Aims and objectives. To describe the implementation, practice and sustainability of Intentional Rounding (IR) within two diverse settings (aged care and maternity).

Background. The profile of patients in hospitals has changed over time, generally being more severe, placing heavy demands on nurses’ time. Routine non-urgent care is often provided only when there is time. IR has been found to increase both patient and staff satisfaction, also resulting in improved patient outcomes such as reduced falls and call bell use. IR is also used as a time management tool for safe and reliable provision of routine care.

Methods. This descriptive qualitative research study comprised of three focus groups in a metropolitan hospital.

Results. Fifteen nurses participated in three focus groups. Seven main themes emerged from the thematic analysis of the verbatim transcripts: implementation and maintenance, how IR works, roles and responsibilities, context and environment, benefits, barriers and legal issues.

Conclusion. IR was quickly incorporated into normal practice, with clinicians being able to describe the main concepts and practices. IR was seen as a management tool, facilitating accountability and continuity of management support being essential for sustainability. Clinicians reported increases in patient and staff satisfaction, and the opportunity to provide patient education. While patient type and acuity, ward layout and staff experience affected the practice of IR, the principles of IR are robust enough to allow for differences in the ward specialty and patient type. However, care must be taken when implementing IR to reduce the risk of alienating experienced staff. Incorporation of IR charts into the patient health care record is recommended.

Relevance to clinical practice. Engaging all staff, encouraging ownership and stability of management are key factors in the successful implementation and maintenance of IR. IR is flexible and robust enough to accommodate different patient types and acuity.
Introduction

In modern health care, hospitals are busy places accommodating acutely ill patients that require intensive treatment and nursing intervention. Demands on nurses are at a premium and routine non-urgent care is often provided only when there is time. Intentional rounding (IR) is a scheduling process for the safe and reliable provision of routine, non-urgent basic patient care (Meade et al. 2006, Halm 2009, Fitzsimons et al. 2011). This study sought to describe the implementation, practice and sustainability of IR in diverse clinical settings.

Background

There are many variations of intentional rounding (IR), including the 4Ps (Studer Group 2007), ‘Caring Around the Clock’ (Hutchings 2012b) and ABCDE (Rondinelli et al. 2012). Most programmes of IR have common elements, including assessing and managing pain, assistance with toileting requirements, repositioning and comfort, and ensuring essential items such as the call bell, telephone and bedside table are accessible to patients.

One of the most important aspects of IR is the nurse asking the patient if they require any other assistance and to inform them that someone will be returning to check on them (Halm 2009, Hutchings 2012b, Rondinelli et al. 2012). The specific wording of this question is important in engendering confidence in the patient that their needs will be attended to on a regular basis (Meade et al. 2006, Studer Group 2007, Woodward 2009, Kessler et al. 2012, Rondinelli et al. 2012, Shepard 2013). The wording of the question is generally similar to ‘Is there anything I can do for you before I leave?’ with some programmes of IR also adding ‘I have time while I am here’. The respect inherent in this question and the physical presence of the nurse in the patient’s room engenders confidence that patient needs will be met, thereby increasing satisfaction and reducing the use of call bells (Rondinelli et al. 2012, Shepard 2013).

IR aims to not only engage and attend to patients, but also address the needs of family members. For example, on a maternity ward, positioning of the baby and breastfeeding is considered an aspect of IR, while addressing the concerns of family members in operating theatre waiting rooms is another (Rondinelli et al. 2012).

Patient satisfaction

The ethos underpinning IR is enhanced patient care, hence the importance of patient satisfaction as an outcome. Patients frequently express satisfaction with the care they receive in terms of how their pain is managed, responses to requests for help (call bells), how attentive the nurse is to their needs (Kessler et al. 2012) and the quality of care they receive (Lowe & Hodgson 2012). IR is designed to take into account these aspects of patient care, and significant improvements in patient satisfaction have been found after the introduction of IR (Studer Group 2007, Dix et al. 2012, Kessler et al. 2012). Further, a recent systematic review found 88% of studies reported an increase in patient satisfaction after the introduction of IR (Halm 2009).

