and liking the style of nursing care, with comments such as: “You always know when the nurse will come back to you.”

Conclusion
Rounding has already been tested in a number of UK settings. The key message from these is that: rounding should be tested, carefully and systematically implemented; the approach should be adjusted to local circumstances; and it should be responsive to staff concerns.

Small tests of change are useful in exploring staff concerns about whether it is effective, or whether it adds to workloads, for example.

The approach is sufficiently flexible that it allows health professionals to be creative with it, and be involved in designing the process, preferably with patients too. It is important that staff feel able to adopt, adapt or abandon specific rounding tools as evidence emerges about what is working well and what is not. Strong leadership support is also critical to the success of rounding both in its implementation and in monitoring its success and providing rapid feedback to staff.

Intentional rounding fits with the ethos of the POC programme, to promote positive patients’ and staff experience of care. Care is designed with the interests of patients as central. Delivering positive patient experiences depends on there being reliable processes of care in place and on having well-supported and satisfied staff. NT

References
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Sarah Lloyd-Davies p24

“There are lots of myths about working in the independent sector that I wish we could debunk”