Keywords: Ward rounds/ Communication/Change of practice

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Introducing hourly ward rounds to a large acute trust led to a reduction in buzzer calls but required staff education, commitment and support from a ward link coach

Caring around the Clock: rounding in practice

In this article...

- The Caring around the Clock scheme
- The benefits of hourly ward rounds
- How to bring about a change in practice

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Abstract Hutchings M (2012) Caring around the Clock: rounding in practice. *Nursing Times;* 108: 49, 12-14.

A large acute trust in the East Midlands looked to the US to inform its implementation of hourly rounding, otherwise known as intentional rounding. A combination of transformational leadership and meaningful interactions form the basis of a new approach to rounding – Caring around the Clock. The trust piloted the concept on 10 wards with results showing a 32% reduction in call lights. The successful change in practice required an investment in staff education to equip staff with the necessary skills. The trust is currently rolling out Caring around the Clock to 79 inpatient wards.

Hourly rounding can reduce patients' use of call buzzers, improve patient satisfaction and reduce incidence of falls (Meade et al, 2006). Gardner et al (2009), Woodard (2009) and Tea et al (2008) have produced further evidence of its positive effects on patient satisfaction. However, while the concept has a valuable place in nursing, there is little evidence on how best to implement hourly rounding.

The project to implement hourly rounding at Nottingham University Hospitals Trust came from me receiving a scholarship to travel to the US to see the system in practice (Hutchings, 2012). The scholarship had a big impact; it helped me realise staff do have the power to change things, and that power originates in the values we believe in as nurses. The concept of Caring around the Clock starts with being able to communicate this vision.

The tick-chart approach

In 2009, we took the concept of hourly rounding (proactive regular checks on patients) for the trust from a well-known study by The Studer Group, an American healthcare consultancy (Meade et al, 2006). The system was then implemented as a "tick-chart" approach across our acute trust, which has approximately 1,700 beds. In doing so, we encountered several challenges, which included poor staff engagement as well as minimal impact on patient care and experience.

In 2011, the Nottinghamshire Roosevelt Travelling Scholarship allowed me to spend three months visiting 14 hospitals in the US (mostly Studer Group-partnered hospitals) to investigate hourly rounding and learn from the experiences of US nurses using the system. This experience and attendance at national and international conferences, healthcare improvement, innovations, nursing excellence and transformational leadership led me to become completely immersed in healthcare leadership. Observation of practice and inspiring leadership created the conditions for ideas to flourish.

Design

After studying different models of rounding I developed Caring around the Clock; the name was chosen in response to the need to break the preconceived idea that rounding was simply a regimented process. Hourly rounding or intentional rounding had negative connotations; for many staff it was prescriptive and insinuated that care was inadequate.

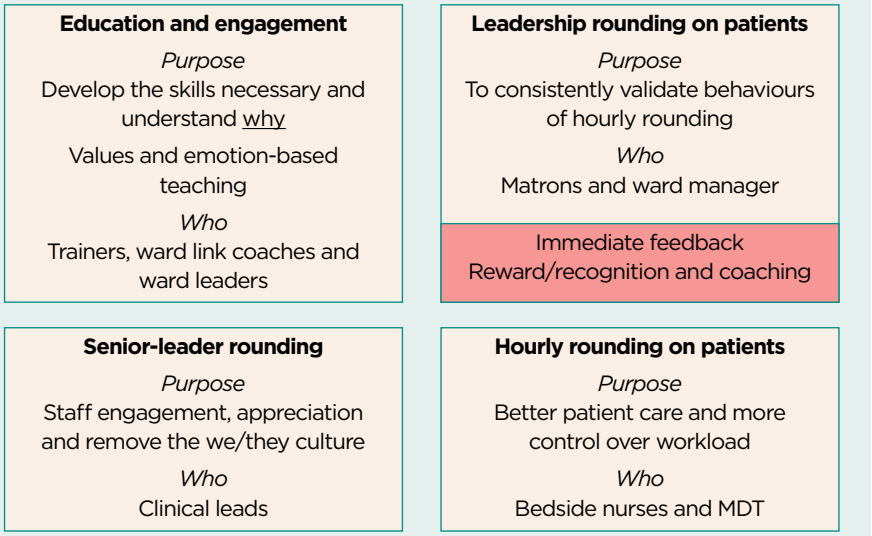
5 key points

1. Observation of practice and inspiring leadership create the conditions for innovations to flourish
2. The focus of Caring around the Clock is to make interactions between patients and staff meaningful
3. Ward leaders should be visible and seek daily feedback from patients using elements of appreciative enquiry
4. Leadership rounding enables ward leaders to use a coaching style with staff to strive for continuous improvement in patient care
5. Positive real-time feedback from patients is meaningful to staff