Nurse satisfaction

Though not as widely reported as patient satisfaction, improvements in satisfaction for nurses have also been found after the introduction of IR (Kessler et al. 2012). IR allows nurses to better manage their time as they are providing continuous assessment and care. Patient concerns are identified earlier (Dix et al. 2012, Rondinelli et al. 2012), with effective and ineffective interventions documented, thereby improving time management (Dix et al. 2012) and reducing occasions of care (Fitzsimons et al. 2011). These practices lead to increases in the perception of efficiency in the ward (Kessler et al. 2012, Shepard 2013) and quality of care given by both themselves and co-workers, including the perceived increased level of interest in providing patient care (Kessler et al. 2012).

IR also provides an opportunity for nurses to build a relationship with their patients (Dix et al. 2012, Hutchings 2012b), thus facilitating holistic care, with obvious benefits to both nurses and the patient (Langdon et al. 2012). Furthermore, increases in patient satisfaction can result in positive feedback which in turn leads to improved morale and greater engagement in IR by nurses (Kessler et al. 2012). Various other measures of nurse satisfaction have been
reported, including rates of sick leave (Cann & Gardner 2012) and staff vacancies (Kessler et al. 2012).

**Patient outcomes**

**Patient falls**
Patient falls are an area of major concern in the hospital setting. As patients’ mobility is often compromised due to their medical needs, their risk of falling can increase. The risk of falling also increases when the assistance of nurses is not available (Woodward 2009). The introduction of IR has been reported to result in a reduction in the incidence of patient falls. Indeed, 77% of studies included in a recent systematic review (Halm 2009) reported a reduction in patient falls after the introduction of IR.

While some research studies have found the reduction to be statistically significant (Studer Group 2007), the majority have found that although fall incidences had reduced, the rate of reduction was not statistically significant (Weisgram & Raymond 2008, Woodward 2009, Cann & Gardner 2012, Hutchings 2012b). Other studies have not reported statistical significance, simply reporting particular wards improved from having the highest rate of falls within their hospital to the lowest (Johnson & Topham 2007). As such, the effectiveness of IR in reducing patient falls has been questioned, with risk assessment and subsequent monitoring of patients identified as being at risk, being seen as more effective (Snelling 2012).

**Call bell use**
A reduction in the use of call bells after the introduction of IR has also been reported (Studer Group 2007, Weisgram & Raymond 2008, Dix et al. 2012, Hutchings 2012b), though the rate of reduction is not always statistically significant (Woodward 2009) or reported (Cann & Gardner 2012). However, many of these studies do not differentiate between urgent and non-urgent use of the call bell, nor the amount of time taken to respond to the call bell. It has been suggested that simply reducing the use of call bells does not necessarily mean patients are receiving better, or even adequate, care (Snelling 2012).

Studies that do examine urgent and non-urgent use of the call bell report that before the introduction of IR, patients often use the call bell for non-urgent needs such as repositioning and turning on the television (Meade et al. 2006, Halm 2009). After the introduction of IR, which addresses these issues, patients were generally found to restrict their use of the call bell to urgent needs only (Dix et al. 2012). Furthermore, nurses report that call bells are more easily heard and more likely to be responded to due to the decreased frequency of use and the perception that the call is in fact urgent (Dix et al. 2012), leading nurses to respond more quickly (Dix et al. 2012).

**Barriers to intentional rounding**
Despite the reported benefits of IR, not all nurses welcome its introduction. Many nurses feel that once a patient has been assessed and oriented, it is unnecessary to assess them repeatedly in a short period of time (Woodward 2009). Furthermore, they consider that the components of IR are already being carried out in the normal course of their patient care, and it is therefore not only unnecessary, but also burdensome (Lowe & Hodgson 2012). This burden may be further compounded by the perception that the processes of IR are patronising to some nurses (Lowe & Hodgson 2012), implying they are not adequately addressing their patient’s needs.

Nurses are often reluctant to undertake IR with patients they perceive as being ‘well’ as it takes away from the time they have available to care for more unwell patients (Dix et al. 2012). Further, some nurses feel that following a formal process takes away from their ability to care for patients as individuals (Fitzsimons et al. 2011).

The importance of engaging nurses in IR was highlighted by a recent study which found that when nurses were supportive of IR, call bell use decreased and conversely increased when nurses were less compliant (Weisgram & Raymond 2008). The introduction of IR therefore requires education about the benefits for both patients and nurses, with the willingness of nurses to incorporate IR into their health care practices being imperative (Dix et al. 2012).

