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

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Scientific summary

Background

The government response to the high profile care failures at Mid Staffordshire NHS Trust was to announce the policy imperative of introducing *"regular interaction and engagement between nurses and patients"* into the NHS. Although a longstanding and cherished principle of nursing is to regularly observe and respond to patient needs, sometimes known as comfort rounds, the need for a national and rapid nursing response resulted in adopting the US model, known as "Intentional Rounding" (IR). IR is a timed, planned intervention that sets out to address fundamental elements of nursing care by means of a regular bedside ward round.

Objectives

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 member (hereafter referred to as 'carers') and staff. The research question was: *'What is it about IR in hospital wards that works, for whom and in what circumstances?'* This was investigated at four levels of the organisation and delivery of health services: national, service provider organisation, individual ward/unit and individual person, to identify the ways in which the context (i.e. the environment and organisation) at each of these levels influenced the mechanisms (i.e. the assumptions and theories about the ways in which IR achieved its objectives) and the outcomes or impact. The study objectives were to:

1. Determine the number of NHS Trusts in England that had implemented IR and analyse how this had been developed and supported.
2. Identify how IR had been implemented 'on the ground' and evaluate its contribution to the delivery of patient care as a whole and how it fits in alongside other approaches to improving quality and safety.
3. Explore nursing staff, healthcare assistants and other clinical and management staff experiences of IR and how it impacts on the way they deliver care.

4. Explore patients' and their carers' experiences and perceptions of how IR influences their experiences of care.
5. Investigate trends in patient outcomes (retrieved from routinely collected NHS ward data) within the context of the introduction of IR and other care improvement initiatives that have been introduced by using statistical process controls methods such as cumulative sum (CUSUM) charts.
6. Examine the barriers and facilitators to the successful implementation of IR.
7. Conduct a bottom-up analysis of the costs of IR by identifying the resources used by case study wards to develop and implement it.
8. Synthesise the data from each of the study phases to identify which aspects work, for whom and in what circumstances.

Methods

A multi-method study design was undertaken using realist evaluation methodology to evaluate the implementation of IR in England. Realist evaluation is a theory-driven approach designed for evaluating complex social interventions. It acknowledges that complex social interventions only ever work for certain people in particular circumstances and sets out to understand and explain the patterns of success and failure by asking the exploratory question: 'what is it about this intervention that works, for whom and in what circumstances?' It does this through the realist evaluation heuristic tool (Context-Mechanism-Outcome configurations – CMOs) in order to generate causal statements of how the intervention works. The study was conducted in four phases:

1. Theory development, which highlighted eight a priori propositions and developed a framework to test emerging findings from subsequent research phases;
2. National survey of all NHS acute Trusts in England;
3. In-depth case studies of six wards in three NHS acute Trusts involving individual interviews with healthcare staff, patients and their carers; observations of IR and nurse shadowing; retrieval of routinely collected ward outcome data; and analysis of costs; and
4. Synthesis of study findings.

A multi stakeholder advisory group provided support to the study throughout – informing the method, receiving and critiquing the emerging results and acting as a critical friend from the perspective of service user, carer, senior manager and policy maker.

Results

The **realist synthesis** of existing evidence highlighted that:

1. Despite the widespread use of IR, there is ambiguity surrounding its purpose and limited evidence of how it works in practice;
2. Differences in the implementation of IR demonstrate the importance of care delivery context and highlight that IR has been adapted in different contexts and over time.

The eight Context-Mechanism-Outcome configurations generated from the synthesis related to: consistency and comprehensiveness; allocated time to care; accountability; nurse-patient relationships and communication; visibility of nurses; anticipation; multidisciplinary teamwork and communication and patient empowerment. These were tested in the national survey and the case study sites against the questions of how IR may work, for whom and in what circumstances.

