

# Intentional rounding in hospital wards to improve regular interaction and engagement between nurses and patients: a realist evaluation

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## Scientific summary

### Intentional rounding in hospital wards

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# Scientific summary

## Background

The government response to the high-profile care failures at Mid Staffordshire NHS Foundation Trust was to announce the policy imperative of introducing 'regular interaction and engagement between nurses and patients' (Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: The Stationery Office; 2013. © Crown copyright 2013. Contains public sector information licensed under the Open Government Licence v3.0) into the NHS. Although a long-standing 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'. Intentional rounding 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 intentional rounding in hospital wards in England on the organisation, delivery and experience of care from the perspective of patients, their family member(s) (hereafter referred to as 'carers') and staff. The research question was 'What is it about intentional rounding 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 – (1) national, (2) service provider organisation, (3) individual ward/unit and (4) 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 intentional rounding achieved its objectives) and the outcomes or impact. The study objectives were to:

- determine the number of NHS trusts in England that had implemented intentional rounding and analyse how this had been developed and supported
- identify how intentional rounding 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
- explore nursing staff, health-care assistants and other clinical and management staff experiences of intentional rounding and how it affects the way they deliver care
- explore patients' and their carers' experiences and perceptions of how intentional rounding influences their experiences of care
- investigate trends in patient outcomes (retrieved from routinely collected NHS ward data) in the context of the introduction of intentional rounding and other care improvement initiatives that have been introduced by using statistical process control methods such as cumulative sum charts
- examine the barriers to and facilitators of the successful implementation of intentional rounding
- conduct a bottom-up analysis of the costs of intentional rounding by identifying the resources used by case study wards to develop and implement it
- synthesise the data from each of the study phases to identify which aspects work, for whom and in what circumstances.

## Methods

A multimethod study design was undertaken using realist evaluation methodology to evaluate the implementation of intentional rounding in England. Realist evaluation is a theory-driven approach designed for evaluating complex social interventions. It acknowledges that complex social interventions work only

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) 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. a 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 health-care staff, patients and their carers; observations of intentional rounding and nurse shadowing; retrieval of routinely collected ward outcome data; and analysis of costs
4. synthesis of study findings.

A multistakeholder 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:

- despite the widespread use of intentional rounding, there is ambiguity surrounding its purpose and limited evidence of how it works in practice
- differences in the implementation of intentional rounding demonstrate the importance of care delivery context and highlight that intentional rounding 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 intentional rounding may work, for whom and in what circumstances.

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

- a total of 105 trusts (97%) had implemented intentional rounding in some way
- 93 (89%) trusts had a mixture of registered and unregistered nursing staff conducting intentional rounding
- 85 (81%) trusts had a structured protocol, script or procedure in place for intentional rounding
- documentation of intentional rounding took place in 96% of trusts
- there were large variations across trusts as to when intentional rounding was implemented and on which wards and for which patients, how regularly intentional rounding was conducted, what aspects of care were included and what educational opportunities staff received about intentional rounding.

Research at the case study sites included 17 semistructured, individual interviews with senior trust and ward managers. The key themes identified were as follows:

- 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 intentional rounding. Senior staff felt that one of the benefits of intentional rounding was the documented evidence it provided, although they acknowledged that this evidence was not always sufficient/reliable.

- Most senior staff described intentional rounding as a checklist, an aide memoire or a framework that 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 intentional rounding should be delivered in a standardised, rigid way at every round.
- Intentional rounding 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 (i.e. intentional rounding documentation had been completed).
- Few senior staff believed that intentional rounding increased the frequency or quality of staff communications with patients.
- Senior staff did not see intentional rounding as providing nurses with 'time to care'. The majority thought that staff were delivering care to patients and that the intentional rounding paperwork supported what they were already doing.