Barriers to IR do not, however, rest solely with the nurse. While most patients respond well to IR, others may find it too overwhelming. For example, patients experiencing mental health issues may find the constant monitoring inherent in IR to be intrusive or disturbing (Moran et al. 2011), while confused patients may not remember being attended to and place extra demands on nurses’ time.

IR has been heavily promoted by the UK Government and is being widely implemented in UK hospitals in response to the Francis Report (Francis 2013). However, the variation in the reported effectiveness of IR requires further investigation. Prior to undertaking a rigorous trial of IR in a local hospital, an initial understanding of the programme, including nurse engagement, change process, barriers and facilitators of the programme need to be identified.

**Aim**
The aim of this study is to describe the implementation, practice and sustainability of IR in two diverse clinical settings.
Methods

Design
This descriptive qualitative study consisted of three focus groups of nurses who work on wards in which IR has been implemented.

Sample
Two diverse clinical settings (one aged care unit and one maternity unit) were included in the study as these units had established IR practices approximately 12–18 months previously, and senior staff perceived that there was considerable variation in the implementation of IR. A convenience sample of nine nurses, who responded to an invitation extended by the research team through the Nursing/Midwifery Unit Manager (N/MUM) of their ward, participated in two focus groups. A third focus group consisted of six current and past N/MUMs and Clinical Nurse/Midwifery Educators (CN/MEs) from the participating wards. The focus groups were digitally recorded and transcribed verbatim for analysis.

Data analysis
Verbatim transcripts of the three focus groups were analysed using QSR NVivo Version 9 (QSR International Pty Ltd, Doncaster, VIC, Australia). To determine latent themes within the data, an inductive approach to thematic analysis was undertaken (Braun & Clarke 2006). Credibility of the analysis was ensured by members of the research team reviewing and discussing major themes. Two research team members then independently reviewed the data and identified further codes (Whitehead 2014). Clustering of the codes to main and subthemes occurred as appears in Fig. 1. Textual data analysis tools such as NVivo were used to increase the transparency of the data analysis (Whitehead 2014).

Quantitative demographic data were analysed using IBM SPSS for Windows Version 22 (IBM Corp, Armonk, NY, USA). As the data set was small, simple descriptive statistics were calculated.

Ethics
Ethics approval for the focus groups was obtained from the health district Human Research and Ethics Committee. Written consent was obtained from all participants.

Results
All participants in the focus groups were female, with an average age of 38 years and 14 years experience (see Table 1). The majority of the participants were registered nurses (RNs)/registered midwives (RMs) (46/7%) and N/MUMs (26/7%), and held a Bachelor’s degree (53/3) or a Diploma (26/7%) (see Table 1).
Participants in the focus groups responded to a number of questions about their wards, how IR was implemented and maintained, what they understood IR to be, and what they perceived to be the benefits of and barriers to IR. The verbatim transcripts of each of the focus groups were read and coded, resulting in 526 comments relating to 35 individual codes. From these 35 individual codes, seven main themes emerged relating to implementation and maintenance, how the system of IR works, roles and responsibilities, context and environment, benefits, barriers and legal issues (see Fig. 1). Throughout the paper, quotes from the focus groups are identified as being from Focus Group 1 (FG1), Focus Group 2 (FG2) or Focus Group 3 (FG3).

Implementation and maintenance

In all wards, IR had been implemented approximately 12 months before the focus groups were conducted. On some wards, the nurses were simply told IR was being implemented, while on other wards staff were consulted and understood the reasoning behind the implementation. In these wards, patient stories were collected, with ‘the impetus for change [coming] from patients’ stories’ (FG2). Despite the difference in consultation, participants in all focus groups remember posters being displayed but little other education. However, what education they did receive appeared to be effective, as IR was quickly incorporated into normal practice, becoming ‘just a normal thing’ (FG1), usually within ‘a month, 30 days’ (FG2) of it being introduced. In fact, most participants felt that they were already carrying out the tasks of IR, and the implementation and naming process simply formalised their existing practices.

