INTENTIONAL PATIENT ROUNDING

INFORMATION FOR CLINICIANS & HEALTH PROFESSIONALS

Intentional Patient Rounding is purposeful hourly communication by a healthcare team member with each patient and/or their carer or family.

Intentional Patient Rounding with purpose:

- Keeps patients and/or their carer or family informed about and involved in their care
- Supports the delivery of safe, quality care
- Regularly evaluates the quality of care delivered
- Creates trust and reduces patient and/or carer or family anxiety by providing clear expectations for each interaction by a known care giver.

It is not an additional attendance to a patient and/or their carer or family on the hour, but is a system of providing holistic care to all patients and/or their carers or families during the course of usual scheduled activities. This means that a planned task such as administering medications or taking observations becomes the opportunity to undertake intentional patient rounding. It enables evaluation of the effectiveness of strategies and plan care in partnership with the patient and/or their carer or family. This ensures awareness of the clinical and personal needs of the patients they are caring for and helps to manage workload proactively. The information gathered during hourly rounding throughout a shift will inform clinical handover information.

Intentional Patient Rounding Behaviours	Expected Results
Use opening key words (greeting: Introduction of self)	Contributes to trust, therapeutic relationship
Ask the patient and/or carer/family what you can do for them	Improve communication and individualised care
Accomplish and document scheduled tasks (planned care, observations etc.)	Contributes to safety, efficiency and delivers on planned care
Assess the following: • Personal needs • Position • Patient environment • Discomfort • Devices • Documentation	Care is provided to meet the individual needs of each patient, which contributes to improved outcomes, quality indicators and reduced risk through activities including: • Personal cares • Analgesic requirements • Positioning and comfort • Maintaining therapeutic relationships
Update Patient Care Boards as required in consultation with patient/family/carer	Individualised care for patients
Inform the patient and/or family or carer when you will be back	Contributes to therapeutic relationship, provides reassurance, is proactive and improves efficiency
Document the round	Quality and accountability

Principles of Intentional Patient Rounding:

- Must be undertaken with each patient and/or carer or family individually and in a manner that allows the patient and/or carer or family to feel they are not taking up staff's time.
- Must be attended with purpose, taking into account the patient's risk factors e.g. falls and pressure injury.
- Must be documented following each rounding.
- Scheduled tasks (ie administering medications, repositioning) are performed in conjunction with rounding.
- Address the 'P's (personal needs, position and patient environment) and 'D's (devices and documentation) and document as follows:
  - Ask the patient, and/or carer or family ***'Is there anything I can do for you?'***
  - If the patient is asleep document 'asleep'.
  - If the patient is absent determine where the patient is and document same in patient health record.
  - If a patient is absent at any intentional rounding and the patient's whereabouts are unknown, follow hospital procedure for absent/ missing patients.
- If nothing further is required, inform them a team member will return in an hour.

* The 'P's& 'D's listed below are an example of elements to be assessed and these should be adapted to meet the needs of specific clinical specialties.

'P's & 'D's	Actions	
Personal Needs	• Involve the patient and/or their family carer in the planning of care as per their wishes • Address fear and anxiety *(What matters to you?)* • Provide ongoing and relevant education to patient and their family or carer • Assist with toileting as required	• Enable nutrition and hydration by assisting patients and/or carers/families with positioning, opening of packaging and feeding as necessary • Support hygiene needs including shower/bath and grooming and hand hygiene
Position	• Reposition as per the pressure injury care plan and patient comfort • Inspect skin for any redness or other injury after repositioning to evaluate effectiveness of care plan	• Check that any pressure relieving/ pressure redistribution equipment is in place correctly and functioning
Patient Environment	• Place call bell in easy reach • Check sensory aids are installed and operating and/or within reach • Check mobility aids and non-slip footwear is within easy reach • Verify that linen is adequate and clean • Check that the environment (including ensuite) is safe and clean with no clutter, spills or trip hazards	• Check oxygen and suction equipment available and working at bedside • In the event of a patient being absent during intentional patient rounding check the bathroom/toilet assigned to their allocated patient rooms for the purpose of checking for persons who may be collapsed or otherwise need assistance
Discomfort	• Attend and document pain score (if applicable) • Assess discomfort or pain and provide interventions as required or charted	• Administer medications if required • Evaluate effectiveness of pain management interventions.
Devices	• Check intravenous device/s for placement, patency and duration (where applicable) • Check catheters and drains for drainage, placement and contents • Check IV fluid/medication is being administered as per IV charted orders and lines are labelled correctly	• Observe O2 delivery and suctioning systems are in place and functioning adequately • Check for device related pressure injuries including removal of bandages (if used) at least once every eight hour.
Documentation	• Check medication charts and document administration of medications as required • Document input and output as required on fluid balance chart • Update all relevant care plans as required	• Document any variances in the health care record • Attend and document observations as per standard observation chart • Escalate care in accordance with patient requirements using ISBAR.

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