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This article describes the introduction of intentional rounding on a busy medical assessment unit and how staff engagement and understanding of the process is essential to its successful rollout. Staff’s reaction to the implementation is highlighted and the benefits to care delivery discussed.

Earlier this month, the prime minister called for changes in the way nurses deliver care. This was in response to recent reports drawing attention to care failings (Care Quality Commission, 2011; Health Service Ombudsman, 2011; Department of Health, 2010). One of the recommendations was for nurses to undertake regular rounds to ensure that every hour they will be able to check that each patient is comfortable.

This method of systematically reviewing all patients on a regular basis to ensure their fundamental care needs are met is not a new nursing concept. For many years, nurses carried out regular “back rounds”, which had a particular focus on skincare and pressure relief (Fitz-simmons et al, 2011).

Anecdotally, nurses believed regular contact with patients had the added value of enabling therapeutic relationships to develop between them. The rounds made patients feel cared for and reassured, knowing that within a couple of hours they would be visited by a nurse and given an opportunity to raise any personal needs.

However, while back rounds ensured all patients were reviewed at least every two hours, they were task-orientated and left little room for delivering individualised holistic care.

**Intentional rounding**

Intentional rounding (IR) is a more recent development imported from the US that could be described as a modernised back round. It involves nurses carrying out regular checks on individual patients at set intervals to assess and manage their fundamental care needs with respect to six core elements:

- Pain;
- Hydration and nutrition;
- Continence;
- Anxiety;
- Falls;
- Pressure ulcer prevention.

IR places the patient at the heart of the ward routine by taking care back to the patient’s bedside.

The system improves patients’ experience of care through the reassurance provided by the increased visibility of nursing staff and the knowledge that they can raise any concerns or needs when they are next visited by a nurse so that they can be dealt with promptly. These can range from needs that may seem relatively unimportant to ward staff but are hugely significant to patients to potentially serious clinical concerns.

Meade and Bursell (2006) noted a significant increase in patient satisfaction and a reduction in pressure ulcer incidence after introducing IR, while the Studer Group’s (2007) work on IR identified similar significant improvements in patients’ experiences of care and clinical outcomes.

Musgrove Park Hospital, part of Taunton and Somerset Foundation Trust, has been using IR for a year. The hospital has more than 600 beds, 30 wards and 15 operating theatres. It serves a population of 340,000 and treats more than 450,000 patients each year.

IR was just one initiative within the hospital’s Back to Basics campaign. It was championed and led on the medical assessment unit by junior sister Jackee Phillips.

IR was initially tested with a bay of patients using rapid cycle testing (plan-do-study-act (PDSA) cycles) on the medical assessment unit in October 2010. It was rolled out across the unit in January 2011. Every patient receives an hourly or two-hourly review by either a nurse or healthcare assistant, with frequency depending on the patient’s clinical condition.

Unlike some hospitals using IR, we include all patients rather than just those that are at risk of falling or skin damage. The overarching principle is that all patients, regardless of presentation, have a right to expect their fundamental care needs to be identified and met promptly.

**Effects of implementation**

After IR was rolled out, an audit was conducted, typically at weekly intervals on different days of the week but at the same hour (1.00-2.00pm). The audit collected the number and frequency of call bells (Fig 1a),...
the completion of the IR form over 24-hours and patient feedback cards. Further metrics are now collected on pressure ulcers, falls and patient satisfaction data.

IR has demonstrated a significant reduction in the frequency of call bell usage and the length of time patients wait to have their call bells answered.

Fig 1b shows that when IR was performed consistently, call bells use reduced from an average of eight an hour before the system was introduced to one an hour after. It also reduced the time taken to respond to the calls from three minutes to less than one (Fig 1c). Evidence demonstrates that patients frequently use call bells for non-urgent needs as they feel it is the only way to gain nurses’ attention (Tea et al, 2008; Meade and Bursell, 2006).

Before IR, call bells were not prioritised due to their frequency (they were typically ringing for 24 minutes in every hour). IR significantly reduced call bell use so now, when a bell is rung, it is usually for a significant reason. The call bell is now more audible because it is used less frequently so not perceived as background noise.

Another positive impact demonstrated more recently concerned the early identification of pressure ulcers. The IR tool was amended to include a section on the form to acknowledge the risk of pressure ulcers, followed by a section indicating whether the patient’s skin has been inspected; this was further developed so nurses now complete the SKIN bundle tool.

