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KING'S
College
LONDON



**Record keeping support staff to care well
for patients**

Aims of my presentation

- Describe Intentional Rounding
- Discuss how it was implemented in England
- Present the findings of a national evaluation of Intentional Rounding
- Discuss the aspects of the intentional rounding documentation that worked (and didn't work), for whom and in what circumstances
- Conclusions and recommendations

Background

The Telegraph

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David Cameron: There is a real problem with nursing in our hospitals

There is a "real problem" with the standard of nursing in British hospitals, David Cameron has said, as he today calls on nurses to make hourly rounds to ensure patients are comfortable.

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Nurses to make hourly rounds to improve patient care

Nurses will be told to carry out hourly ward rounds under government plans to improve hospital care standards in England.

Patients will also be encouraged to lead inspections in a series of measures to be announced by David Cameron to help tackle a "real problem" with patient care.

The prime minister says he believes nurses have too much paperwork and he wants them to spend more time with patients.

Jane Hughes reports.

06 Jan 2012

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Alexandra Topping and agencies

Fri 6 Jan 2012 13:40 GMT



Nurses to make hourly rounds under Cameron plans

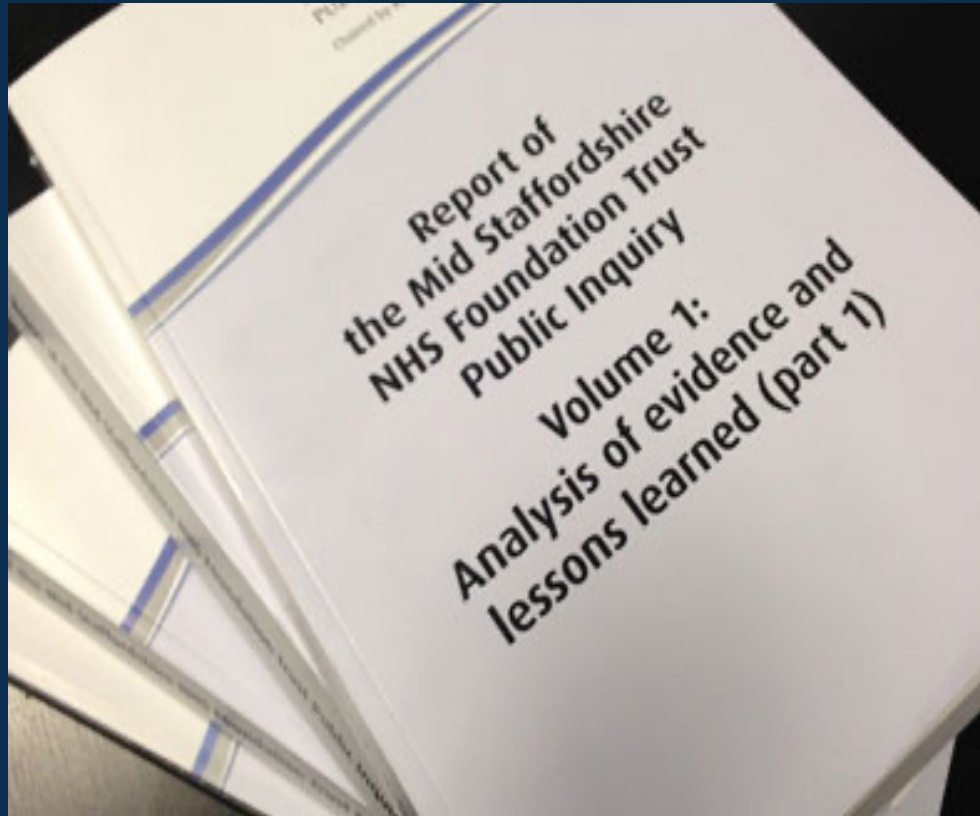
Prime minister wants hospital nurses to concentrate on 'patients not paperwork' to drive up standards



▲ Nurses will make regular rounds to talk to patients under plans to be put forward by David Cameron. Photograph: Getty Images

Nurses will be told to undertake hourly ward rounds while members of the public will be allowed to inspect hospitals, the prime minister has announced on a visit to a hospital in Salford.

