

Proactive Patient Rounding: developing nursing practice to improve the quality of patient care

Whipps Cross University Hospital NHS Trust, London, UK

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1 Summary of project

The project, led by a staff and patient project group, introduced Proactive Patient Rounding (PPR) on two orthopaedic wards. PPR involves nursing staff using predetermined questions to ask patients on a regular (two hourly) basis about care needs and checking the patient environment to ensure that it is clean and uncluttered and that everything is in reach of the patient. Proactive rounding of relatives/carers, which focused on their information needs, was also included in the project. A baseline audit (Exploratory Phase) demonstrated that nurses were often reactive rather than proactive in meeting patients' needs and that patients were dissatisfied with this. These findings were fed back to nursing staff, who were given the opportunity to reflect on their care and to learn about PPR (Education Phase). During the Implementation Phase, PPR was introduced on the two wards and a daily audit of four patients and four relatives carried out to determine their perceptions of care. The baseline audits were repeated in the Evaluation Phase alongside staff evaluation. The results demonstrated that there was an improvement in the staff responsiveness to patients' need and patients were positive about this. Patients reported that not all staff were carrying out PPR and relative rounding proved more difficult to introduce. Nursing staff could see the benefits of PPR but continued to believe that it was difficult to carry out in times of staff sickness/shortages. The project demonstrated that preparation of staff in the use of PPR and continuous feedback when it is introduced help to contribute to its success.

2 Background

Whipps Cross University Hospital NHS Trust (WXUHT) is a 600 bedded district general hospital in East London, serving an ethnically diverse population of approximately a quarter of a million.

The project was carried out on the Orthopaedic Unit, which consisted of two wards – Sage and Sycamore – each with 28 beds of four 6-bedded bays and four single side rooms. Sycamore Ward admitted primarily trauma patients and Sage Ward elective orthopaedic patients, although at times of bed pressures there was some overlap and both wards would also receive non-orthopaedic patients. The majority of patients on Sycamore Ward were those with a fractured neck of femur and on Sage Ward patients having hip/knee replacement or lumbar spine surgery. Each ward had a whole time equivalent staff of 20 registered nurses with nine support workers on Sage Ward and 13 on Sycamore Ward. Both wards had registered nurses and support worker vacancies during the project. Each ward had a ward clerk and shared a discharge co-ordinator and a housekeeper. The Ward Managers were managed by the Modern Matron. One Ward Manager (Sycamore Ward) had experience of patient rounding in a previous hospital and was keen for it to be

implemented. Other senior nurses within the Unit who were involved in the project were the Orthopaedic Advanced Practice Nurse (the Project Lead), Senior Nurse – Practice Development, Orthopaedic Nurse Practitioner and Trauma Sister.

The project was carried out because a number of informal and formal patient complaints on the Orthopaedic Unit highlighted that nursing staff were reactive rather than proactive. Patients reported that they had to ask for help and visitors had to ask for information. Informal discussion with nursing staff indicated that they felt they were too busy to be proactive in anticipating patient needs and they perceived that such an approach would lead to an increase in nursing workload.

The literature suggests that patients use call bells for non-emergency needs because staff are not always responsive to those needs (Meade et al., 2006; Tea et al., 2008). In the United States research studies have examined the introduction of nursing rounds, where staff proactively ask patients on a regular (one or two hourly) basis whether they have any needs. Patients have a more positive view on the timeliness of response to requests and the discussion of needs by nursing staff through such rounds (Tea et al., 2008), patient satisfaction increases and the use of call bells decreases (Meade et al., 2006). In the United Kingdom similar patient comfort rounds have been proposed (Castledine, 2002) and described (Castledine, Grainger and Close, 2005) but not formally evaluated. Evidence from the National Patient Survey suggests that the time taken to answer patient call bells is a concern across the NHS in England for patients (Garratt, 2009). Results from the 2008 national survey indicate that 15% of patients nationally usually waited longer than five minutes for a response with a minority (2%) saying that they never got help when they used the call button. Nursing rounds are also about involving patients in their care and the National Patient Survey indicates that one in ten patients nationally felt that they were not involved as much as they wanted to be in decisions about care. The results for Whipps Cross University Hospital NHS Trust indicated that it was in the worse performing 20% of trusts with regard to patients being involved in decisions about care and in the intermediate 60% of trusts in terms of call button response. Whilst these figures are Trust rather than Unit specific, they indicate that the Trust could improve its performance in these key quality areas.

Evidence from the US suggests that proactive rounding may reduce the number of patient falls (Meade et al., 2006) and pressure ulcer incidence (Leighty, 2006) though these outcomes were not studied as part of the PPR project.

The project examined two hourly rather than hourly rounding. The Project Group members, who facilitated the project (see section 4.1, p8 for details of group) believed that it would be more practical and more acceptable to staff. The evidence on the effectiveness of hourly compared with two hourly rounding is sparse. Only one study (Meade et al., 2006) included areas using both time frames and whilst it found that those rounding hourly had higher patient satisfaction and reduced falls, two

hourly rounding also resulted in positive changes in satisfaction and falls reduction. They concluded that comparison was difficult due to the quality of the data.

The project was carried out at the same time as a Trust wide initiative - the 'Patient Experience Revolution'. This was designed to enhance both patient experience and staff morale at the hospital. Through a series of workshops and listening events, patients, relatives, carers and staff were involved in helping to highlight ways in which the patient experience could be improved. The Revolution delivered a clear set of values for hospital staff, a promise to patients around how they will be treated and ten behavioural/service standards for all staff which were contained in a manifesto. These developments impacted on the project as staff from the Orthopaedic Unit were involved in the Trust wide workshops and were expected to follow the behavioural/service standards. One hourly rounding was introduced on the other wards in the hospital as part of the Revolution.

3 Aims and objectives

The aim of the project was to improve the service for patients and increase patient satisfaction with nursing care by introducing and evaluating two hourly Pro-active Patient Rounding (PPR) to the two wards within the Orthopaedic Unit at Whipps Cross University Hospital NHS Trust.

For the purposes of the project PPR was defined as nursing staff using predetermined questions to ask patients on a regular (two hourly) basis if there is anything they need and checking the patient environment to ensure that it is clean and uncluttered and that everything is in reach of the patient. Relative/carer rounding involves proactively asking a nominated relative/carer about any information needs they may have about a patient.

The objectives were to:

1. Identify from patients and carers the types of needs they have when calling for nursing help and what their perception of 'timely response' to requests is.
2. Categorise the type and frequency of nurse call bell use by patients.
3. Identify the perceived enablers and barriers to introducing PPR from the nursing staff's perspective.
4. Devise a standard for PPR, a 'script' for nurses to use when proactively meeting patient needs, and an audit tool to evaluate PPR implementation.
5. Educate nursing staff in the use of PPR so that they understood the reasons behind it and its use in practice.
6. Pilot the use of PPR in practice and evaluate the results from a patient/carer and nursing staff perspective.
7. Introduce PPR on an ongoing basis.
8. Share the good practices developed both within and outside the Trust.

Advice was sought from the Research Department at the Trust who concluded that the project was audit rather than research, as existing local practice was being

examined and changed. The project was registered with the Audit Department, who were able to offer advice but not data inputting or analysis due to a lack of resources.

4 Methods and approaches

A number of approaches were used to facilitate the introduction and evaluation of PPR. These were:

- A multidisciplinary project group of staff and patients to manage the project
- Patient questionnaires and interviews
- Audits of care
- Staff reflection and education sessions
- Staff questionnaires and interviews

Table 1 outlines the timeline of the project.

