Patient Safety Tip of the Week

April 24, 2018 Review on Hourly Rounding

We've been big advocates of "**hourly rounding**", also known as "purposeful rounding", "intentional rounding", and other names. Our July 26, 2011 Patient Safety Tip of the Week "Hourly Rounding" discussed how hourly rounding, when done well, not only improves patient satisfaction but also reduces nurse interruptions and may improve patient safety outcomes. Our September 2014 What's New in the Patient Safety World column "Update on Hourly Rounding" discussed some of the models and issues and barriers to implementation of hourly rounding programs.

Following a 2013 report on deficient patient care in one UK hospital, the UK mandated that all NHS hospitals implement intentional rounding. Now a recent systematic review paints a more pessimistic view of "intentional rounding" (Sims 2018). Sims and colleagues conclude that, despite widespread use of intentional rounding, their review highlights ambiguity surrounding its purpose and limited evidence of how it works in practice.

The researchers used a "realist synthesis" approach, a theory-driven approach to evaluating complex social interventions such as intentional rounding, using empirical evidence from the literature. A total of 44 papers met their inclusion criteria. Over half the studies were from the US.

They described a "typical" intentional rounding program as having the following characteristics:
During each round, the following standardized protocol is used by a nurse for each patient:

- An opening phrase is used by the nurse to introduce his or herself and to put the patient at ease.
- Scheduled tasks are then performed.
- A discussion of the four key elements of the round, often called the '4 P's':
    - Positioning—making sure the patient is comfortable and assessing the risk of pressure sores.
    - Personal needs—assessing patients' personal needs, including whether they need assistance with getting to the toilet.
    - Pain—asking patients to rate their level of pain on a scale of 0–10.
    - Placement—ensuring any items a patient needs are within easy reach.
- An assessment of the care environment, such as checking the temperature of the room or any fall hazards.
- Ending the interaction with a closing phrase such as "Is there anything else I can do for you before I go?".
- The patient is informed of when the nurse will return.

- The nurse documents the round.

If patients are unable to respond during the round, the nurse may follow this process with family members.

A majority of the papers in the systematic review found:

- A reduction in call bell use by patients
- A reduction in falls
- A reduction in pressure ulcers
- A reduction in patient complaints

But studies failed to show an impact on readmissions or overall costs.

The authors identified eight proposed mechanisms or reasons for implementing intentional rounding:

(1) when implemented in a comprehensive and consistent way, intentional rounding improves healthcare quality and satisfaction, and reduces potential harms
(2) embedding intentional rounding into daily routine practice gives nurses 'allocated time to care'
(3) documenting intentional rounding checks increases accountability and raises 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, provides reassurance and reduces potential harms
(6) more frequent nurse–patient contact enables nurses to anticipate patient needs and take pre-emptive action
(7) intentional rounding documentation facilitates teamwork and communication
(8) intentional rounding empowers patients to ask for what they need to maintain their comfort and well being.

Regarding consistency and comprehensiveness of care, they did find evidence that intentional rounding prompted and guided the delivery of care, helping staff remember to conduct all aspects of care on every round. However, there was often a tendency to pay more attention to high risk/high need patients. Also, time limitations, low staffing levels and conflicting priorities made meeting this goal more difficult.

Evidence of providing more time to provide care was conflicting. The reduction in call bell use often did provide more time for care but staff attitudes varied considerably, with some staff feeling this was "nothing new", that it increased their workload and actually took time away from care, and that documentation of rounding also took time away from care.

Regarding accountability (both personal and organizational) was perceived by some to underpin intentional rounding. But there was some concern that both personal accountability and organizational accountability focused more on staff compliance with documentation procedures rather than actual care rendered (i.e. "tick boxes" mentality).

With regard to nurse–patient communication, it was widely reported that intentional rounding increased the amount of time nurses spent in direct contact with patients/family members and thereby increased the frequency of their communications. But there was little evidence about the quality of the communication. In fact, some staff even felt that using predetermined intentional rounding scripts stripped nurse–patient communications of authenticity and routinised patient contact.

Regarding nurses' anticipation and proactively addressing patient needs, staff often stated intentional rounding enabled them to be proactive rather than reactive (eg. responding to call bells) in anticipating patient needs and that this was associated with increased patient satisfaction and reassurance, decreased patient anxiety, a reduction in call bell usage, and an overall sense of calm on the ward and decreased staff workload. Moreover, intentional rounding was also reported to enable nurses to intervene earlier when a patient's medical condition was deteriorating.

Interestingly they cited one study (Berg 2011) that changing position and getting in and out of bed were identified as activities that could be anticipated and addressed by intentional rounding but not pain management or toileting needs. That is of concern since one of our most consistent recommendations for prevention of falls is using hourly rounding to anticipate toileting needs.

They also found supportive evidence that intentional rounding has a positive impact on staff communication and teamwork, as well as empowering patients.

The authors identified a number of discrepancies between how intentional rounding is purported to work and how it operates in practice, as well as international differences in how the intervention has been implemented. They note that intentional rounding in the US has a more structured approach, compared to the UK where the approach is more flexible. They think the difference may be in the impetus for implementing intentional rounding. They note that in the US, intentional rounding programs are often marketed, whereas in the UK they responded to the mandate. The authors also note that poor understanding of how and why intentional rounding works as a major challenge to learning, replication and sustainability of the intervention.

The authors conclude that weak evidence did not give sufficient justification for the implementation of intentional rounding in the UK (though it reviewed international literature, the study was really focused on intentional rounding in the UK).

Probably the best contribution of this systematic review is the collection of an extensive bibliography. If you want to see the many underlying individual studies reviewed, there are links to most of them.

We've also previously voiced some of the concerns raised in this review and acknowledge that there is often a disparity between nursing leadership and frontline nurses regarding the practice. But we remain advocates of hourly rounding or intentional

rounding programs. We hope you'll go back to our July 26, 2011 Patient Safety Tip of the Week "Hourly Rounding" and our September 2014 What's New in the Patient Safety World column "Update on Hourly Rounding". We feel that, especially in the US, well done hourly rounding not only improves patient satisfaction but also reduces nurse interruptions and improves patient safety outcomes (such as falls, pressure ulcers, and patient complaints). The latter column also discusses some of the models and issues and barriers to implementation of hourly rounding programs. In particular, hourly rounding models may include "reliable" rounders and "variable" rounders to deal with "predictable work" and "unpredictable work".

You should also note that some of the functions that underlie the utility of hourly rounding programs might be carried out by specialized teams operating independently of the unit nursing staff. Such teams might address issues such as turning and repositioning patients, attending to toileting activities, feeding patients who need assistance feeding, and ambulating. We know of no formal studies that have looked at the relative cost effectiveness of using such teams compared to more traditional nurse hourly rounding programs.

References:

Sims S, Leamy M, Davies N, et al. 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; Published Online First: 14 March 2018
http://qualitysafety.bmj.com/content/early/2018/03/14/bmjqs-2017-006757

Berg K, Sailors C, Reimer R, et al. Hourly rounding with a purpose. Iowa Nurse Reporter 2011; 24: 12-14
https://www.highbeam.com/doc/1G1-289217372.html

http://www.patientsafetysolutions.com/

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