Thirty-three semistructured, individual interviews were also conducted with front-line nursing staff. The key themes identified were as follows:

- All front-line nursing staff mentioned accountability in some way during their interview. However, most did not talk about intentional rounding influencing their own personal accountability for standards of care delivered, although some acknowledged that it may improve standards in hospitals that were providing poor care.
- Half of all front-line nursing staff interviewed felt a positive outcome of intentional rounding 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.
- All front-line nursing staff mentioned the consistency and comprehensiveness mechanism in some way during their interview. Many referred to intentional rounding as a checklist or system for checking on a wide variety of patient needs. They also felt that intentional rounding offered a useful prompt or reminder to prevent staff from forgetting to undertake particular tasks.
- Opinion was divided on whether or not intentional rounding should be applied to all patients, but no front-line nursing staff felt that intentional rounding should be applied using a structured, systematic approach at every round. Instead, they talked about using their clinical judgement and common sense to tailor intentional rounding to each patient.
- Some front-line nursing staff felt that intentional rounding increased the frequency of nurse–patient interactions, although these communications were usually brief, rather than lengthy discussions. Few believed that intentional rounding could improve the quality of nurse–patient interactions.
- No one felt that they had been given specific, allocated time in which to undertake intentional rounding.
- Half of all front-line nursing staff felt that intentional rounding encouraged or improved staff communication; they thought that there was generally an improved handover of information about patients between nursing staff or across shifts.
- Few front-line nursing staff felt that intentional rounding affected nurse visibility, anticipation of needs or patient empowerment.

Twenty-eight semistructured, individual interviews were carried out with members of the multidisciplinary ward team, including doctors, occupational therapists, physiotherapists, a dietitian, a pharmacist and administrative staff. The key themes identified were as follows:

- The understanding of intentional rounding in this sample was mixed, because although some had direct experience of delivering intentional rounding, others had learned about it only through their own observations of nursing care.
- It was rare for other health-care staff to directly refer to intentional rounding documentation. Although some realised that they asked patients similar questions, it was more usual for other health-care staff to find a nurse on duty to speak to.

- Other health-care staff recognised the dilemma between having a structure that was used in a standardised and formal way for everyone and the need for flexibility to adapt to suit patient need.
- Other health-care professionals saw the value of having documented evidence of nursing care being delivered.

Thirty-four semistructured, individual interviews were carried out with patients and 28 interviews were carried out with carers across all case study sites. The key findings were as follows:

- Interviews provided insight into what patients and carers valued, although it was unclear whether or not IR was the best vehicle for delivering these attributes of nursing care.
- 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.
- 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.

A total of 188 hours of direct care delivery were 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. The key findings were as follows:

- Front-line 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 that they were observed to document IR retrospectively. On occasion, staff delivered what looked like IR but did not complete IR documentation.
- 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.
- Intentional rounding was never observed to be completed by anyone other than nursing staff; non-nursing staff rarely looked at it.
- 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 intentional round.
- There was some evidence that nursing staff were anticipating patient needs but it was difficult to say if this was due to IR.
- Intentional rounding was not observed to make any difference to nurse visibility or patient empowerment.
- On average, patients had a direct interaction with a member of hospital staff (e.g. medical, nursing, allied health professionals, housekeeping) every 12.62 to 15.94 minutes.
- On average, patients had a direct interaction with a member of nursing staff (e.g. a registered nurse, health-care assistant, student nurse) every 17.52 to 21.8 minutes, which was considerably more frequent than the recommended frequency of IR.
- On average, patients had a direct interaction with a member of the 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 registered nurses. Patients in acute wards had a direct interaction with a registered nurse, on average, every 29.03–30.00 minutes, compared with an average of 43.3–49.81 minutes for patients on care of older people wards.

The realist evaluation focused on 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:

- In the revised, evidence-informed programme theory, only two of the original eight mechanisms in the context–mechanism–outcome 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).
- Contexts that 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. A total of 240 intentional rounds were observed in 188 hours of care delivery observation. Although 86% of all IR interactions were observed to be documented, fidelity to the original intervention (i.e. Studer Group protocol) was generally low.

## Conclusions

To our knowledge, 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 that the effectiveness of IR, as implemented and adapted in England, is very weak. It is suggested that the insights from this study inform a national conversation about whether or not IR is the optimum intervention to support the delivery of fundamental nursing care to patients.

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