David Cameron said most patients were happy with NHS care but there had been well publicised cases of patients not getting good basic treatment or being treated with respect.



“.... regular interaction and engagement between nurses and patients and those close to them should be systematised though regular ward rounds”(Francis Report, Vol III, Recommendation 238, “.... regular interaction and engagement between nurses and patients and those close to them should be systematised though regular ward rounds”

(Francis Report, Vol III, Recommendation 238, p1610)

Intentional rounding in hospital wards: What works, for whom and in what circumstances?

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Nigel Davies, *Specialist in Healthcare Leadership*

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Report available:

<https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr07350#/abstract>



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What is Intentional Rounding?



Pain **P**osition **P**otty **P**ossessions

Intentional Rounding Checklist

Rounding occurs on all patients

Schedule: Nurses round approx. every 2 hours on odd hours; NA/PMC round approx. every 2 hours on even hours

Date:	12am	2 am	4am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9 pm	10pm
Intentional rounds completed by: (place initials in box indicating time of rounds, check all items below that apply for that time)																				
3 P-s																				
Pain Assessment																				
Toileting (potty) - assist patient to restroom																				
Positioning																				
Environmental scan																				
Fall risk hazards: bed in low position, cords are secured																				
Phone, water, tissue, urinal, bedside table, trashcan, and call light are within reach																				
Temperature of room, blankets, pillows																				
Prior to leaving room																				
Ask, "Is there anything else I can do for you? I have the time."																				
Remind the patient that a staff member (let them know who) will be back in about an hour to round on them again.																				
Document the round on the patient's chart.																				

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____

Signature/Initials: _____



Pain Personal care, Patient, Professionals
"How is your pain?"

Study aim

The **overall aim** of the study was to investigate the impact and effectiveness of IR in hospital wards in England on the organisation, delivery and experience of care from the perspective of patients, their family carers and staff.

Study methodology

The **study design** was multimethod underpinned by **realist evaluation** (Pawson & Tilley 1997)



Phase 1: Realist synthesis

Phase 2: National survey of all NHS acute trusts in England

Phase 3: Case studies

Phase 4: Accumulative data analysis

What is realist evaluation?

- Realist evaluation is a strategy for evaluating *complex social interventions* which provides an explanatory analysis of how and why a complex intervention works (or doesn't work) in particular contexts and settings.
- It does this by:
 - Unpacking the *mechanisms* (or underlying theories about *how* a social intervention works or doesn't work).
 - Exploring the *contexts* which trigger or deactivate these mechanisms.
 - Linking these *contexts* and *mechanisms* to their subsequent *outcomes*:



What is a Context, Mechanism and Outcome (CMO)?

Mechanism

- Mechanisms describe what it is about programmes and interventions that bring about any effects. It is not programmes that work, but the resources they offer to enable their subjects to make them work. This process of how subjects interpret and use the resources offered by the intervention is known as the mechanism.

Context

- Mechanisms will only be active in particular circumstances, that is, in different contexts. Context describes those features of the conditions in which programmes are introduced that are relevant to the operation of mechanisms. Context must not be confused with locality; it can include cultural norms, economic conditions, existing public policy, for example.

Outcome

- Also known as outcome patterns. Outcome patterns comprise the intended and unintended consequences of programmes, resulting from the activation of different mechanisms in different contexts. They can be proximal, intermediate or distal.

Dalkin et al. "Exposing the impact of intensive advice services on health: A realist evaluation. *Health and Social Care in the Community*". 2018, 27(3): 767-776.

Phase 1: Realist synthesis

Stage 1: Identify *theories* or *assumptions* about why/how intentional rounding works or is expected to work. **89** documents included. **8** programme theories identified.

Stage 2: Identify *empirical research* to support/refute theories identified in stage 1 or identify any new ones. **44** documents included.