At times IR activity reduced, for example when the workload was particularly demanding; Fig 1a and 1b show that when this happened, the use of the call bell increased, as did call bell duration. IR activity falling away from time to time coincided with a reduction in ward support by members of the IR project team. This was fed back to the ward sister and measures put in place to refocus the ward staff. The support from the project team, led by our practice development nurse, was essential in the early stages of implementation.

In addition to reducing call bell usage, IR has increased patient satisfaction. Musgrove Park Hospital uses many methods of collecting patient feedback, one of which is a system of feedback cards to identify any concerns or recognition of good practice. The cards are completed voluntarily by patients or relatives and deposited in a post box before discharge.

In the pilot MAU, we received nine exit card responses (eight beds) over a three-week period compared with just four from the rest of the ward (12 beds). In the first three weeks after IR had been implemented across the whole unit (20 beds), we received 27 exit card responses, all with positive comments. This compares to just four responses from the test bay of 12 beds over a same time period before rollout – a significant increase of approximately 58%.

While these numbers are small, there has been a noticeable rise in the number of thank-you cards received by the ward since the introduction of IR and a reduction in complaints and concerns (Fig 1d).

**Staff concerns**

Before implementing IR, we anticipated that staff would see the system as too time-consuming. We therefore reviewed potential problems identified in each of the six IR care domains in the pilot. It became apparent that most patients required little in the way of intervention (90% of rounds did not require any problems to be addressed), but patients valued being asked (feedback card responses valued the visibility of staff).

The majority of interventions/problems were resolved by the next round (85% in the trial period audit).

In addition, persistent problems are more readily identified and documented, and, since the effectiveness of interventions becomes clear quite quickly, this
intervention of the ward manager, matron and director of nursing. This issue was also highlighted in similar work carried out on an orthopaedic ward at Whips Cross University Hospital (Lucas et al, 2010).

**Staff evaluation**

A questionnaire was circulated to staff at the time of rollout (January 2011) asking questions on their perceptions of patient care; a follow-up sent out in June 2011 included additional questions directly comparing how they scored care out of 10 before IR and after IR. The response rate for the first survey was 28%, which improved slightly to 36% for the follow-up. The results were mixed.

There was no perceived change in the ability to provide individualised care during the initial pilot phase of implementing IR. Surprisingly, staff perceived they had less time to spend with each patient. Some comments from the questionnaire suggest that performing IR on well patients is seen to be to the detriment of those who are unwell as it takes staff away from these patients.

Staff were also asked to rate their own satisfaction with the care they were able to provide. Data appeared to show that staff were less satisfied since the implementation of IR. However, despite the negative evaluations of the impact of IR on staff time and satisfaction, when they were asked to compare the quality of care in January with that in June, they appear to report a significant improvement since IR was implemented.

Other comments on the questionnaires suggested that some staff did not fully understand the concept of IR. For example, several staff interpreted hydration to mean simply offering hot beverages at two-hourly intervals, which would be difficult to achieve and is neither necessary nor the purpose of including hydration as an element of IR.

We did, however, receive a significant number of positive comments, some of which are shown in Box 1.

**Staff buy-in to IR** is essential for successful implementation. It is imperative that all staff are provided with education and training before implementation and the director of nursing and senior nursing team are IR champions. Staff perceptions of the IR process need to be managed carefully and it should be emphasised that the patient should always be at the heart of the organisation.

As with any change process, there is always an element of resistance, which has to be managed sensitively.

**Conclusion**

Although some staff expressed concerns about the appropriateness of IR on a busy MAU, it has proved effective and not required additional staff.

The only obvious costs so far have been around the production and supply of the IR tool, and in maintaining the audit process. However, the latter is minimal as we already had a well-established ward audit process. With minimal organisational cost but a fundamental shift in ward routine, huge improvements in care have been achieved through implementing IR to the rest of the organisation over the past year.

The key to success is to reorientate ward activity to fit around the system rather than trying to fit IR into existing activity.

Conducting checks on patients simply with the intention of filling in a form will not resolve their problems. Perversely, it will take valuable time and will act as self-fulfilling prophecy for those wishing to dismiss the system as a paper exercise. This is still a problem in a small group of staff, despite clear evidence showing that when IR is done properly and consistently, patient experience significantly improves and improvements in the quality of care can be achieved.

It is also important that senior management recognise that staff need to be supported in implementing IR, through the provision of continued training.

The system requires a cultural change so managers cannot assume that, because IR focuses on fundamental care, it is easy to achieve.

**References**