Table 1: Phases of project and methods/approaches used

Date	Oct 09	Nov 09	Dec 09	Jan 10	Feb	Mar	April	May	June	July	Aug	Sept	Oct
Project stage	Exploratory Phase			Staff Education Phase		Implementation Phase				Evaluation Phase			
Meetings	Monthly project meetings (except March 2010)												
Activities	<ul style="list-style-type: none"> • Audits of care • Patient interviews • Patient questionnaires • Staff reflection sessions 			<ul style="list-style-type: none"> • Staff education sessions 		<ul style="list-style-type: none"> • Audits of care • Staff reflection sessions 				<ul style="list-style-type: none"> • Patient interviews • Patient questionnaires • Staff reflection sessions • Staff interviews/questionnaires 			

4.1 Monthly project meetings

A project group was established consisting of the following staff:

- Project Lead (Orthopaedic Advanced Practice Nurse)
- Three patient representatives
- Ward Managers
- Two staff nurse representatives (one from each ward)
- Orthopaedic Modern Matron and the Orthopaedic senior nurses
- FoNS project facilitator

The staff nurse representatives were identified by the Ward Manager. Two of the patients were members of the support group for patients after total joint replacement – the Joint Information Group (JIG) – and volunteered after hearing about the project from the Project Lead at a JIG meeting. The third patient representative was a member of the Trust's Patient Panel, ensuring the project was connected with ongoing patient involvement work within the Trust. The patient representatives were paid a £10 allowance from the project fund for each meeting attended, to cover travel and other.

The purpose of the group was to facilitate the project. The monthly meetings lasted for approximately 90 minutes and were held in the seminar room close to the orthopaedic wards, maximising the possibility that staff would have time to attend. At each meeting progress against the action plan was discussed, early results examined and future actions for the project agreed. Action notes were taken by the Project Lead and a summary e-mailed to the participants and sent by post to the two patient representatives who did not have e-mail access. Copies were also sent to the Lead Nurse for Surgery and the Deputy Director of Nursing, to ensure that the Nursing and the Surgical Directorates were kept informed about the project. Both were invited to the meetings but due to time pressures the Lead Nurse could attend only one and the Deputy Director of Nursing could not attend any.

Attendance of individual members varied at the meetings during the project. The major barriers to attendance for staff were work pressures or annual leave. For the patient members, one worked free-lance and could only attend one meeting due to time commitments. Those who could not attend meetings were able to contribute to the project through suggestions via e-mail or telephone after receiving action notes from meetings, and this happened on occasion.

In order to understand the project group members views about PPR a 'Claims, Concerns and Issues' exercise was carried out at the December 2009 meeting, led by the FoNS facilitator. This method, developed by Guba and Lincoln (1989), allows individuals to consider the positives (claims), concerns and questions (issues) about

a particular issue. Sixteen Claims, twelve Concerns and nine Issues emerged. The Claims were related to the positive impact on the patients, for example feeling more valued, and on the staff through developing their interpersonal skills. Concerns were centred on the attitude of the nursing staff to PPR, the perceived extra workload it might involve and whether the planned training and education could be carried out in time. Issues included how to evaluate the impact of PPR and how to embed it in practice. These were shared with the nursing staff at the staff reflection sessions (section 4.5 p12).

4.2 Patient questionnaires

Patient questionnaires were distributed during the Exploratory and Evaluation stages. Their purpose was to ascertain patients' views about the proactiveness of the nursing staff in introducing themselves to patients, involving them in care planning and asking them regularly if they had any care needs.

The questionnaire was developed by the Project Group, as no existing questionnaire was identified. It consisted of nine questions, related to staff responsiveness throughout the day. The questions were closed ones with 3 possible responses ('Always', 'Never', 'Sometimes') and space for free text comment. An introductory paragraph explained why the patient was being asked to complete it and that it would be anonymous.

In the Exploratory Phase 40 patient questionnaires were distributed on each ward. The first 40 patients to be discharged were given the questionnaire plus a stamped addressed envelope. 28 questionnaires were returned from Sycamore Ward patients and 11 from Sage Ward patients.

40 questionnaires were similarly distributed in the Evaluation Phase to patients on each ward. The return rate from Sage Ward patients was poor and therefore an additional 20 were sent out. The final response rate was 24 from Sycamore Ward patients and 10 from Sage Ward patients.

All returned questionnaires were kept in a filing cabinet in the Project Lead's office, which was locked when not in use.

The quantitative data was analysed by the Project Lead using descriptive statistics i.e. frequency of responses. The qualitative data was analysed and themes identified by the Project Lead. A summary of the results was used to feedback to staff and to help inform the development of the script staff would use when undertaking patient rounding.

4.3 Patient interviews

Patient interviews were carried out during the Exploratory Phase and in the Evaluation Phase. They provided more in-depth data than the patient questionnaires,

allowing patients to expand on particular issues of importance to them. The interviews were semi-structured and based on the questions within the postal questionnaire.

In both Phases five patients per ward who were being discharged were identified by the Ward Manager and an information sheet about the project and the interviews was given to them. If they agreed to take part the Project Lead contacted them and an interview date was arranged. Notes were taken during the interview, including verbatim quotes if they were felt to be significant, as tape-recording was felt to be too intrusive.

In the Exploratory Phase the five patients from Sage Ward were interviewed by the Project Lead whilst they were attending a follow-up outpatients appointment. Four of the patients from Sycamore Ward were interviewed by the Senior Nurse Practice Development in the rehabilitation unit they had been transferred to and one patient preferred to be interviewed in their own home (which was undertaken by the Project Lead with one of the patient representatives in attendance). In the Evaluation Phase the interviews were undertaken by the Orthopaedic Nurse Practitioner and the Senior Nurse Practice Development in the outpatient department or a rehabilitation unit.

Thematic analysis was undertaken by the Project Lead for both interview phases. The notes were examined individually and key themes identified. The themes from each interview were then compared and grouped into common themes. A summary of the themes was then produced for use in the staff reflection sessions (section 4.5 p12) and to aid development of the PPR script of questions staff would ask patients when rounding.

4.4 Audits of care

Audits of care were necessary to understand the reality of practice before and during the introduction of PPR, to measure the impact.

In the Exploratory Phase observational audits were undertaken of call bell usage and patient requests for help. The call bell usage audit tool was designed by the Project Group and documented:

- the frequency of call bell use
- time to answer call bell
- reason for call bell use
- patient views on whether answered within acceptable time
- any additional patient comments

Seven one hour audits on Sage and five on Sycamore were carried out by different staff members of the project team on different days and times of the day, in order to gain a broad picture of call bell usage. Staff volunteered to observe dependent on their availability. For each audit episode the observer sat at the nurses' station, where a panel indicated when and where a call bell was being activated. The auditor would mark the time it took to answer the call bell, and then check with the patient the reason for the call bell use and the acceptability of the length of time to wait. A potential ethical issue was leaving call bells to ring for a long time if nurses were busy, but in reality this did not happen. The results (described below) indicated that call bell usage was relatively low on both wards and therefore a second audit – patient requests for help – was undertaken to determine the reasons for low call bell usage.

