The introduction of intentional rounding in Musgrove Park Hospital led to improvements in fundamental aspects of nursing care

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. Rounds 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,
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 area care rated Increased from 6/10 to 7/10.

Community-acquired pressure ulcers (all grades) 10-fold increase in detection

Reported falls incidents 32% reduction

Patient concerns 37% reduction

Average duration of call bell ring time 54% reduction

Patient complaints 73% reduction

Number of call bells/hour 78% reduction

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>
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<tr>
<td>Patient complaints</td>
<td>73% reduction</td>
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<tr>
<td>Average duration of call bell ring time</td>
<td>54% reduction</td>
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<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</td>
</tr>
<tr>
<td>Staff perception of care rated</td>
<td>Increased from 6/10 to 7/10</td>
</tr>
</tbody>
</table>

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