Managers were seen as the main drivers and maintainers of IR. Participants reported managers carrying out ‘spot checks’ (FG1) and reminding staff members of the importance of IR. Managers were also reported to discuss IR at staff meetings, and informally at handover.

The IR schedule was used as a management tool, being reviewed regularly as part of routine daily management to ensure that IR had been carried out and the forms signed, and also when complaints were received. Managers reported checking the IR forms when incidents such as falls were being entered into the Incident Information Management System (IIMS) database to determine what care had been given to the patient and by whom.

The importance of continuity of management in ensuring IR was maintained was reported, particularly the importance of stability to ‘know where you’re going and what’s going to be happening’ (FG2) to maintain the practice of IR. Various difficulties arising from the lack of continuity were discussed, most notably the time taken for new managers to learn about the process of IR which impacts on their ability to maintain the momentum.

Finally, the location of the schedule and other documentation was also an important topic of discussion in how it contributed to the ease of undertaking IR. Participants in all focus groups reported placing the schedule at the end of the bed with the medication chart / in the patient’s folder was useful in that it was in a central place and also acted as a reminder for them to check their patients.

How IR works

The education participants received appeared to be effective, as they were able to use a mnemonic to describe the main tasks of IR. A simple mnemonic such as the 4Ps ['pain, pressure care, proximity, paperwork and pan' (FG1)] was important for nurses to be able to identify and understand the main tasks of IR. IR was also contextualised for different wards, to take into account the differences in patient type. For example, on a maternity ward, the ABC ['A [is] analgesia ... B is anything baby ... C is just general concerns for mum and baby' (FG2)] mnemonic is used.

Most importantly, participants in all focus groups reported asking variations of the crucial question of IR: was the patient OK and did they require any further help. By doing so, they indicated an understanding of the underlying principles of IR.

‘Are you comfortable? Are you OK? Do you need any help?’ (FG1)

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‘Everything else alright, any problems? Do you want me to move the light or are you right there?’ (FG2)

‘I ask them if they’re OK, have they got pain, do they need anything’ (FG3)

This question was perceived by some participants to go beyond simply asking if there was anything the patient required, and showed the underlying respect and compassion nurses held for patients. This was especially true with confused patients who not only required monitoring of their medical condition, but also psychological care and reassurance.

One of the main elements of IR is the timing of the rounds, with most systems being hourly. However, many participants reported they were unable to conduct their rounds hourly. Instead, they spoke about the flexibility of the timing, ensuring patients were seen ‘sometime within the hour’ (FG2).

Reasons for the inability to complete the rounds on the hour varied, with participants citing the clinical condition of patients, Medical Emergency Team (MET) calls and other emergencies, and the number of patients on the ward as reasons for not undertaking IR on the hour. Another main reason was the patient being asleep: participants spoke about their reluctance to wake patients, instead visually checking them.

Roles and responsibilities
IR was reported to be undertaken by all nurses on the ward, regardless of their position or qualifications. Indeed, IR was regarded as the responsibility of all, with casuals and new staff being educated and encouraged to undertake IR as part of their normal practice.

However, participants reported difficulties when staff turnover was high, staff experience was low or the patient to nurse ratio was high. These factors increased the workload of experienced nurses, placing a greater demand on the time they had available to undertake IR.

Context and environment
Patient type not only influenced which IR system was used, but also the way in which participants undertook the tasks of IR. Nurses on wards where patients are considered to be ‘well’ tended to be more flexible with their IR, reporting these patients often do not appreciate being disturbed and are more proactive in ‘asking for something they want’ (FG3), allowing nurses to instead focus their attention on patients who were more ‘unwell’.

Patients on aged care wards, on the other hand, required different levels of attention. Participants felt patients with dementia did not fully comprehend the care nurses were giving them, and demand on nurses’ time was heavy. For example, confused patients often rang the call bell even when a nurse was in the room attending to them, with nurses attending to them ‘multiple times in an hour’ (FG1).

The layout of the ward was also discussed, with a more open layout facilitating IR, while a closed or cluttered layout was a barrier. This was considered especially important for dementia patients who had been moved from a ward with wide corridors to a more cluttered, narrow ward. A more open, but secure, layout allowed confused mobile patients to move freely around the ward and also to be brought together for constant observation, easing patient anxiety and facilitating IR. Further, participants also reported that a higher number of staff on the ward and a more open layout, rather than closed individual rooms, allowed multiple patients to be checked more easily and quickly, again facilitating IR.