The second audit tool was devised by the Project Group and documented:

- if the call bell was in reach and working
- if patients had asked for assistance from nurses within the previous 12 hours and the reasons why
- whether the nursing response was within an acceptable time
- if patients felt able to ask nurses for help and whether they would prefer it if nurse came and asked patients if they needed help
- any additional patient comments

The audit tool was administered to 20 patients on Sycamore Ward and 35 patients on Sage Ward during the Exploratory Phase by various members of the Project Group, according to availability.

The Project Lead designed a spreadsheet for the audits and entered the data. From this simple frequency calculations were made. The audits were not repeated in the Evaluation Phase as the Project Group considered the results (section 5.1.2 **pError! Bookmark not defined.**) indicated that call bell usage was not a particular issue.

For the Implementation Phase two audits were devised by the Project Group (Appendix 1 p31, Appendix 2 p32). They were designed to provide evidence of the experience of PPR from the perspective of four patients and four relatives/carers daily (Monday to Sunday). The patient audit included a question designed to identify individual nursing staff who had provided a high standard of care. At the end of each month the nurse or support worker named most frequently would be awarded the title 'Nurse/Support Worker of the Month' and receive a £10 gift voucher.

The Project Group agreed that it would be the Ward Managers' responsibility to ensure that the daily audits of patients and visitors took place. Nursing staff would not audit their 'own' patients but staff would audit across the nursing team. In reality however there was little time for ward nursing staff to do this and audits were

generally undertaken by the Ward Manager or other members of the Project Group, in particular the Senior Nurse Practice Development when he was on the ward working with staff. At the weekends, when the Project Group members were not usually on duty, the ward staff undertook the audits. For the audit one patient and one visitor from each of the four bays on both wards were chosen at random, taking into account the patients' clinical condition and the availability of visitors.

The relative/carer audits proved difficult to undertake: visiting did not begin until 14.30 but the Ward Managers finished their shifts at 15.30 – therefore they were often auditing before nurses had had a chance to proactively introduce themselves to visitors. As with the patient audit it was often difficult for nurses to undertake the relative/carer audits.

This meant that there were some gaps in the audit information gathered from patients and relatives/carers. For example in May 2010 one of the wards audited patient views on 19 out of 31 days.

The Project Lead designed a spreadsheet and inputted the audit data. Graphs of the results were produced on a weekly basis and distributed to the wards so that progress could be reviewed by the ward teams. The results were also discussed at the Project Group meetings.

4.5 Staff reflection sessions

It was important that staff on the two wards had the opportunity to reflect on the project and its implementation so that their issues and concerns were voiced and addressed. Reflection sessions were therefore organised in the Exploratory, Implementation and Evaluation Phases. In all Phases the sessions were facilitated by a member of the Project Group and staff from both wards attended joint sessions in the day room of one of the wards. Sessions were repeated several times, depending on the availability of facilitators, to maximise the total number of staff who could attend.

In the Exploratory Phase the aims of the sessions were to share the results of the patient questionnaires/interviews and the audits of call bell usage, and to provide an opportunity for reflection on the project. The results were displayed in the staff room prior to the reflection sessions, so that staff had an opportunity to read them in advance. The reflection sessions were organised over the first two weeks of January 2010 (Monday to Friday) with two 45 minute sessions each day (13.45 and 14.30) for eight days (on the other two days educational sessions had already been arranged for staff). In total thirty eight nursing staff (registered and unregistered) attended.

The first part of the session was a discussion about the audit results and the planned implementation of PPR. The second half was devoted to exploring the staff's

thoughts using the 'Claims, Concerns, Issues' format. The facilitator noted down the responses which were collated and themed by the Project Lead. The results were discussed at the Project Group meeting, displayed on the staff room walls and formed part of the staff education sessions (section 4.6 p13).

Seven thirty minute reflection sessions were held in early March, during the Implementation Phase, which 18 staff attended. The 'Claims, Concerns, Issues' format was used and the collated responses were used to help highlight any changes in the way PPR was being implemented.

During the Evaluation Phase seven thirty minute reflection sessions were held and 30 staff in total attended. A semi-structured topic list agreed by the Project Group was used, and covered the implementation of PPR including what worked well, PPR with agency nurses and confused patients, and issues still remaining. Notes were taken of responses. The results were collated by the Project Lead and presented to the Project Group.

4.6 Staff education sessions

During the Education Phase a staff education session, repeated eight times over a two week period, was held in a training room within the Trust. The aims of the session were to answer any 'concerns/issues' staff had voiced in the reflection sessions through demonstrating how PPR would work in practice. The session was two hours in length and facilitated by a member of the Project Group. Staff came in their own time and were paid agency rates for their attendance, or were released from duty on the ward and agency staff employed to cover them. Costs were covered from project funds.

The session began with a review of the 'Claims/Concerns/Issues' from the reflection sessions, highlighting how these would be addressed during the session. The remainder of the session was built around short video clips which had been filmed in the Trust simulation suite, using the Ward Managers/Senior Nurse Practice Development and members of JIG. These short (1-2 minutes) videos demonstrated how PPR would work at the beginning of the shift, when performing a PPR round, when performing a task such as blood pressure monitoring, and PPR with relatives/carers. Each clip had a contrasting clip which demonstrated how not to perform PPR. The videos were used as the basis for discussion with participants. At the end of the session it was checked whether the 'Concerns/Issues had been addressed.

18 out of 27 Sage Ward staff and 26 out of 28 Sycamore Ward staff attended. The decision had been made to hold the sessions over a two week period immediately prior to the piloting of PPR so that they would be fresh in the minds of the staff. However this did mean that some staff, those away on annual leave in particular, could not attend. Others found it difficult to attend in their days off due to carer commitments. The Project Group agreed that those who had not attended would be

given the opportunity to have an education session on a one-to-one or small group basis once the pilot had begun, but in reality this did not happen, usually because it was not possible to identify a mutually suitable time for a facilitator and the staff. Some staff therefore learnt about PPR through implementing it, which was not ideal.

4.7 Staff interviews/questionnaires

As part of the Evaluation Phase the views of the ward staff about their experience of PPR implementation were sought through staff questionnaires, to capture the majority of staff, and staff interviews, for more in-depth views.

The staff questionnaire was devised by the Project Lead and agreed by the Project Group. The questions were open and designed to give staff the opportunity to write their views about the project. The 12 questions covered the following areas related to PPR implementation: the advantages for staff/patients/visitors, concerns, whether two hourly was sufficient for the bays and for single side rooms, implementation with confused patients, documentation of rounding. Space was also provided for any additional comments.

The questionnaires were distributed to each member of the ward staff. To encourage completion a 'prize draw' was organised whereby on handing in the anonymous questionnaire a tear off slip with the staff member's name on it was also handed in. The prize was a £25 gift voucher, paid for out of the Project funding. However no responses were received from staff, despite the closing date being extended. No reasons for this were established

The interviews were carried out by the FoNS facilitator for the project, using the questionnaire as a basis. Interviews took place within the Trust, usually in the staff room, and were tape recorded. 12 staff were identified by the Ward Managers as willing to take part; all staff nurses. The tapes were analysed using thematic analysis by one of the Ward Managers and the Orthopaedic Nurse Practitioner. The tapes were stored in a locked cabinet and were erased after analysis had been completed.

