Demonstrating the value of nursing care: “Let’s go round again”

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Understanding the context of frontline care

- What’s good about it?
- What’s not so good?
- What could be improved?
It’s a Fact that …

“Without good and careful nursing many must suffer greatly, and probably perish, that might have been restored to health and comfort, and become useful to themselves, their families, and the public, for many years after.”

Benjamin Franklin (1751)
The State of Care

- CQC reports
  - Dignity and Nutrition
  - The State of Care
- Ombudsman report
- Mid Staffordshire Review

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CQC report findings
Dignity and Nutrition

- patients’ privacy not being respected – for example, curtains and screens not being closed properly.
- call bells being put out of patients’ reach, or not answered soon enough.
- staff speaking to patients in a dismissive or disrespectful way.
- patients not being given the help they needed to eat.
- patients being interrupted during meals and having to leave their food unfinished.
Co-coordinating Care
Getting it right
The Reality in Practice
How do we make sense of all the expectations & bring the work into a coherent whole

- Health Foundation
  Safer Communities

- National Patient Safety Agency (NPSA)
  Safety Alerts
  Matching Michigan

- CNO High Impact Changes

- QUIIPP & Safety Express

- NHS III
  LIPs
  Productive Series

- WHO World Alliance for Patient Safety

- NICE
  Quality Standards

- Department of Health (DoH)
  High Quality Care for All
  IP&C

- Safer Patients Network (SPN)
  The Health Foundation (with IHI)

- CQUIN targets
Health Care Processes

Current - Variable, lots of autonomy not owned, poor if any feedback for improvement, constantly altered by individual changes, performance stable at low levels

Desired - variation based on clinical criteria, no individual autonomy to change the process, process owned from start to finish, can learn from defects before harm occurs, constantly improved by collective wisdom - variation

Terry Borman, MD Mayo Health System
Where Do Things Fall Through The Cracks?

- System failures
- Communication failures/styles
- Inherent human limitations
  - Limited short term memory
  - Negative effects of stress
  - Fatigue
  - Multitasking, interruptions, distractions
Reliability occurs by design not by accident
Transforming Patient Experience

Metanoia:

- Reorientation of one’s way of life
  *(The New Economics. Deming, p. 95, 1993)*
- Begins with individual
- More than a change
- Develop new habits of
Getting to Goal

- Will
- Ideas
- Execution
Improvement requires a clear aim

Measurement & Action
Intentional Rounding

Background

- The Studer Group-
- Management Consultancy
- Alliance for Health Care Research
- Controlled trial
  - 38% Reduction in Call Lights
  - 12 point mean increase in Patient Satisfaction
  - 50% reduction in patient falls
  - 14% reduction in pressure ulcers

Flaws in the study but…
What is Intentional Rounding?

- Concerns about essential nursing care have refocused attention on the need to ensure fundamental aspects of care are delivered reliably.
- Intentional rounding involves health professionals carrying out regular checks with individual patients at set intervals.
- The approach helps nurses to focus on clear, measurable aims and expected outcomes.
- It also helps frontline teams to organise their workload, providing more systematic, consistent care.
- Rounding can reduce adverse events, improve patients experience of care and provide much needed comfort and reassurance.
Intentional Rounding – What is it?

- Rounding must have be linked to an aim/intent
- 8 key behaviors
  1. Opening key words – managing up
  2. Perform scheduled tasks
  3. Address the 3 p’s of pain, potty? (personal needs), and position
  4. Assess additional comfort needs
  5. Environmental assessment
  6. Closing key words
  7. Explain when you or others will return
  8. Document the round on the log
OMHS Intentional Rounding - wins

- 59% reduction in Pressure ulcers
- 54% reduction in call lights
- (2878 fewer calls after rounding)
- Patient feedback – ‘I know someone will be back to check on me, when they come…’
- Improved employee satisfaction – 5.67 on a 7 point scale compared to national norm of 4.66 (Baird and Borling)
- Reduction in cost
Visual Measurement

Days since last...

___ days
Tools – Badge Card

Intentional Rounding

Rounding occurs on all patients. Explain process to patients on admission. Use key words ‘our goal is to provide better than expected care’

Schedule: Nurses round on odd hours; NA/PMC round on even hours

Rounding Checklist:
- Pain Assessment
- Toileting – Assist patient to restroom
- Positioning
- Environmental scan
  - Fall risk hazards:
    - Bed in low position, cords secured
  - Ensure items are within reach: phone, water, tissue, urinal, bedside table, trashcan, & call light within reach
  - Comfort: temperature of room, blankets, pillows
- 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.
### 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

<table>
<thead>
<tr>
<th>Date:</th>
<th>12am</th>
<th>2am</th>
<th>4am</th>
<th>6am</th>
<th>8am</th>
<th>10am</th>
<th>11am</th>
<th>12pm</th>
<th>1pm</th>
<th>2pm</th>
<th>3pm</th>
<th>4pm</th>
<th>5pm</th>
<th>6pm</th>
<th>7pm</th>
<th>8pm</th>
<th>9pm</th>
<th>10pm</th>
</tr>
</thead>
</table>

**Intentional rounds completed by:**
(Place initials in box indicating time of rounds, check all items below that apply for that time)