SYSTEMATIC REVIEW

6 OPEN ACCESS

Realist synthesis of intentional rounding in hospital wards: exploring the evidence of what works, for whom, in what circumstances and why

Sarah Sims,¹ Mary Leamy,¹ Nigel Davies,² Katy Schnitzler,³ Ros Levenson,⁴ Felicity Mayer,⁵ Robert Grant,⁶ Sally Brearley,⁶ Stephen Gourlay,⁶ Fiona Ross,⁶ Ruth Harris⁶

ABSTRACT
Background Intentional rounding (IR) is a structured process whereby nurses conduct one to two hourly checks with every patient using a standardised protocol.
Objective A realist synthesis of the evidence on IR was undertaken to develop IR programme theories of what works, for whom, in what circumstances and why.
Methods A three-stage literature search and a stakeholder consultation were completed. A variety of sources were searched, including AMED, CINAHL, MEDLINE, PsycINFO, HMIC, Google and Google Scholar, for published and unpublished literature in line with realist synthesis methodology, each study's 'theory for purpose' was assessed by considering its relevance and rigour.
Results A total of 44 papers met the inclusion criteria. To make the programme theories underpinning IR explicit, we identified eight a priori propositions: (1) when implemented in a comprehensive and consistent way, IR improves healthcare quality and satisfaction, and reduces potential harms; (2) embedding IR into daily routine practice gives nurses 'allocated time to care'; (3) documenting IR checks increase accountability and set fundamental standards of care; (4) when workload and staffing levels permit, more frequent nurse-patient contact improves relationships and increases awareness of patient comfort and safety needs; (5) increasing time when nurses are in the direct vicinity of patients promotes vigilance, prevents escalation and reduces potential harms; (6) more frequent nurse-patient contact enables nurses to anticipate patient needs and take pre-emptive action; (7) IR documentation facilitates teamwork and communication; and (8) IR empowers patients to ask for what they need to maintain their comfort and well-being. Given the limited evidence base, further research is needed to test and further refine these propositions.
Conclusions Despite widespread use of IR, this paper highlights the paradox that there is ambiguity surrounding its purpose and limited evidence of how it works in practice.

INTRODUCTION
In 2013 the Francis Inquiry¹ examined evidence about the reasons for failures in patient care at Stafford Hospital, UK, and made recommendations for improvement. One of these recommendations was that 'regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds' (p1710).² This recommendation has become synonymous with 'intentional rounding' (IR), a structured process developed in the USA and marketed by the Stodex Group,³ whereby nurses carry out one to two hourly checks with every patient using a standardised protocol and documentation (box 1).
The UK government's response to the Francis report expected all National Health Service (NHS) hospitals to implement IR within 1 year,⁴ reinforced by a 'comply or explain' approach used in Case Quality Commission Hospital Inspections,⁵ and as a result IR has been introduced in the majority of hospitals. A number of benefits have been claimed, including a reduction in call bell use, falls and pressure sores, and increased patient satisfaction.⁶⁻¹⁴ However, substantial limitations to this evidence base have been highlighted, including concerns around selection bias, potential conflicts of interest, and weaknesses in study design and analysis,¹⁵⁻¹⁹ which may, in part, be due to what Marshall et al¹⁶ would say is the urge to act (or inaction) in the absence of a scientific approach to improvement science.²¹ In line with recommendations for evaluative approaches in improvement science advocated by Don Berwick,¹⁸ for this study we adopt a realist evaluation.¹⁴

Check for updates

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743

So, what is a programme theory?



It's just how and why you think the intervention will work.