5 Findings and discussion

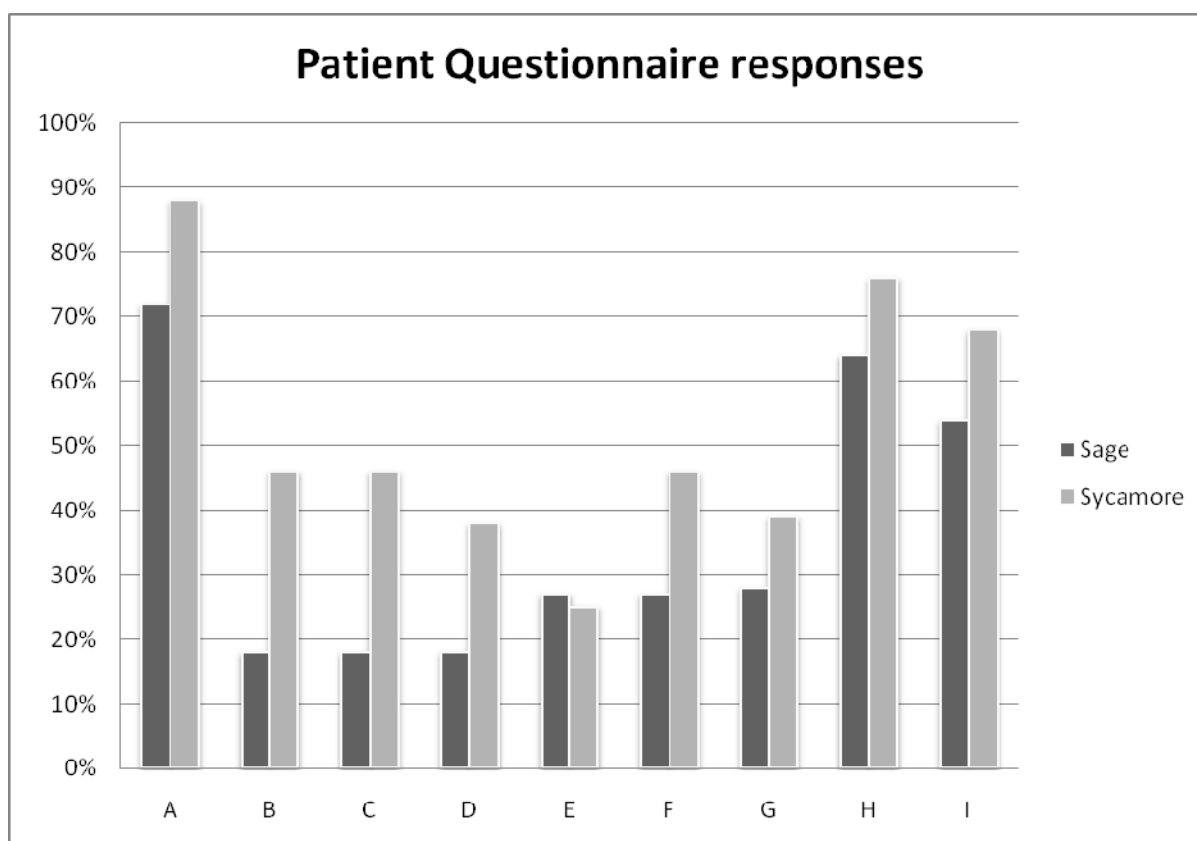
The findings will be discussed according to the phases of the project; that is the Exploratory, Education, Implementation and Evaluation phases.

5.1 Exploratory Phase findings – patient experience

5.1.1 Patient questionnaires and interviews

The questionnaire and interview results revealed that care before the introduction of PPR was inconsistent with some nurses introducing themselves and proactively involving patients whilst others did not. Table 2 outlines the questionnaire results:

Table 2: Baseline patient questionnaire responses



Key: For each response A-G the percentage shown is those patients who felt that nursing staff always:

A	Introduced themselves and explained how call bell worked on patient admission
B	Introduced themselves in the morning
C	Introduced themselves in afternoon
D	Proactively asked patients at regular intervals if had any care needs
E	Proactively discussed care with relatives/carers
F	Introduced themselves at night

G	Proactively rounded at night
H	% of patients always happy with attitude of staff caring for them
I	% of patients who always felt call bell answered within reasonable time period.

The figures suggest that nurses would introduce themselves and proactively help patients when they were first admitted but that for the rest of the inpatient stay this did not occur consistently. The results for Sycamore Ward were more positive and may have reflected the fact that the Ward Manager had experience of patient rounding in a previous post and was keen to implement it. Patients on both wards were more positive about the attitude of the nursing staff and the time to answer call bells, although there was still room for improvement. Results must be viewed with caution given the low response rate from Sage Ward patients.

The interview data revealed similar themes:

- *Nurse rarely introduced themselves* – ‘A few introduced themselves but you got to know their names by looking at their name badges’, ‘Only one nurse introduced herself, learnt names of others from name badge or from listening to nurses talking to each other’
- *Patient care was not proactive* - ‘The nurse would help when asked but would stick to the request, would not really offer any other assistance’, ‘Nurses should ask all patients if they want anything otherwise a small number of patients dominate’
- *Patients and visitors had to ask for information* – ‘At visiting times very few nurses were visible except when doing observations or at mealtimes’, ‘Nurses would say they were too busy to talk to relatives’
- *Attitude of nursing staff* – ‘The nurses weren’t friendly, I can’t name one who was friendly’, ‘I sometimes felt that help was given grudgingly’

The data suggested that there were pockets of good practice with individual nurses being approachable and proactive, but that this was variable with no consistency.

5.1.2 Observational audits

The audit of call bell usage revealed relatively low numbers of call bells used, with generally less than four per hour. These were generally answered within one minute and all within two minutes. The most common reasons for patients calling were elimination needs, followed by pain and nutritional needs (wanting a drink for

example). The second audit demonstrated that call bells were generally working but not always within patient reach. Patients generally felt that call bells were answered within a reasonable time and used them to call for help related to elimination needs followed by pain. The majority of patients felt that they could ask nurses for help but would prefer it if nurses were more proactive in ascertaining patient needs.

Examination of the patients' perspectives indicated that on both wards there were pockets of good practice but no consistency in care. Patients wanted nurses to be more approachable and proactive. The main reasons patients were seeking nursing assistance were elimination, pain, and nutrition. Collection of the data relied on the senior orthopaedic nurses and sometimes it was difficult to find time for the audits, which impacted on the amount of observation and patient feedback which could be obtained. Nevertheless a picture was built up of the baseline situation from a patient perspective. It also allowed the draft PPR script to be developed – the questions that patients were to be asked based on the needs identified in the Exploratory Phase (appendix 3 p33).

5.2 Exploratory Phase findings – staff perspectives

The staff reflection sessions provided evidence for the thoughts and feelings of the staff on the proposed PPR project.

5.2.1 Staff Claims about PPR

Staff made 39 positive statements about PPR, which could be categorised into the following four themes (with examples):

- *Nurse –patient relationship* - 'I think it will reduce the number of complaints', 'I think that patients won't feel neglected'
- *Identifying patient needs* – 'I think that it will help us to recognise patient deterioration', 'I think it will highlight unknown patient problems so that we intervene to help'
- *Nursing workload* – 'I think that it will help staff to plan their work', 'I think that it will reduce the number of call bells'
- *Miscellaneous* – five statements including 'I think that if patients are saying things we must listen'

Staff could therefore see the potential benefits of introducing PPR for themselves and for the patients. It is interesting that they perceived that call bell usage would reduce, even though the observational audits had indicated that patient usage was not high.