Benefits
While participants were divided on call bell use, most felt that the introduction of IR had reduced the number of falls. This was especially true on maternity wards, where the risk of babies falling out of the bed they were sharing with their mother was perceived to have reduced due to the ‘increased vigilance about ... patients’ (FG2), particularly during the night. Participants also reported they took advantage of these situations to provide education to the mother about falls. However, a reduction in falls was not always perceived on other wards, particularly aged care, as participants felt older patients would fall ‘even if they’re standing in front of you’ (FG1).

Another consequence of increased vigilance is the increase in visibility of nurses by patients. Participants reported receiving thank you letters from patients who wrote about the presence of staff and recalled ‘lists of names’ (FG2) of staff (midwives), which does not happen unless ‘someone’s frequenting the room constantly throughout the day’ (FG2). Further, participants reported a decrease in the number of complaints, confirmed by the Patient Liaison Officer.

Participants also reported a higher level of professional satisfaction among themselves, especially in relation to having a better understanding of the care of their patients. Participants reported using IR as an opportunity to educate and reassure their patients, leading to a higher level of both personal and patient satisfaction.
Barriers

Intentional rounding was sometimes considered intrusive, with occasional complaints being received about ‘going into [the] room all the time’ (FG3). This also impacted on how participants themselves felt about IR, making them feel whatever they did was wrong and they ‘[couldn’t] win’ (FG2).

However, some of these complaints led to practice change. It was common for doors to be shut and curtains pulled across at night by patients who wanted privacy. When these patients became annoyed at the door squeaking or a torch being shined on them, etc., participants took the opportunity to educate the patient about IR and doors remaining open.

Participants also voiced their concerns about the documentation of IR not reflecting the amount of care given. Documentation of IR often appeared the same for particularly unwell patients who were seen ‘multiple times [but] documented just once’ (FG1) and patients who did not require any special attention during the hour.

This led to a discussion on the perceived impracticality or ineffectiveness of IR. Some participants felt IR did not benefit their practice, especially with confused patients who occasionally rang the call bell even when they were ‘in the room’ (FG1) providing them with care. Other participants reported IR being irrelevant to their practice as they were ‘attending to [their] patients all the time anyway’ (FG3).

Indeed, some participants felt the implementation of IR was an insult to their professional practice as it may ‘take away from actual patient care’ (FG1). They felt the tasks of IR should be undertaken as part of normal practice and that ‘if you’re doing your job properly you don’t need these forms’ (FG1).

Legal issues

The form was described as covering multiple days with space provided to sign hourly, and forms were being kept with the medication chart at the end of the bed. In some cases, the form was a different colour ‘so it [stuck] out’ (FG2). However, participants also voiced concerns about the legality of the form, particularly that it is not audited and not part of the medical record. Managers reported collecting and keeping the form in their own record system ‘otherwise they’d be thrown away’ (FG2).

Concerns regarding the legality of the form raised the issue of signing. In rare cases the form had been ‘presigned for the whole shift’ (FG2), while others also voiced their concerns about signing the form but not checking the patient. If such incidents arose, the form was seen as a management tool to confirm nurses’ understanding of their accountability and being ‘responsible for their signatures’ (FG3).

While some participants felt the amount of documentation was overwhelming, others realised the importance of the IR form to account for their care of their patient and as a document that could be recalled to defend their practice. In some instances, complaints had been received about care not being given, with managers being able to check the IR form to ‘demonstrate [that] due care has been provided’ (FG2). Similarly, when confused patients were unable to recall receiving care, the IR form was able to be recalled to assure family members their relative was being cared for.

Discussion

IR was introduced on a number of wards and quickly embedded into everyday practice. The concepts of IR were embraced by nurses and correctly practiced after education in the form of posters. The comprehensive understanding and quick uptake of IR did not require extensive or complex education. Two approaches were taken in the implementation of IR: one where the unit was simply instructed to commence IR, and another involving a consultancy model. Despite the differences in approach, nurses and managers on both wards reported similar levels of understanding, uptake, and outcomes.