RAMESESPROJECT.ORG

Sims et al. *BMJ Quality & Safety* Sep 2018, 27 (9) 743-757

8 preliminary theories of intentional rounding

- Allocated time to care
- Visibility of nurses
- Nurse-patient communication
- Consistency and comprehensiveness
- Accountability
- Anticipation of needs
- Staff communication
- Patient empowerment

Mechanism title	Mechanism (resources)	Mechanism (reasoning/responses)
Consistency and comprehensiveness*	<ul style="list-style-type: none"> ● IR helps keep patient care consistent through the use of a structured, systematic approach, ensuring that all patient needs are met and potentially less obvious aspects of care are considered and managed at every round ● IR also helps ensure that carers are provided with consistent care and information in line with their needs (e.g. the need for information, to be respected and to be comforted) ● It can also prompt agency staff to deliver care to a required standard 	This provides reassurance and confidence in the quality of care to patients, their carers and staff
Allocated time*	IR gives nurses allocated 'time to care' (i.e. gives time to check that patients are comfortable and their needs are being met, thereby treating patients with dignity, and replaces 'presumed care')	This helps nurses to organise their work and feel able to prioritise this aspect of nursing care
Accountability*	Staff are required to complete and sign the IR document to say that they have carried out hourly checks	<ul style="list-style-type: none"> ● This makes staff feel personally accountable for the standard of care ● This enables ward managers to monitor and audit the standard of care provided by nursing staff
Nurse–patient relationships and communication*	<ul style="list-style-type: none"> ● IR provides increased and improved communication between staff, patients and carers, and ensures that the patients' perceived basic fundamental needs are met ● It also provides more opportunities for positive nurse–patient relationships to develop based on trust, respect and caring 	This enables staff to get to know patients better and become more aware of their needs, notice unusual behaviours/appearances and detect subtle/significant changes that can affect comfort and safety



Mechanism title	Mechanism (resources)	Mechanism (reasoning/responses)
Visibility*	IR increases the visibility/presence of nurses within a unit by increasing the time that nurses spend in the direct vicinity of their patients (i.e. it gets nurses to the patient's bedside)	<ul style="list-style-type: none"> • This relieves the uncertainty and anxiety often associated with vulnerable patients' hospital experience (i.e. the inability to predict when care will be delivered and when someone will be available to assist them with care) • This is comforting to carers because it denotes frequent and continuous assessment of the patient and their needs
Anticipation*	IR enables nurses to anticipate/pre-empt and proactively address patient needs instead of being reactive and waiting for patient call bells and alarms	This ensures that all patients receive regular care instead of unequally distributed care among patients focused towards those who have frequent call bell use
Staff communication and/or teamworking	IR provides health-care professionals with documented evidence	This is used to enhance staff communication, teamwork and prioritise care in future rounds
Patient empowerment	IR provides an opportunity for nursing staff, patients and carers to get to know each other better	This empowers patients to ask for what they need in order to maintain their comfort and well-being

Main findings from Phase 1 – Realist Synthesis

- This synthesis generated eight CMO configurations, which were tested and refined in subsequent phases of the study.
- Despite the widespread use of IR, there is ambiguity surrounding its purpose and limited evidence of how it works in practice.
- Differences in the implementation of IR demonstrate the importance of care delivery context and highlight that IR has been adapted in different contexts and as time has progressed.



Phase 2: Main findings from national survey (n=108, 70% RR)

- 
- **97%** of NHS acute trusts in England had implemented IR in some way, (although considerable variation in implementation).
 - **89%** of Trusts had a mixture of registered and unregistered nursing staff conducting IR.
 - **81%** of Trusts had a structured protocol, script or procedure in place for IR. Additional items e.g., checks of intravenous lines, fluid balance charts
 - Documentation of IR took place in **96%** of Trusts.
 - **64%** of Trusts had implemented IR on all wards
 - **80%** of Trusts reported that, on the wards where IR had been implemented, it occurred for all patients.
- 

Phase 3: Case Studies



- 3 purposively sampled case study hospitals; 1 acute ward and 1 care of older people in each hospital site = 6 wards in total
- **One-to-one interviews** were conducted with 17 senior nurse managers, 33 frontline nursing staff, 26 non-nursing healthcare professionals, 34 patients and 28 family carers.
- 188 hours of direct care delivery was observed by four research staff over day and night shifts using QUALPACS to measure quality of care. 39 nursing staff also 'shadowed'.
- Safety thermometer data
- Cost analysis