5.2.2 Staff Concerns about PPR

Staff had 17 Concerns about PPR, which were categorised into four themes:

- *Time/staffing levels* – eight statements including ‘I am concerned that there may not be enough staff to do it all the time’, ‘I am not sure whether I will have time to do it’
- *Staff consistency* – three statements including ‘I am concerned that not all staff will do it’
- *Patient issues* – four statements including ‘I am concerned that patients might misuse the system, that their expectations might be raised unrealistically’
- *Miscellaneous* – two statements – ‘I am concerned that the expectations are very high, are we ever going to meet them’ and ‘I am concerned that if we don’t improve this could lead to ward closure’

Time and staffing levels appeared to be particular concerns from the staff reflection sessions.

5.2.3 Staff questions about PPR

Staff had 12 questions about PPR, seven of which related to how it would be organised in practice, including ‘How will it fit in with the ward routine?’ and ‘What will the role of the trained nurses and Health Care Support Workers be in PPR?’ The remaining five questions were related to how PPR would work on nights, how it would be documented and would PPR help to get the wards more staff and equipment.

The reflection sessions provided some evidence that staff could see the benefits of PPR but also had concerns about how it might be implemented, in particular whether they would have sufficient time and staff to do so. The staff education sessions were a vehicle with which some of these issues could be addressed.

5.3 Education Phase findings - staff education sessions

The staff education sessions provided the opportunity for staff to consider the practical application of PPR and for any Concerns and Issues to be addressed. The videos were well received as they provided real-life examples of how PPR could work in practice. The sessions also provided the opportunity to finalise the ‘Script’, the list of questions staff would ask patients/visitors during PPR, and the record sheet to be kept at the patient bedside (Appendix 4 p34). Discussion took place on issues such as the need to combine rounding with other activities, for example when a nurse was undertaking a drug round s/he was already asking about pain and providing a drink so that drugs could be taken; the other PPR questions could be asked at the same time and any interventions carried out by the nurse or by another member of staff. In this way it was stressed that PPR was not necessarily an

additional task but could be incorporated into current routines. During the education sessions it was also made clear that both registered and unregistered nursing staff could, and should, undertake rounding as well as student nurses. PPR was designed to be a team activity and staff had the opportunity to discuss how this might work in practice.

5.4 Implementation Phase findings

Implementation began in the third week of February 2010, immediately following the education sessions. Each member of staff had a copy of the 'Script' and each patient's nursing notes had a copy of the record sheet for recording that PPR had taken place.

5.4.1 Staff reflection sessions

Staff reflection sessions were held in March 2010 to provide the opportunity for staff to discuss implementation.

Staff had 24 Claims about PPR, 22 Concerns and eight Issues. The Claims centred around the appropriateness of 2 hourly rounding (as opposed to 1 hourly), the impression that it reduced call bell usage, that patients felt more cared for and that the 'Nurse of the Month' was a good staff motivator. The Concerns were similar to those in the Exploratory Stage, that PPR was difficult when staffing levels were low due to sickness/ when the ward was busy and that some staff were not carrying it out.

Two issues raised were the documentation of PPR and whether PPR was necessary for all patients. At the beginning of the Implementation Phase staff ticked to indicate they had asked patients the PPR questions (appendix 3, p33) and if they had performed an intervention, such as giving pain relief, they would document this on the PPR sheet. However staff felt that this was duplicating what was written in the documentation and therefore the sheet was changed to incorporate a section for ticking that an intervention had been carried out, with the details being written in the nursing documentation – appendix 4 is the final version (p34).

Discussion took place about whether all patients should be included in PPR as some staff felt that more 'able' patients or those about to be discharged would not benefit from it. It was agreed that all patients would be included as the patient data in the Exploratory Phase had indicated that some patients had needs but were wary of expressing them because they felt that the nurses appeared busy. By including all patients each would receive equal attention.

5.4.2 Patient/relative audits

The results of the daily audit of four patients' experience can be seen in Tables 3 and 4:

Table 3: Sage Ward patient audit results

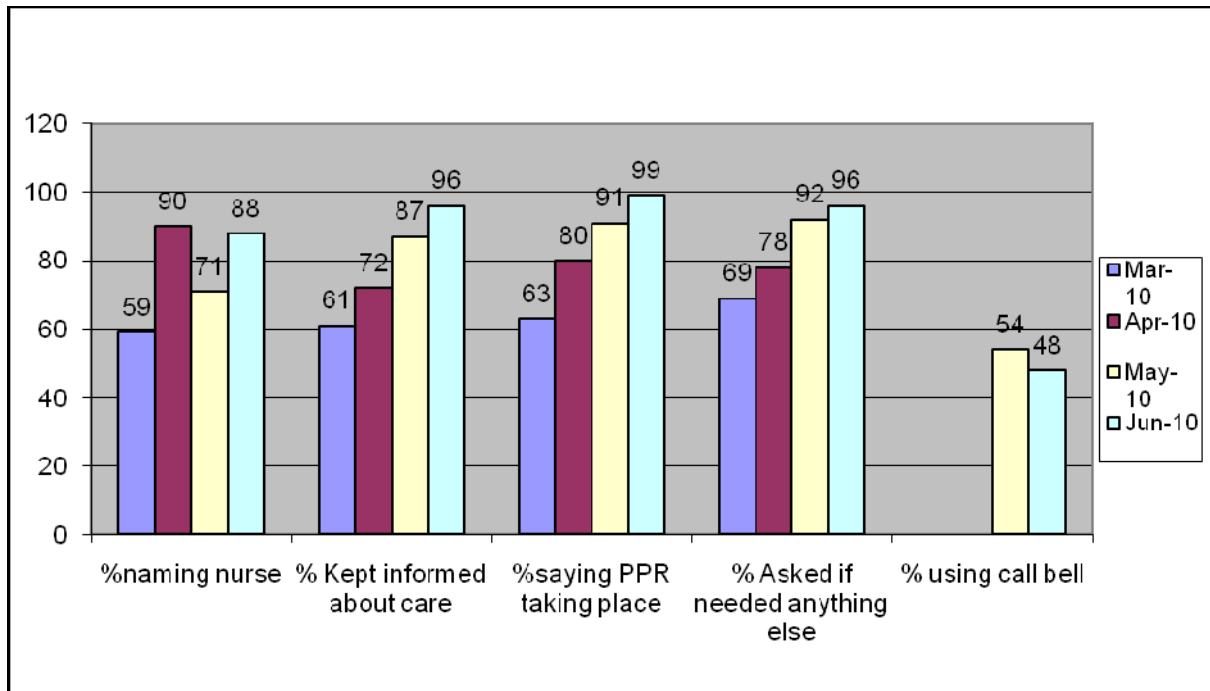
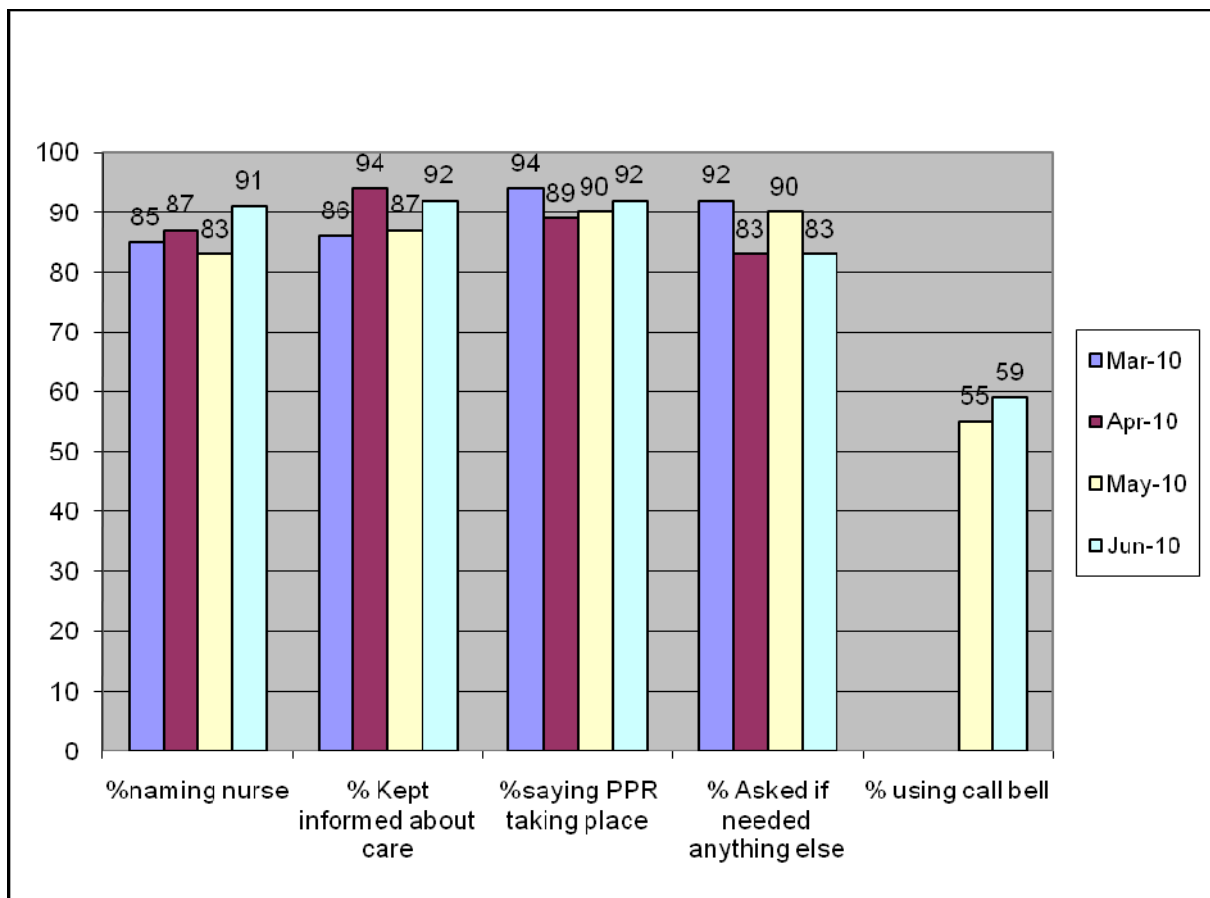