<table>
<thead>
<tr>
<th>Time</th>
<th>3 P’s</th>
<th>Pain Assessment</th>
<th>Toileting (potty) - assist patient to restroom</th>
<th>Positioning</th>
<th>Environmental scan</th>
<th>Fall risk hazards: bed in low position, cords are secured</th>
<th>Phone, water, tissue, urinal, bedside table, trashcan, and call light are within reach</th>
<th>Temperature of room, blankets</th>
<th>Checked to make sure bed alarm is plugged in and turned on</th>
<th>Prior to leaving room</th>
<th>Ask, &quot;Is there anything else I can do for you? I have the time.&quot;</th>
<th>Remind the patient that a staff member (let them know who) will be back in about an hour to round on them again</th>
<th>Document the round on the patient's chart</th>
</tr>
</thead>
</table>

**Signature/Initials:**

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Hardwiring Rounding-Leaders/ Matron’s role in Quality Assurance

- On a weekly basis randomly sample 5 rounding logs from participating units/wards.
- Did actually rounding happen? Yes or No?
- Were key elements addressed? Yes or No?
- Ask five patients how the rounding process felt from their perspective?
- Feedback findings to the teams
- Match findings with outcome and process data
- Remove barriers
- **CELEBRATE SUCCESS !! PROMOTE GOOD PRACTICE**
# Accountability Tool

## Hourly Rounding

<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>DATE</th>
<th>TIME</th>
<th>DEPARTMENT</th>
<th>DATE</th>
<th>TIME</th>
<th>DATE</th>
<th>TIME</th>
<th>DATE</th>
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<th>DATE</th>
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</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>EVALUATOR TYPE</th>
<th>SELF ASSESS</th>
<th>PEER</th>
<th>SUPERVISOR</th>
<th>PT/FAMILY</th>
<th>INTERVIEW</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVALUATOR NAME</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

### Each Round: Address the 3 Ps: Pain, Position, Potty
- Knock on door prior to entering pt room
- Ask patient how their pain is, medicate if needed
- Toileting - encouraged pt to go to restroom
- Positioning: ask patient if they are comfortable
- Promote comfort (provide blanket/s, pillows, etc)

### Each Round: Assess the Environment
- Scan for fall risk hazards: bed in low position, cords secured, etc
- Move items within reach (phone, water, tissue, urinary, bedside table, call light, etc)
- Verify temperature of the room is ok

### Perform Scheduled Tasks
- Complete MD ordered treatments, procedures
- Complete nursing care as needed
- Administer scheduled medications

### Prior to Leaving the 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 your rounding on the intentional rounding checklist by
  initiating the box and checking off items completed

Complete first evaluation yourself, ask a peer to complete the second evaluation, then have your supervisor, charge nurse, or manager complete the third evaluation and pt/family interview.
Round the UK

- Wales/South West/South Central/UCLH/Northern Ireland/Scotland
- Falls reduction/pressure ulcer reduction/less call bells
- Help social isolation
- Patient and staff satisfaction increase
- Less ‘chaotic’ care
- But message is to test it and then implement it systematically
Hope is not a plan...

- Centred on patients.
- Catches all.
- Provides a quality assurance framework for care.
- Evidences what nurses do.
- Demonstrates the impact.
It is the nature of systems that smaller systems are embedded in bigger systems
The Steps To Change

1. Develop a change
2. Prototype a change
3. Test under a variety of conditions
4. Implement a change
5. Embed in daily operations
6. Spread throughout the system

Prerequisites for change

Confidence that change is effective
Change vs. Improvement

"Of all changes I’ve observed, about 5% were improvements, the rest, at best, were illusions of progress."

W. Edwards Deming

- We must become masters of improvement
- We must learn how to improve rapidly
- We must learn to discern the difference between improvement and illusions of progress
The Seven Spreadly Sins
or What NOT to do if you want successful spread

- Sin # 1
- Start with large pilots!
Sin # 2

- Find one person willing to do it all!
Sin # 3

- Expect vigilance and hard work to solve the problem!
Sin # 4

- If a pilot works then spread the pilot unchanged!
Sin # 5

- Require the person and team who drove the pilot to be responsible for system-wide spread
Sin # 6

Look at process and outcome measures on a quarterly basis
Sin # 7

• Early on expect marked improvement in outcomes without attention to process!
The Seven Spreadly Sins
Don’t take the shortcut!
You are this Hospital

You are what people see when they arrive here.

Yours are the eyes they look into when they’re frightened and lonely.
Yours are the voices people hear when they are in the lifts and when they try to sleep and when they try to forget their problems. You are what they hear on their way to appointments that could affect their destinies and what they hear after they leave those appointments.

Yours are the comments people hear when you think they can’t. Yours is the intelligence and caring that people hope they’ll find here. If you’re noisy, so is the hospital. If you’re rude, so is the hospital. And if you’re wonderful – so is the hospital.

No visitors, no patients can ever know the real you, the you that you know is there — unless you let them see it. All they can know is what they see and hear and experience.

And so I have a stake in your attitude and in the collective attitudes of everyone who works at Cooley Dickinson Hospital. We are judged by your performance. It is judged by the care you give, the attention you pay and the courtesies you extend.

Thank you for all you are doing. CEO Cooley Dickinson Healthcare Org
To conclude

• “Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around”

• Leo Buscaglia
Thank You!
Questions?

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