Documentation in the three case study hospitals

Hospital 1

- Four-page A4 booklet.
- Frequently revised according to perceived need.
- Includes 4Ps questions and the 'Is there anything else I can do for you?' question
- **Adaptation of IR beyond Studer format**
- IR documentation included questions about mobility, bed rail position, special mattress, body map to record skin integrity and presence of medical devices

Hospital 2

- Two-sided form.
- Includes 4Ps questions and the 'Is there anything else I can do for you?' question
- **Adaptation of IR beyond Studer format**
- IR documentation included questions offering drinks/snacks, falls prevention, body map to record skin integrity and presence of medical devices.
- Space available to document any actions resulting from IR

Hospital 3

- Two versions of the IR form.
- Both are part of a 49-page nursing documentation bundle
- IR form for those with a Waterlow score of < 10 includes 4Ps questions but not the 'Is there anything else I can do for you?' question
- IR form for those with a Waterlow score of \geq 10 includes assessment of surface, skin, position, incontinence and nutrition but not the 4 Ps questions or the 'Is there anything else I can do for you?' question
- **Adaptation of IR beyond Studer format**
- IR form for patients with a Waterlow score of \geq 10 included assessing skin inspection, nutrition and special mattress needs

IR documentation site 1

Intentional rounding																			
Patient name					Hospital number.....					Ward.....									
NHS No.....					Date.....														
RN responsible for care: RN Night.....			RN AM.....			RN PM.....			RN Night.....										
4 P's		RN 02:00	04:00	06:00	RN 8:00	9:00	10:00	11:00	RN 12:00	13:00	14:00	15:00	RN 16:00	17:00	18:00	19:00	RN 20:00	22:00	00:00
	PROMPT: Pain																		
	PROMPT: Personal Cares																		
	PROMPT: Positions																		
	PROMPT: Possessions Glasses/Hearing Aid/Dentures/ Water Jug/Glass/Nurse Call etc																		
Falls risk	Falls Risk: G = green, A = Amber, R = red																		
	Alert/Confused/Asleep/ Agitated/Delirium/Dementia A/C/As/Ag/Del/Dem																		
	Is footwear appropriate Hourly – Yes/No																		
SKIN bundle	Surface – Appropriate mattress?/seat cushion appropriate/sheets smooth																		
	Skin Condition – Document skin check key (Document frequency in variance box)																		
	Change position																		
Designation																			
Signature																			

Is there anything else I can do for you?

IR documentation site 2

Daily intentional rounding													
Patient name.....				RN responsible for care				Key:					
Hospital no.....				RN Day.....				When checked <input type="checkbox"/>					
Ward..... Date.....				RN Night.....				Off ward OW					
Please enter patient's response to the 4 comfort questions Y = Yes N = No UC = unable to communicate NA = not applicable													
Please enter time patient received rounding													
Would you like a drink and/or a snack?													
Do you need to go to the toilet?													
Are we managing any pain you have adequately?													
Is there anything else I can do for you?													
Falls prevention													
At risk of falls? Yes <input type="checkbox"/> No <input type="checkbox"/> Bed rails up <input type="checkbox"/> Bed rails down <input type="checkbox"/>													
Is the bed area safe, clean and free of clutter?													
Check the call bell is within easy reach?													
Is the bed at lowest height?													
SKIN bundle													
Surface Check position of all invasive devices													
Is mattress/seat appropriate/sheets smooth?													
Document skin check key													
Keep Moving Document position key													
Incontinence Clean and dry please check													
Nutrition Malnutrition screening tool completed as per Trust guidelines													
Check heels													
Designation													
Signature													
Position keys OW Off ward ST/C Standing from chair SB Sat in bed F Front R Restless T Therapy H Patient refused LR Log rolled P Position changed for care M Mobile LT Left side RT Right side etc.....													
SKIN check keys A No marking B Blanching erythema C Non-blanching erythema D Broken or blistered (Commence wound care plan) E Intact dressing etc. Type of mattress..... Frequency of positioning..... Pressure ulcer risk assessment: High (2 hourly rounding min) <input type="checkbox"/> Medium (4hourly) <input type="checkbox"/> Low (daily) <input type="checkbox"/>													

IR documentation site 2 – second page

Pressure ulcers are generally more localised above bony prominences

Check all these areas on your patient. Please indicate any devices present on the patient by placing the numerical code on the Body Map where appropriate. If any pressure damage identified please place a cross on the relevant area on the body map. If broken or blistered skin, start a wound care plan and complete e-AIMS.