Table 4: Sycamore patient audit results



The results indicated that PPR was having an impact. The baseline patient questionnaire results had indicated that less than 20% of patients on Sage Ward and less than 50% of patients on Sycamore Ward believed that nursing staff always introduced themselves. The daily audits during PPR implementation suggest that nurses were introducing themselves more regularly, as indicated by the percentage of patients who knew the name of the nurse caring for them.

Proactive rounding was also more prevalent with both wards scoring over 90% by the end of the Implementation Phase compared with less than 40% in the baseline patient questionnaire audit. Nursing staff also appeared to be integrating PPR with activities such as undertaking observations, as indicated by the percentage of patients being asked if they needed anything else when staff were attending to them. The patient interviews in the Exploratory Phase had indicated that this was a patient concern, and this was now being addressed. Patients were asked from May 2010 if they had used the call bell, to give an indication of whether usage was declining. Results suggest that the call bells were still being used, which is not surprising as patients were being advised to ring if they had any needs between rounds.

The results for Sycamore Ward were consistently high from the beginning of implementation and this may reflect the Ward Manager’s early enthusiasm for and prior knowledge of PPR. Sage Ward began more slowly but by the end of the pilot was achieving comparable results to Sycamore Ward. On both wards the results of the daily audits were fed back to staff on duty, which allowed positive reinforcement for staff who were successfully carrying out PPR and the opportunity to discuss any issues with staff who did not appear to be as successful in incorporating it into their workload.

The results of the daily audit of four visitors are shown in Tables 5 and 6:

Table 5: Sage relative/carers audit results

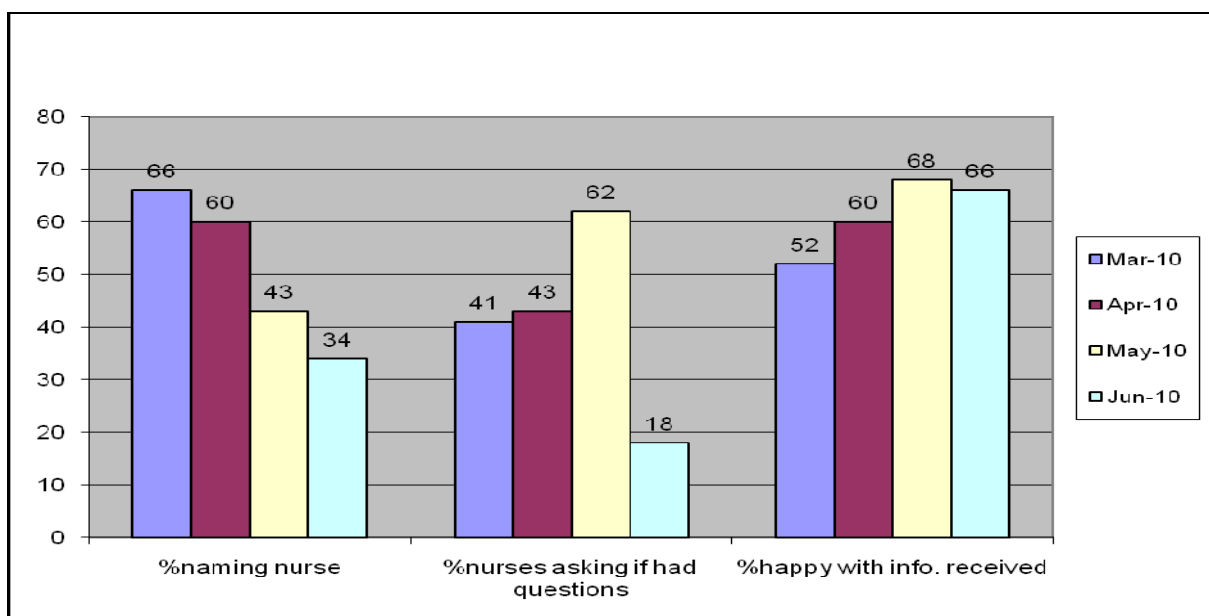
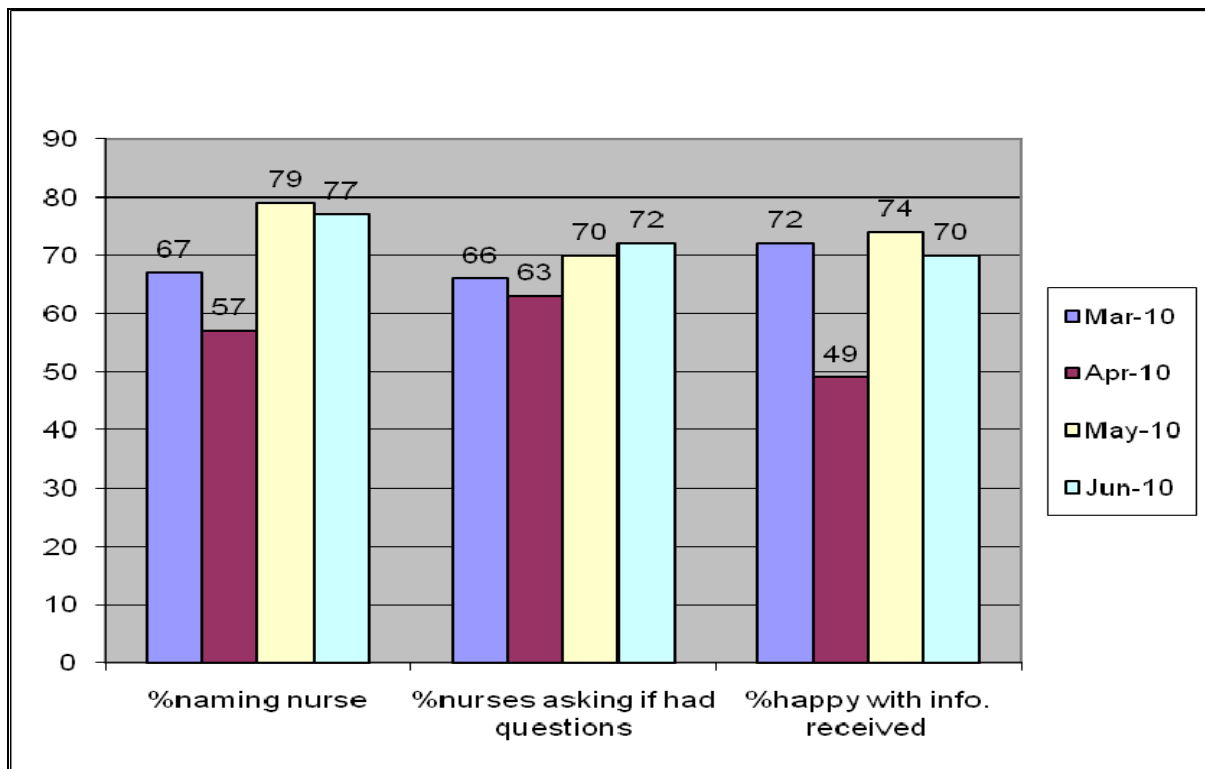