"Treat every patient as you would want your family to be treated"

Bernie Wilson p26

FIG 1. **THE CARING AROUND THE CLOCK MODEL**



Caring around the Clock is an umbrella term for three types of rounding combined with an education approach that engages staff (Fig 1). The term describes the processes involved in enabling us to guarantee to our patients they will receive good care (Fig 2).

Hourly rounding aims to make patients feel safe, cared for and confident in their care through regular interactions. Their needs can be anticipated and planned for by breaking down tasks and communicating nursing routines with patients and families. Staff put a physical clock at the patient's bedside, displaying the time they plan to return next; we chose this over a documentation-based approach based on best practices I saw in the US. I found clocks were the most interactive way of communicating with patients and families/carers about when they should expect the next routine attendance from nursing staff; the system also enables staff to plan attendances based on individual needs rather than in routine cohorts.

Staff need to be flexible and realistic in planning a return so they do not set themselves up to fail. Communicating this return should be a contract to the patient, and it should be visible to reassure patients and their families or carers.

Interaction with patients

The focus of Caring around the Clock is to make the interaction between patients and staff meaningful. The correct questioning around relevant safety and comfort issues is essential if we are to achieve the desired outcomes cited such as reductions in falls and pressure ulcers, and improved patient satisfaction. Staff should therefore avoid non-specific phrases such as "are you alright?" as this is too vague. Instead they are expected to ask questions based on a list known as the Ps and Qs (for example, pain, personal care, plan of care, questions and supplies), selecting only that which is appropriate for the patient in the next hour.

Leadership rounding

Ward-level leaders should be visible and seek feedback from patients on a daily basis using elements of appreciative enquiry. This means framing questions to elicit positive information instead of finding problems – that is, "What is going well with your care?" instead of "How is your care going?". This enables leaders to give staff real-time positive feedback that recognises and rewards good care.

Leadership rounding also gives ward leaders a clear idea of areas in which staff need to improve their practice and be given coaching by the leader. Leaders should use a coaching style with staff to enable continuous improvement.

Staff surveys carried out in the trust report staff do not feel valued and do not receive enough recognition. To address this, each ward has a staff recognition board in a public area, which is used to display comments obtained from patients during leadership rounding. The names of staff mentioned by patients as giving exceptional care are displayed with the comments in patients' words; it shows staff their positive effect on patient care and enables patients and staff to share positive feedback.

Senior-leader rounding

This strategy aims to make clinical leads (corporate-level leaders) visible and positive when in contact with staff. Interactions with staff should use elements of appreciative enquiry and senior leaders should recognise excellence. Another key feature of this is to facilitate discussions to overcome barriers to delivering high-quality care with Caring around the Clock.

Education and engagement

This is the fourth and most dynamic component. Staff need to commit to this change if it is to thrive and transform care; it requires communication that is meaningful to staff.

We created an emotional and values-based film, *Hands and Hearts*, featuring trust staff and patients to explain the rationale behind Caring around the Clock to other staff and call staff to action. The film includes values-based words written on the hands of staff to communicate their commitment and the purpose of nursing, as well as emotional words written on heart-shaped cards held by patients.

The pilot

Caring around the Clock was piloted on 10 wards; these were recruited on a voluntary basis after ward managers who heard an overview of the project expressed interest in taking part. The wards included spinal, neurosurgery, colorectal surgery, elective orthopaedic, healthcare of the older person, gastroenterology, stroke recovery, respiratory medicine, oncology and gynaecology.

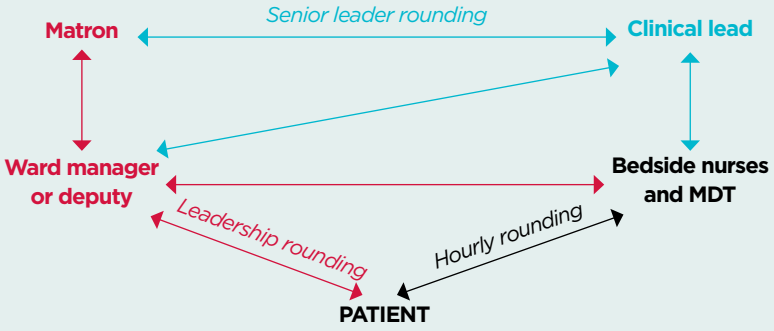
After ward staff had received training on the principles of Caring around the Clock, wards began hourly rounding, using clocks and Ps and Qs, supported by leadership rounding. After 4-6 weeks, pilot wards attended feedback sessions to share their experience by reporting "what went well" and "even better if". This feedback was vital to improving plans to roll out the initiative.