1. O2 mask
2. Cannulae
3. Monitoring devices and cables
4. Epidural/block site
5. Patient extremities not touching foot or head board
6. Drips and drains
7. EVD drain
8. Pressure damage
9. Urinary catheter
10. Remove all VTE devices (stockings, intermittent pneumatic compression e,g Flowtrons) to check heels daily

Body map 1 & 2 drawn here
(Front and back view)

Document any variance/deviation and any actions resulting from rounding e.g. Pain control medication administered:

IR documentation site 3 - (for patients with a Waterlow score of ≥ 10)

DAY X SKIN & ADVANCE COMFORT CARE BUNDLE DAY X

Complete for all patients with a Waterlow Score of 10 or over or with restricted mobility

Continuously complete one form each day. Use the best practice care standards outlined in the Prescription of Care detailed in each section below to develop an appropriate individualized care plan

DAY X – Date:

Document Time																				
Signature (initials)																				
SURFACE	Bed mattress FM foam mattress AMO air mattress overlay AMR air mattress replacement chair cushion FC foam cushion AC air cushion Heel protection OB offloading boots HRS heel relief shoe/sandal PD patient has declined use of specialist surface O other: specify in action taken / comments																			
Mattress type																				
Inflation on/off																				
Heels off loaded																				
Check bed height (safety)																				
SKIN INSPECTION	N no pressure damage found G1: Grade 1 G2: Grade 2 G3: Grade 3 G4: Grade 4 ML moisture lesion (skin excoriation and incontinence associated dermatitis)																			
Left heel																				
Right heel																				
Sacrum																				
Buttocks																				
Ears																				
Nose																				
Other																				
Anti-embolic																				
KEEP MOVING	IN independent 1. Left side 30 tilt 2. Right side 30 tilt 3. Sitting in bed 4. Lying in bed 5. Sitting in chair 6. Stand /walk 7. Declined (document discussion in care plan)																			
Position changed																				
Pain level checked																				
Call bell within reach																				
INCONTINENCE	I independent C continent U urine F Faeces B both																			
Clean and dry																				
Barrier applied																				
Toilet needs checked																				
NUTRITION	I independent NB nil by mouth IV IV maintenance fluid EF Enteral feeding																			
Drink taken																				
Food taken																				
Supplement taken																				
Teeth/dentures/m mouth care offered																				

Prescription of care to be completed by the registered nurse responsible for the patient on the early shift – tick as appropriate

SURFACE (mattress, heels off loaded, chair cushion) **SKIN** (new full skin assessment completed, TEDS removed / heels checked etc) **KEEP MOVING** (turning regime etc) **INCONTINENCE, NUTRITION** etc

Case study findings – Nurse-patient communication

Interview data

- Whilst some nursing professionals believed IR increased the frequency of nurse-patient communication, very few believed it improved the quality.
“... the contact becomes transactional rather than enriching, so you’re not having a conversation with that patient” (Senior Nurse)
- Patients and family carers valued the relational elements of their interactions with nursing staff. They wanted care when they needed it and were less concerned about the precise regularity or structure of rounding.
- Some patients disagreed with a structured, scripted approach to communication and preferred nursing staff to use their “initiative and sensitivity”.
“I don’t think that’s very people friendly really.” (Carer)

Case study findings – Nurse-patient communication

Observation data

- Nursing staff and patients were observed to talk to each other often, although the majority of interactions were not observed to be part of an IR.
- On average, patients had a direct interaction with a member of nursing staff (e.g. registered nurse (RN), healthcare assistant, student nurse) every **17.52 to 21.8 minutes**.
- On average, patients had a direct interaction with a member of registered nursing staff every **36.29 to 38.92 minutes**.