Table 6: Sycamore relative/carer audit results



The results suggest that the project was less successful in implementing rounding of relatives and carers, particularly on Sage Ward where the results deteriorated over the pilot phase. There were two possible reasons for the relatively low figures. The first was that relatives/carers were asked the audit questions in the mid/late afternoon when nursing staff may not have had the opportunity to introduce themselves and ascertain whether there were any information needs. Discussions were held with the Voluntary Services Manager to identify and train volunteers to undertake the audits in the evenings, but this had not been finalised by the end of the project.

The second reason why the figures may have been lower could be that nurses were reluctant to approach relatives/carers as they were afraid that they may not know the answers to questions raised. This is a tentative explanation, although some staff did mention this in the reflection sessions (section 5.5.3 p26), and further studies are needed to examine this.

Whilst the figures were lower compared with the results for patient rounding, they compare favourably with the baseline questionnaire results where less than 30% of patients indicated that nurses proactively discussed care with relatives/carers. Two thirds of relatives/carers surveyed during the Implementation Phase were satisfied with the information received but there was a need to increase this and develop staff to be more proactive in offering this information.

Data from the Implementation Phase demonstrated that staff were engaged with PPR and able to suggest changes in its implementation such as the documentation of rounds. The daily patient and relative/carer audit results indicated improvements in staff responsiveness to patients and visitors, one of the key aims of the projects. Issues related to relative/carer rounding had not been fully resolved, both staff proactiveness and the mechanics of undertaking meaningful audit.

5.5 Evaluation Phase findings

5.5.1 Patient questionnaires

The questionnaires returned by patients who had been in-patients during the Implementation Phase demonstrated that there had been some shift on both wards in patient perception of nursing attitude and proactiveness when compared with the baseline data.

Table 7: Comparison of pre and post implementation patient questionnaire results – Sage Ward

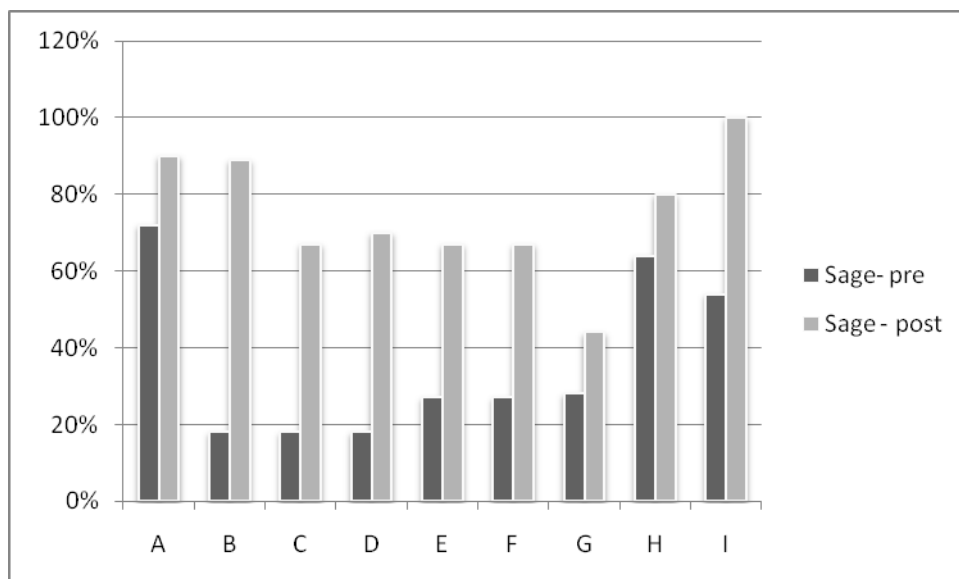
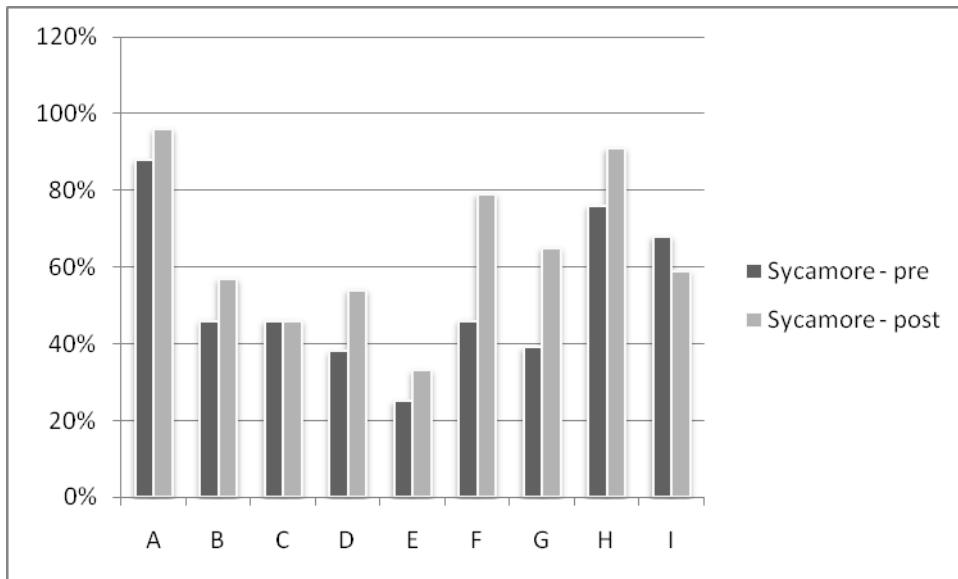