A key lesson from the pilot was that clocks used at patients' bedsides need to be appropriate to the patient group and positioned correctly. Four versions have now been designed; these are for use with children, adults, neurological patients and older patients, to meet their differing needs. On children's wards, the clock should be aimed at parents and positioned away from the immediate bedside; patients who are cognitively impaired need it to be away from the bedside to avoid being confused.

Signs of success

Early results from the pilot revealed a reduction in the use of call buzzers in

FIG 2. **CARING AROUND THE CLOCK FRAMEWORK**



seven of the 10 wards, resulting in a 32% overall reduction (Table 1). There was also a reducing trend in falls (however this could be attributed to a concurrent falls prevention campaign) and some patients commented on a noticeable positive difference. Anecdotal positive changes were also noticed in leadership at ward level and above.

Education

The success of the pilot persuaded the trust to set up a programme to deliver role-specific interactive training workshops. This was not only to facilitate the implementation of Caring around the Clock but also to support the cultural transformation needed to achieve excellence.

I worked closely with the learning and organisational development department to design the role-related workshops. These use a number of methods including filming role-play scenarios and use of live actors to enable each individual to develop the knowledge and practical skills they need to implement, embed and sustain Caring around the Clock.

Phased rollout

The new system is currently being implemented across the trust in a phased rollout. The rollout covers 79 inpatient wards but excludes critical care and the labour suite.

The trust created a ward link coach role to support the change in practice during the rollout period. In total, there are 11 ward link coaches, all of whom are senior nurses experienced in managing change or implementing projects; the main responsibilities of the role lie in delivering education and providing coaching at ward level. The coaches also act to enable supportive conversations at multiple levels in the nursing hierarchy to embed the processes and cultural changes of Caring around the Clock.

Each ward goes through a concentrated six-week period of support from the ward link coach to begin to embed the principles of Caring around the Clock. This involves training in week 1, intensive support in weeks 2 and 3, and lighter-touch support in weeks 4-6.

The rollout is currently in its infancy, and aims for approximately 16 wards to launch simultaneously around every three weeks, completing by spring 2013. Currently 47 wards are live with Caring around the Clock, including the pilot wards.

TABLE 1. **NUMBERS OF CALL BUZZERS BEFORE AND AFTER THE INTERVENTION**

Ward type	Pre-intervention calls	Post-intervention calls	Reduction (%)
Spinal	49	24	51
Neurology	17	10	41
Colorectal care	35	22	37
Orthopedic	37	23	38
Older people	35	19	46
Gastroenterology	46	24	48
Stroke	6	10	0
Oncology	9	12	0
Gynaecology	10	13	0
Respiratory	48	41	15
Overall	**292**	**198**	**32**

Challenges to implementation

Although we have had many positive experiences in introducing Caring around the Clock, a change in practice of this magnitude is difficult. The main difficulty at the beginning was staff engagement; many staff support the principles of Caring around the Clock but struggle with how to adapt ways of working to make it practical. This is why we created the ward link coach, to work alongside staff, guiding and coaching them to understand and adopt the principles of Caring around the Clock.

The clocks have been a key topic of controversy. Engaging staff with setting the clocks has required constant vigilance and coaching from ward managers. Patients' views have varied from finding clocks reassuring to seeing them as insulting to nursing staff. It has become clear it is vital to include patients in education and explanations when introducing the clocks to a ward setting.

Staff recognition boards have not always been welcomed; in several wards, staff disliked the idea of having their name displayed alongside the positive feedback from patients. We now gradually build up to displaying names on the boards, and allow wards to take their own approach to using the boards to ensure they fit the ward culture in relation to recognition.

We can see from the evidence in the literature and our own experience so far in rolling out Caring around the Clock, that the impact on patients will be hugely beneficial. Although challenging at times, it is worth investing time and leadership to create the cultural change that will lead us to install Caring around the Clock throughout the trust. **NT**

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