Nurse-patient communication – revised theory

No evidence that IR was a vehicle for meaningful *nurse-patient conversations*, even if nurses deviated from script/set questions and developed their own style of doing IR. No outcomes were associated with this mechanism.

Mechanism not activated.

Case study findings – Accountability

Interviews

- Frontline nursing staff and managers worried the main focus of IR was in completing the documentation rather than in the conversation with the patient.

“... the task had become the documentation not the actual conversation or the care”

(Senior Nurse)

- Nursing staff viewed IR documentation primarily as a means of protecting themselves, rather than patients, by providing written evidence that they had provided care should incident or complaint arise.

Interviewer: “Do you think if you didn’t have to sign it, you might not go in [to a patient’s room to do IR]?”

Staff Nurse: “Oh, no, I think I would go in but I think it’s a good way of showing that I’ve gone in”

(Staff Nurse, Band 5)

- Concerns raised that IR documentation was not always accurate, which could lead to a false sense of security for nursing managers and incorrect information provided to family carers .

“...from what I see on an audit, it literally is a tick, tick, tick, tick, tick, tick, tick, tick.

Now, for me, that doesn't necessarily mean it was done...”

(Senior Nurse)

Case study findings – Accountability

Observation data

- Frontline nursing staff were very busy and carried out a wide range of tasks. IR was usually combined with other activities and staff were frequently interrupted when undertaking IR. Staff were therefore often observed to document IR retrospectively.
- On occasion, staff delivered what looked like IR but did not complete IR documentation.
- IR was also observed to be completed prospectively.

Case study findings – Accountability

Fidelity to the original IR intervention

- 240 IRs were observed within 188 hours of care delivery observation. Whilst **86%** of all IR interactions were observed to be documented, fidelity to the original intervention (i.e. Studer Group protocol) was generally low. For example:
- ‘Positioning’, ‘personal needs’, ‘pain’ and ‘placement of items’ questions were observed to be asked in **27%, 26%, 26% and 23%** of rounds, respectively.

Accountability – revised theory

Some evidence that when documented ‘authentically’, IR provided nurses, ward and senior nursing managers with reassurance and evidence that basic, fundamental patient care had been delivered.

When the accountability mechanism was activated, this contributed to the following outcome:

Nurses said they could use IR documentation to provide evidence that they had delivered basic, fundamental patient care to a minimum standard.

No evidence that IR increased personal accountability, as nurses said they already felt a professional accountability for the care they delivered.



IR documentation:

*What works well and what
doesn't work well*

What aspects of Intentional rounding documentation worked?

- Assurance of care delivered

“... from an executive nurse’s perspective, gives me some assurance that if you’ve ticked box then

you’ve done it, and if not ticked box, you haven’t.” Executive Director of Nursing

- A ‘checklist’, an ‘aide memoire’ or a ‘framework’, which supported staff to deliver care and prompted them to think about safety aspects of patient care
- Helpful for junior and temporary staff or those unfamiliar to the ward to know what they should be doing
- Staffing levels and job demands enabled nurses to complete and document IR without continuous interruptions or having to prioritise other duties
- Facilitate some communication between nursing staff, although this tended to focus on whether or not patients had been checked.
- Staff were encouraged to complete documentation accurately
- There were clear instructions about how to adapt to meet patient need e.g., frequency of risk assessments
- Documentation was kept by the patient’s bedside

What aspects of Intentional rounding documentation did not work?

- Where IR is undertaken in a prescriptive way – care can be missed
... so we've got kind of one kind of uniform approach, and it's all in one booklet. But then there's certain things that aren't in the booklet, so then there's risk of, if it's not in the booklet we don't have to do it, does that make sense? Matron
- Focus on completed documentation not the care delivered
... the task had become the documentation, not the actual conversation or the care. Director, service development
- When there was a shortage of staff or frequent interruptions, staff were not able to complete the IR and/or document at the time the care was given.
- Documentation had fixed timepoints rather than space to write actual time
- The IR had expanded to include many additional items which took a long time to complete
- Staff were unclear about the purpose of the IR and documentation
- Where documentation was completed inaccurately.
- Where IR was undertaken by unqualified staff only
- Where there was no space for nursing staff to record any variation/deviance or any actions resulting from rounding (e.g. pain control, medication administered).

