Kathleen Stoddart and colleagues relate one nursing team’s positive experience of implementing regular patient checks

Abstract

Person-centred, safe and effective care is at the heart of the fundamentals of caring. However, there are many challenges to achieving this reliably and consistently. This article describes one nursing team’s experience of implementing ‘care and comfort’ rounds, which has led to proactive rather than reactive nursing care delivery. The number of patient falls and the use of call buzzers have reduced, patient experience has been enhanced, a more controlled environment is provided for patients, and staff satisfaction in care delivery has improved.

Keywords

Care and comfort rounds, rounding

The need to assure the quality of care for patients has never been such a cause for concern to the public and healthcare professionals. The findings and implications of the Francis Report (Francis 2013) have combined to become a ‘moral panic’ and the associated controversies cause anger, anxiety and indignation in almost equal measure for patients and healthcare staff.

Previous reports have been critical of care delivery, but Francis describes failure of organisational systems and processes, as well as humanity. To redress the imbalance created by this focus on failure, nurses are turning to quality improvement initiatives to enhance and demonstrate the quality of care they deliver to patients as teams. Conducting systematic ‘rounds’ for patients is one way of trying to ensure the highest standards of care.

There is limited UK research about rounding, which is variously described with ‘intentional’, ‘care’ or ‘comfort’, and is commonly recognised as a system of regular checks on patients to fulfil and evidence the delivery of fundamental care. Contemporary work in the UK draws on evidence from the US (Meade et al 2006, Halm 2009, Bartley 2011), but UK commentators are critical of the quality of that evidence and concerned about the lack of evidence to guide implementation, the introduction of rituals that could compromise individualised care and the role of political drivers (Snelling 2013a, 2013b, Braide 2013). The emerging experience of rounding in the UK contributes to debate in the nursing press and to nursing understanding of the benefits of it (Duffin 2010, Fitzsimons et al 2011, Díx et al 2012, Hutchings et al 2013).

Throughout NHS Scotland, where the initiative reported in this article took place, person-centred, safe and effective care is uppermost in operational and strategic improvement strategies. To contribute further experience to the issue of rounding, this article details the implementation of ‘care and comfort rounds’ in one hospital using supporting evidence. The fundamentals of care are captured in the action-driven initiative plus inclusion of the priorities of person-centred, safe and effective practice.

These fundamentals and priorities are driven by the Scottish Government’s overarching Healthcare Quality Strategy (2010) and, in this instance, delivered by nursing leadership and teamwork. This initiative was supported further by local (NHS Forth Valley) and other relevant leadership-oriented national policies and reports (Scottish Executive Health Department 2006, NHS Scotland 2007a, Scottish Government Health Department (SGHD) 2008, SGHD 2009).
### Box 1 Sequence of implementation events

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tr>
<td>June 2011</td>
<td>Rounds fully implemented. 96% compliance with completion of forms. Slight reduction in incidence of slips, trips and falls. Reduction of use of call buzzers in the evening. Information leaflet, checklist and audit tool reviewed and revised.</td>
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<tr>
<td>February 2012</td>
<td>Reduction in falls and use of call buzzers maintained. Patient experience questionnaire results show increased satisfaction with regular checks and anticipation of care needs. Checklist remains under regular review. Rounds linked to other projects (management of dementia, nutrition, delirium). Review of interface with e-ward (on screen) care plan in progress. Roll-out to other clinical areas in progress.</td>
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### Context

Effective team leadership is recognised as requisite to improving care. In the hospital discussed in this article, a senior charge nurse (SCN) committed to Leading Better Care (SGHD 2008, NHS Scotland 2011) recognised and acted on this.

The SCN designed and led the implementation of care and comfort rounds in conjunction with her team who were involved from the start and empowered to contribute to every stage of the planning and implementation process.

Importantly, and supported by training and discussion, the nursing team adapted and committed fully to the initiative, while the multidisciplinary team as a whole engaged in its development and delivery, and senior nurses at every level were supportive throughout.

Implementation of care and comfort rounds took place in an acute hospital with 29 beds in NHS Forth Valley. There were 604 admissions to the orthopaedic and surgical rehabilitation ward during the implementation period from April 2011 to April 2012, and skill mix on the ward was considered satisfactory following application of the NHS Scotland workforce planning model.

Nursing students on placement from Stirling University also contributed to the implementation process, for example by auditing and analysing call buzzer use, and said they had a unique and exciting learning experience.

### Project aims and methods

The aims of the initiative were to deliver proactive rather than reactive nursing care, to reduce the number of patient falls, to enhance the patient experience, to provide a more controlled environment, and to increase staff satisfaction in care delivery.

A range of patient safety data are collected and submitted routinely in Scotland, including the incidence of slips, trips and falls (NHS Scotland 2007b). From that routine submission the monthly pre-implementation data for slips, trips and falls for the clinical area in the period 2010 to 2011 were extracted and collated.

This specific data were also collated on a monthly basis during implementation in the period 2011 to 2012, and comparisons were drawn between the monthly data in 2010 to 2011 and 2011 to 2012.

The use of call buzzers was considered as a proxy measure of unmet or unanticipated patient needs. The number of times call buzzers were used was audited over 24-hour periods before and during implementation, and comparisons drawn.

Staff education sessions were held before implementation. Having agreed to ‘rounding’ in principle, pre-implementation, the ward team held frequent meetings over a three-month period to gain deeper understanding, review their data and develop all elements of the implementation they planned.

Together they developed checklist documentation that was subject to review and revision throughout the implementation period. An information leaflet for patients and visitors was also developed, which was reviewed and revised during implementation by drawing on data from routinely gathered patient experience questionnaires and staff evaluations.
The sequence of implementation events and effect is shown in Box 1. Implementation review meetings were held by the ward team in each time sequence.