The **national survey** had an excellent response of 108 (70%) of all NHS acute Trusts in England. The survey highlighted that:

1. One hundred and five Trusts (97%) had implemented IR in some way.
2. Ninety three (89%) of Trusts had a mixture of registered and unregistered nursing staff conducting IR.
3. Eighty five (81%) of Trusts had a structured protocol, script or procedure in place for IR.
4. Documentation of IR took place in 96% of Trusts.
5. Large variations were noted across Trusts as to when IR was implemented; on which wards and for which patients; how regularly IR was conducted; what

aspects of care were included; and what educational opportunities staff received about IR.

Research at the **case study sites** included 17 semi-structured, individual interviews with senior trust and ward managers. Key themes identified were:

1. All senior Trust and ward managers mentioned accountability in some way during their interview. Accountability was seen to be demonstrated primarily by the *documentation* of IR. Senior staff felt that one of the benefits of IR was the documented evidence it provided, although they acknowledged that this evidence was not always sufficient/reliable.
2. Most senior staff described IR as a checklist, an aide memoire or a framework which supported nursing staff to deliver care. However, there were concerns that it could be used in a prescriptive, task orientated way, when it should be delivered in a conversational way, tailored to individual patient needs. None of the senior staff interviewed thought that IR should be delivered in a standardised, rigid way at every round.
3. IR was thought to facilitate some communication between nursing staff, although this was limited and tended to focus on whether or not patients had been checked.
4. Few senior staff believed IR increased the frequency or quality of staff communications with patients.
5. Senior staff did not see IR as providing nurses with 'time to care'. The majority thought that staff were delivering care to patients and that the IR paperwork supported what they were already doing.

Thirty three semi-structured, individual interviews were also conducted with frontline nursing staff. Key themes identified were:

1. All frontline nursing staff mentioned accountability in some way during their interview. However, most did not talk about IR influencing their own personal

accountability for standards of care delivered, though some acknowledged it may improve standards in hospitals that were providing poor care.

2. Half of all frontline nursing staff interviewed felt a positive outcome of IR was that it provided evidence that nursing care had been delivered. Most viewed this as a means of protecting oneself following an incident or complaint.
3. All frontline nursing staff mentioned the consistency and comprehensiveness mechanism in some way during their interview. Many referred to IR as a checklist or system for checking upon a wide variety of patient needs. They also felt IR offered a useful prompt or reminder to prevent staff forgetting to undertake particular tasks.
4. Opinion was divided upon whether IR should be applied to all patients but no frontline nursing staff felt IR should be applied using a structured, systematic approach at every round. Instead, they talked about using their clinical judgement and common sense to tailor IR to each patient.
5. Some frontline nursing staff felt IR increased the *frequency* of nurse-patient interactions, though these communications were usually brief, rather than lengthy discussions. Few believed IR could improve the *quality* of nurse-patient interactions.
6. No one felt they had been given specific, allocated time in which to undertake IR.
7. Half of all frontline nursing staff felt IR encouraged or improved staff communication; generally an improved handover of information about patients between nursing staff or across shifts.
8. Few frontline nursing staff felt IR impacted upon nurse visibility, anticipation of needs or patient empowerment.

Twenty six semi-structured, individual interviews were carried out with members of the multidisciplinary ward team including doctors, OTs, physiotherapists, dietician, pharmacists and administrative staff. Key themes identified were:

1. The understanding of IR within this sample was mixed, because whilst some had direct experience of delivering IR, others had only learned about it through their own observations of nursing care.

2. It was rare for other healthcare staff to directly refer to IR documentation. Although some realised they asked patients similar questions, it was more usual for other healthcare staff to find a nurse on duty to speak to.
3. Other healthcare staff recognised the dilemma between having a structure which was used in a standardised and formal way for everyone verses the need for flexibility to adapt to suit patient need.
4. Other healthcare professionals saw the value of having documented evidence of nursing care being delivered.