Tensions of checklists in nursing care delivery

- *Type of activity*
 - task-orientated activities (i.e. anyone can do it if they have a checklist) vs. worker-orientated activities (i.e. requires knowledge and skill that goes beyond any checklist).
 - In UK the site-specific adaptations tailored to individual patients requires additional nursing knowledge and skill than the original US version of intentional rounding developed by Studer Group.

Tensions of checklists in nursing care delivery

- Checklists to improve safety
 - *“... advantages to standardising performance, time is not critical, the series of tasks is too long to be committed to memory (or there are likely to be interruptions to execution of the task that might interfere with memory retrieval), and the environment enables a physical list to be accessed and used.”*

Clay-Williams and Colligan

Tensions of checklists in nursing care delivery

- Nursing requires an approach with more flexibility than a standard checklist e.g. in aviation
- Nurses were encouraged to do IR around other tasks, rather than a discreet activity
- IR completed every one to two hours
- Intentional rounding in its original 4 P's structure is not complex
- Ongoing versus one-off activities



Overall conclusions

- IR reduces the scope of nursing practice, privileging a transactional and prescriptive approach over relational nursing care.
- Intentional rounding is used by nursing staff as a defence/safety net
- IR protocol as defined by the Studer Group in United States is not sufficient in England
- IR adds to the tension inherent in the delivery of systematised care vs. individual patient care
- IR is not visible to patients and carers
- IR does not contribute to multidisciplinary care
- This study shows the effectiveness of IR, as implemented and adapted in England, is weak.

Recommendations

- “Well, if I were you, I wouldn’t start from here”.
- We suggest that there is a need for a national discussion/debate among nursing managers and leaders about whether IR is the best way to support the delivery of fundamental nursing care to patients.
- De-implementation - or “stopping practices that are not evidence-based” or “to abandon care that wastes resources or delivers no benefit to patients”
- Significantly revise IR to address weaknesses identified in this research.

Key study publications (all open access):

- **Harris R, Sims S, Leamy M, Levenson R, Davies N, Brearley S, et al.** Intentional rounding in hospital wards to improve regular interaction and engagement between nurses and patients: a realist evaluation. *Health Serv Deliv Res* 2019;7(35). Available at: <https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr07350/#/abstract>
- **Sims S, Leamy M, Levenson R, Brearley S, Ross F, Harris R** (2020) The delivery of compassionate nursing care in a tick-box culture: Qualitative perspectives from a realist evaluation of intentional rounding. *International Journal of Nursing Studies* 107, July Accessed at: <https://doi.org/10.1016/j.ijnurstu.2020.103580>
- **Sims S, Leamy M, Davies N, Schnitzler K, Levenson R, Mayer F, Grant R, Brearley S, Gourlay S, Ross F, Harris R** (2018) Realist synthesis of intentional rounding in hospital wards: exploring the evidence of what works, for whom, in what circumstances and why. *BMJ Qual Saf* 2018;27:743-757. <http://dx.doi.org/10.1136/bmjqs-2017-006757>
- **Harris R, Sims S, Levenson R, Gourlay S, Ross F, Davies N, Brearley S, Favato G, Grant R** (2017) What aspects of intentional rounding work in hospital wards, for whom and in what circumstances? A realist evaluation protocol. *BMJ Open* 2017;7:e014776. <https://bmjopen.bmj.com/content/7/1/e014776>
- **Nursing Standard podcast:** what is intentional rounding – and is it worth doing? <https://rcni.com/nursing-standard/newsroom/podcast/nursing-standard-podcast-what-intentional-rounding-and-it-worth-doing-161056> 13th

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Thank you

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