**Supporting documentation** Figure 1 shows the care and comfort round checklist (version 5, 2013) developed over time. The criteria in the checklist are derived from the key areas identified in the Scottish Government’s Healthcare Quality Strategy (2010), and while the fundamentals of care are uppermost in the criteria included, patient safety and experience are major threads.

A nurse from the team is assigned to care and comfort rounds for a group of patients on each shift.

The checklist is supported by a suggested dialogue sheet (Box 2, page 22) that is designed to be accessible and understandable for everyone.

The information leaflet describes the ‘what, why and how’ of care and comfort rounds in the ward for the benefit and comment of patients and visitors.

**Implementation data** The data collected in relation to slips, trips and falls, and use of call buzzers, are presented in Figures 2 and 3 (page 23) and show pre- and post-implementation data.

**Results**

Success was determined by matching evidence to the aims of the project; the evidence shows the aims were achieved in an environment where patients had significant care needs. Comparisons were drawn with pre-implementation data and the results show that, during the implementation period, falls were reduced by 39 per cent and the use of call buzzers by 36 per cent.

- Review of patients’ care and comfort documentation, patient experience questionnaires and staff evaluation provided further evidence of success in the following:
  - A quieter environment was provided for patients.
  - Patients were being offered and assisted with food and fluids.
  - Communication with family/carers was improved.
  - Documentation was improved.
  - Time was given to education sessions for staff.
Meeting the patient

Introduce yourself.
Tell the patient you will attend them every two hours but to use the call buzzer at any time if required.
Agree a plan of care with the patient – ‘any goals you would like to achieve today?’ – and document.
Agree a work plan with your team.

Daytime rounding

**Ask:**
How are you?
Do you have any pain?
Do you need to go to the toilet?
Can I pour some water/ juice for you?
Let me help you change position?

**Check:**
Is everything in reach?
Is the environment tidy?
Is the call buzzer within reach?

**Before leaving:**
Is there anything else I can do before leaving?
Someone will be round in two hours’ time but use the call buzzer if needed.

Night-time rounding

Check all patients two-hourly. For patients who are awake, who need observations carried out or who need pressure-area care, carry out as in daytime rounding.
If the patient is sleeping, record ‘asleep’ on the checklist.

Relatives and carers

Ask the patient and document if they are happy for you to speak to relatives or carers, and which ones.
Ask relatives or carers if they have any questions about their relative’s care (prompts = general condition, date of discharge, discharge support arrangements, concerns about care).

General guidance

There is no requirement to introduce yourself to the patient or explain care and comfort rounds every time you perform a nursing intervention unless the patient has cognitive impairment. Record this with an X following initial introduction.
If the patient has a degree of cognitive impairment, introductions and full explanation must be provided at each intervention.
If the patient is independent with aspects of care, record ‘I’ on the chart against appropriate criteria.
Initials of the healthcare practitioner undertaking care, not ticks, are required in all boxes.

- Staff satisfaction in care delivery was increased.
These results show that significant progress has been made in delivering fundamental care for patients. Person-centred care is enhanced and safe, and effective practice is improved. Lessons continue to be learned and the need for further improvement is recognised and being worked towards.

Recommendations for the future

Care and comfort rounds are now being implemented in acute and community hospitals across NHS Forth Valley. Challenges in implementation were overcome because the nursing and multidisciplinary team could see improvement from the evidence; for example, concerns about changes to ward routine, including shift times, were addressed by changing shift times to create opportunities to communicate with relatives and to accommodate protected meal times.

Further data are being collected, mindful of responsibilities for continuous quality improvement based on evidence.

Several standards of care related to the criteria in care and comfort rounds have been developed and are in use, and more are in development. Associated documentation also continues to be developed, with simplicity combined with effectiveness in mind. Documents are being developed into a 24-hour format that includes a care management plan with integrated standards of care, as well as evaluation of care.

Conclusion

Care and comfort rounds have proved to be successful and have become a central means to assure quality of care. In leading better care, the senior charge nurse is responsible and accountable for ensuring the delivery of person-centred, safe and effective care.

Commitment to improvement on the front line needs a systematic and informed team approach, such as the one described here.

The team implementing rounding has to be fully aware of, and committed to, the best standards of nursing practice, otherwise improvement initiatives would be superficial and not yield evidenced success. To be successful, quality improvement also needs commitment and support.

Taking these two central pillars together, as evidenced in this article, care and comfort rounds can contribute to safe and effective care. Other evidence indicates the strengths of care and comfort rounds in relation to person-centred care, including communication. Anticipation of patient needs and concerns is a strategy for success. The explicit nature of care and comfort rounds can be reassuring for patients, carers and staff.

In all of these terms, care and comfort rounds have potential, but it is not what you do it’s the way that you do it that matters for patients and that brings us full circle back to humanity. Intentional implies the ‘intentions’ of nurses, ‘care and comfort’ conveys humane, person-centred care.
**Figure 2** Slips, trips and falls data

![Bar chart showing slips, trips, and falls data from April 2010 to March 2012. Data is represented for each month with bars indicating the number of incidents per month for each year (2010-11 and 2011-12).]

**Figure 3** Use of call buzzers

![Bar chart showing the use of call buzzers at different times of the day for pre-pilot and specific months in 2011-12, with data for May 2011 (6/52), July 2011 (3/12), January 2012 (9/12), and April 2012 (12/12).]

**References**


Scottish Government Health Department (2009) Releasing Time to Care. SGHD, Edinburgh


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**Conflict of interest**

None declared