Thirty four semi-structured, individual interviews were carried out with patients and twenty eight interviews were carried out with carers across all case study sites. Key findings were:

1. Interviews provided insight into what patients and carers valued, although it was unclear whether IR was the best vehicle for delivering these attributes of nursing care.
2. There was no convincing evidence that IR was widely understood or perceived by patients, and its potential for empowering patients was limited as a stand-alone approach to engaging and empowering them and those close to them.
3. In so far as IR may help to bring nurses regularly to patients' bedsides to attend to their current needs, this would be welcomed by patients and carers, although IR is unlikely to be the only means of achieving regular contact, nor a reliable way of anticipating future needs.

One hundred and eighty eight hours of direct care delivery was observed by four research staff over day and night shifts. Non-participant observation was used when shadowing 39 members of nursing staff across the case study sites. Key findings were:

1. Frontline nursing staff were observed to be very busy and to carry out a wide range of tasks. IR was usually combined with other activities and staff were frequently interrupted when undertaking IR, which meant they were observed to document IR retrospectively. On occasion, staff delivered what looked like IR but did not complete IR documentation.

2. Considerable variation in the practice of IR was observed. Across all sites, staff demonstrated a flexible approach to how IR was delivered and a scripted approach to IR was never used.
3. IR was never observed to be completed by anyone other than nursing staff and non-nursing staff rarely looked at it.
4. 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.
5. There was some evidence that nursing staff were anticipating patient needs but it was difficult to say if this was due to IR.
6. IR was not observed to make any difference to nurse visibility or patient empowerment.
7. On average, patients had a direct interaction with a member of hospital staff (e.g. medical, nursing, allied health professionals (AHP), housekeeping etc) every 12.62 to 15.94 minutes.
8. 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, which was considerably more frequent than the recommended frequency of IR.
9. On average, patients had a direct interaction with a member of registered nursing staff every 36.29 to 38.92 minutes, which was also considerably more frequent than the recommended frequency of IR.

Although there was similarity between the time intervals of direct interactions with all staff and all nursing staff between acute wards and care of older people wards there was a marked difference in the time intervals of interactions with RNs. Patients in acute wards had a direct interaction with a RN on average every 29.03 to 30 minutes compared to an average of 43.3 to 49.81 minutes for patients on care of older people wards

The **realist evaluation** focused upon identifying causal mechanisms that explained how IR worked, for whom and under what circumstances, with the aim of understanding the complex relationship between these mechanisms and the effect that context has on their operationalisation and outcome:

1. In the revised, evidence-informed programme theory only two of the original eight mechanisms within the CMO configurations were partially activated ('consistency and comprehensiveness' and 'accountability'), the evidence for two of the mechanisms was inconclusive ('visibility' and 'anticipation'). There was minimal evidence for one mechanism ('multidisciplinary teamwork and communication') and no evidence for the remaining three mechanisms ('allocated time to care', 'nurse-patient relationships and communication' and 'patient empowerment').
2. Contexts which enabled or inhibited the activation of these mechanisms were explored. These included the type of patients; patient and carer awareness, understanding and involvement; nursing staff characteristics; leadership characteristics; implementation factors, such as staged or simultaneous implementation; staff engagement and motivation; staff education, training and understanding of IR; design and suitability of IR documentation; and environmental and structural factors such as ward setting/layout, job demands and staffing levels, skill mix/workforce stability, senior nursing management/IR organisational policies, NHS context health policy, and NHS culture.

Fidelity to the original intervention was also assessed. Two hundred and forty 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.

Conclusions: This is the first theory informed, large-scale, mixed methods evaluation of IR. There was ambivalence and concern expressed that IR reduces the scope of nursing practice, privileging a transactional and prescriptive approach over relational nursing care, and prioritising accountability and risk management over individual responsive care. The evidence shows the effectiveness of IR, as implemented and adapted in England, is weak. It is suggested that the insights from this study inform a national conversation about whether IR is the optimum intervention to support the delivery of fundamental nursing care to patients.

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