Managers were seen as playing a pivotal role in driving the process of implementation and maintenance of IR. This included checking practices and discussing IR both formally and informally with staff and patients. Indeed, IR was seen by managers as a time management (Dix et al. 2012) and scheduling (Meade et al. 2006, Halm 2009, Fitzsimons et al. 2011) tool. The use of IR also included reviewing staff compliance with the practice and using documentation as evidence in managing reportable incidents.

Continuity and stability of management is also an essential component in the successful implementation and maintenance of IR (Hutchings et al. 2013). The experience on one ward in the current study clearly demonstrated that changes in, and instability of, management interfered with the momentum of the practice of IR while new managers learned the process and became adept at reinforcing it among nurses. Once managers learned the process of IR, their attitudes towards the practice were positive. These positive attitudes, and the commitment shown by managers, were important in motivating nurses on the wards in their practice of IR (Hutchings 2012a).

As with changes in management, staff turnover and level of experience posed a challenge to the sustainability of the
practice of IR, with established staff being responsible for the education of new staff. Staff to patient ratio, increased workload, and demands on time are potential areas of concern during the implementation of IR (Lowe & Hodgson 2012). Importantly, the responsibility of IR was seen as being shared among all staff, including new and casual staff.

It is therefore imperative that nurses are engaged in the processes of IR (Dix et al. 2012, Braide 2013). While the majority of nurses positively engaged in the tasks of IR, some nurses held reservations about the benefit to their own practice and the wellbeing of patients. In particular, the introduction of IR was viewed by a minority of nurses as being an insult to their professional practice (Lowe & Hodgson 2012) as the tasks involved in IR should be practiced as a matter of course. Further, IR was also seen by some nurses as intruding on patients who were considered to be well (i.e. maternity) (Dix et al. 2012) or ineffective for patients who were confused (Moran et al. 2011).

However, the principles of IR are robust enough for the practices to be varied to suit the specialty of the ward and the patient type. Indeed, while the standard approach of the 4Ps (Studer Group 2007) was used on one ward, the other ward involved in the study used an ‘A (analgesia, pain), B (baby concerns), C (care for mother and child)’ approach adapted to the type of patient on their ward. Although the mnemonic nurses used was not always technically correct (one nurse added an extra ‘P’ for ‘paperwork’), identifying the key tasks and what they entailed for their patients was the primary concern.

Most importantly, nurses understood the key component of IR – asking the patient if there was anything else they needed (Halm 2009, Hutchings 2012b, Rondinelli et al. 2012) – and included it in their practice. Not only was the question routinely asked, the querying was done in such a way to show respect and compassion for the patient and assure the patient they would be well cared for (Meade et al. 2006, Studer Group 2007, Woodward 2009, Kessler et al. 2012, Rondinelli et al. 2012, Shepard 2013).

Indeed, demonstrating the ethos of nursing care, nurses went beyond simply asking the patient if there was anything further they required, to viewing IR as an opportunity to build a relationship with their patient (Dix et al. 2012, Hutchings 2012b), provide education and emphasise the provision of safe care. This was clearly seen in a number of situations. For example, on maternity wards nurses took the opportunity provided by IR to educate mothers about the safety of co-sleeping with their babies. Further, nurses caring for confused patients provided not only physical but also psychological care and reassurance. These differences in patient type and acuity were among the main reasons the practices of IR, such as not disturbing patients at night, were varied.

The ability to vary the practices of IR while still maintaining the integrity of the principles was also demonstrated in the flexibility of the timing of rounds. Interruptions such as Medical Emergency Team (MET) calls, the number of patients under a nurse’s care, and sleeping patients were considered when scheduling rounding. It is therefore important for staff to build IR times into their work routine rather than a prescriptive ‘on the hour’ model. This allows for differences in patient acuity, with more ‘unwell’ patients being given the care they require while still acknowledging the importance of delivering appropriate care to all patients.

Unfortunately, IR was not universally well received by nurses. A minority of nurses felt the introduction of IR was an insult to their professional practice and that the tasks of IR should be carried out within their normal practice (Lowe & Hodgson 2012). As such, the risk of insult to professional practice should always be considered when introducing IR. However, as discussed above, the way in which IR was practiced on the wards in the current study, with variation in the practices to allow for differences in patient type, and a more flexible approach to timing, ensured individual patient needs were met. Further, IR was seen as reinforcing and formalising already existing good practice, rather than introducing new practices.

An unanticipated finding of this study was that ward layout impacted IR. Open layouts were considered easier to navigate, for both staff and patients, compared to closed or cluttered areas which created difficulties with patient distribution and moving between patients. The ability to meaningfully check multiple patients within shorter time period is important in the facilitation of IR. This was considered to be especially true for dementia patients, who were sometimes brought together in open areas of the ward for closer observation. With an ageing population requiring more care, the design and layout of wards for particular patient types is therefore a critical component in facilitating meaningful and adequate care.

One of the main benefits of this study was the perceived increase in patient satisfaction. The increased visibility of nurses due to IR (Braide 2013) led to an increase in the patient’s ability to identify staff by name, including in written correspondence post discharge. This, coupled with anecdotal evidence of decreased patient complaints, demonstrates the effectiveness of IR in increasing patient satisfaction (Meade et al. 2006, Dix et al. 2012, Kessler et al. 2012). Higher levels of staff satisfaction were also reported, including an improved understanding of patient care needs.
Other benefits of IR were also discussed in the literature, including reduction in call bell use (Studer Group 2007, Weisgram & Raymond 2008, Dix et al. 2012, Hutchings 2012b) and patient falls (Halm 2009). While data to support such claims were not collected during the current study, there was a perception by some nurses of a reduction in call bell use and fall-related incidents. The perception on one unit was of a significant improvement in these aspects when combined with patient education.

Surprisingly, the documentation form developed to support IR was found to raise the most concerns with nurses. A strong preference was voiced from clinical staff for the form to be formalised and legalised and filed in the medical record. The design and location of the form was considered important, including the need for the form to cover multiple days, the ability to sign each hour, and the preference for the form to be kept at the end of the bed as an aid in documentation. Further, the form was also used by managers, in the investigation of incidents, to demonstrate sufficient and routine care had been provided. However, nurses sometimes felt the documentation process under-represented the amount of care given. Pre-signing the form or signing when IR was not attended were considered relatively uncommon though worth noting. While improvements in documentation have been found to facilitate holistic care (Langdon et al. 2012) and lead to better patient care (Dix et al. 2012), documentation of IR has not previously been studied. These findings may therefore support the development of future documentation of the practice in the health care record.

**Conclusion**

This study has described aspects of implementation, practice and sustainability of IR within two clinical settings: aged care and maternity units. Nurses accurately described their knowledge of the concepts and practices of IR and how the model had been implemented on their wards with limited education.

Nurses reported perceived improvements in patient and staff satisfaction and reductions in call bell use and fall incidents (dependent on the setting). Patient outcomes associated with IR vary depending upon the clinical setting, and feedback to nursing staff on the impact of IR (named staff member in patient reviews of service, reductions in falls) on patients is recommended.

Additional benefits included the opportunity to provide holistic care to patients, including education and psychological care. IR proved to be easily implemented and quickly incorporated into every day practice without the need for extensive or complex education, with managers using it as a management tool. The principles of IR also proved robust enough to allow for differences in patient type and acuity, while ward layout and staffing levels are important considerations in the facilitation of IR. However, care must be taken when implementing IR to reduce the risk of alienating experienced staff as most agree the tasks of IR are already being practiced in the normal course of patient care. Further to this, documentation tools that did not form part of the patient’s health care record were a concern, and incorporation of the IR charts into the health care record is therefore recommended.

**Relevance to clinical practice**

Successful implementation and maintenance of IR relies on staff engagement and ownership of practices, and stability of management. IR can be used as a management tool to encourage best practice and accountability for patient care, and provides evidence of patient care. IR can also be used as an opportunity to provide patient education alongside routine, nonurgent care. The practices of IR are flexible and robust enough to be implemented in a variety of settings, accommodating different patient types and variations in acuity.

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**Contributions**

Study design: KF, KW, MM, CW, MJ; Data collection and analysis: KF, KW, RL, MM, CW, MJ; Manuscript preparation: KF, KW, RL, MM, CW, MJ.

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