Table 8: Comparison of pre and post implementation patient questionnaire results - Sycamore Ward



Key: For each response A-G the percentage shown is those patients who felt that nursing staff always:

A	Introduced themselves and explained how call bell worked on patient admission
B	Introduced themselves in the morning
C	Introduced themselves in afternoon
D	Proactively asked patients at regular intervals if had any care needs
E	Proactively discussed care with relatives/carers
F	Introduced themselves at night
G	Proactively rounded at night
H	% of patients always happy with attitude of staff caring for them
I	% of patients who always felt call bell answered within reasonable time period.

The results should be viewed with caution. There were only 10 responses from Sage Ward and results are therefore influenced by responses of one or two patients. In only one category – acceptable time limit for answering of call bells – was there a reduction in the percentage of ‘Yes’ responses, for Sycamore Ward. There is no apparent reason for this. The questionnaire results demonstrated that call bells were

still used (23 out of the 24 patients on Sycamore Ward and all ten patients on Sage Ward indicated that they had used the call bell during their admission) but no data was collected on how frequently this was.

The comments on the questionnaires suggest that patients were satisfied with their care:

'Attitude of staff at all times was fantastic, explained everything, nurses very knowledgeable about my condition' (Sycamore Ward)

'Although they were so busy they still had time to help individuals' (Sage Ward)

This perceived 'busyness' of nurses was mentioned by patients on both wards, reinforcing the decision agreed with the nursing staff that rounding encompassed all patients so that those who did not want to interrupt nurses still had their needs addressed.

There were still issues with the attitude of some staff:

'Staff sometimes very abrupt to the extent of being rude' (Sycamore Ward)

'Most of the staff were very caring but there are a few who do need to improve their attitude to patients' (Sage Ward)

The Project Group acknowledged that staff attitudes would not be altered solely through patient rounding but may also require additional support, education and actions through managerial avenues.

The results were not as positive as those from the daily audits of patients during the Implementation Phase. This could be for several reasons. Patients may have been less likely to be critical whilst still an in-patient which may explain the more favourable audit results. However patients completing the questionnaire may have had less accurate recall about inpatient events due to the passage of time. The patient/carer inpatient audits consisted of a much bigger sample size, which may mean that the results are more indicative of the wider patient experience. Both the questionnaire and the audit results indicate an improvement in the responsiveness and attitude of staff, although this is less marked with the questionnaire results.

5.5.2 Patient interviews

The ten patient interviews revealed a mixed picture on both wards. Patients generally felt that the nursing staff were very busy and this impacted on the time they could spend proactively attending to patients. Not all nurses introduced themselves. One patient who had also been on Sage Ward the previous year noted that the nurses were 'asking more this time compared to last year'. However others felt that the nurses were not going round two hourly, and believed this was because they were too busy. The majority of the interviewees were happy with the attitude of the

nursing staff with one characterising them as 'polite and respectful'. One respondent felt that some nurse did not look happy in their work. Night staff were generally reported as being less likely to ask patients if they needed anything and few patients reported that nurses actively asked relatives if they had any information needs.

The patient interview results mirror those of the questionnaires in that whilst there appeared to be an improvement in the patient experience this was not consistent.

5.5.3 Staff reflection sessions

The seven reflection sessions held at the end of the Implementation Phase provided some evidence about the views of 30 staff about PPR.

The experience of implementing PPR had been positive in that it improved relationships with patients, who felt more at ease to communicate. The staff also believed it helped with other aspects of care such as skin integrity and pain monitoring. There was some perception that it had reduced the numbers of buzzers by pre-empting patient needs such as changing urine bottles, getting drinks and providing analgesia. Staff believed that they knew the patients better and that this led to better teamwork because they could hand more information over to the next shift. No-one believed that one hourly rounding would be possible due to time constraints and it was felt that two hourly was sufficient to meet patient needs.

There were some issues raised about the feasibility of PPR during what were perceived as busy times on the ward. Some staff felt they were visible in the bays even if they couldn't undertake rounding two hourly, although they could not confirm that it was also the patients' perception that the staff were available. Some agency staff were reluctant to undertake rounding, though the Sage/Sycamore Ward staff indicated that agency nurses were informed about PPR verbally and showed the chart to complete at the beginning of the shift.

The issues around who should undertake rounding – the staff nurses and/or health care support workers – did not appear to have been formally resolved and the staff reported that usually it was not discussed formally at the beginning of the shift who would round with which patients. There was agreement however that both staff nurses and health care support workers could, and did, round.

Documentation of PPR was not seen as overly time consuming, especially with the addition of tick columns to indicate interventions had taken place rather than having to document details on the sheet. However there was frustration about the duplication of documentation with the concurrent use of pain, fluid and repositioning charts. Discussion indicated that staff still had some questions about documentation of PPR in practice, in particular if patients were attended to outside of the two hourly rounding and, who signed the chart (health care support worker and/or staff nurses). This suggests that additional reflection sessions during the Implementation Phase may have been helpful as a forum to address these practical concerns. Alternatively

other ways for staff to raise these questions may have been used, such as a question sheet on the notice board in the staff rooms.

In the Exploratory Phase some questions had been raised about how PPR would work with patients with confusion or cognitive deficits. The reflection sessions indicate that staff believed that PPR was still possible, with staff checking patient needs such as nutrition rather than asking them.

There were some issues with the daily auditing of patient views by senior orthopaedic nursing staff. The staff could see the benefits of the audits and they preferred that they were undertaken by senior staff as they felt that the ward staff would not have time to audit each other's practice. However there was some concern that patients did not always remember if staff had told them their names, and that some staff names were more difficult to remember. They believed that sometimes patients therefore did not give a true picture to those auditing the rounds. For this reason they believed that immediate feedback of the audit results to the staff was important, so that they had the opportunity to explain what care they had provided.

Some concerns were also voiced about visitor rounding and the auditing of it. Some staff felt that whilst it was good to proactively approach visitors – 'Before PPR we didn't really get to talk to the relatives' – they sometimes did not have sufficient time to talk to them and the visitors would ask questions that staff could not answer, such as about the operation. There were concerns that those auditing visitor PPR might not identify the visitors the staff had talked to, to ensure that accurate responses were given.

5.5.4 Staff interviews

The staff interviews provided twelve staff with the opportunity to reflect more deeply on PPR. As with the reflection sessions there was agreement that two hourly was sufficient even though this was sometimes difficult to achieve due to time pressures. For more independent patients it was suggested by one respondent that four hourly rounding might be sufficient. The staff felt that PPR reduced patient complaints and six of the staff felt that they had had a good experience of undertaking PPR.

The staff felt that patients benefitted from PPR as some didn't want to bother nurses by ringing the call bell. Patients did not feel ignored and were still not afraid to call out between rounds. They also believed that pain was better controlled and pressure sore incidence reduced

Staff could see the benefits of PPR on their own work, particularly the increased ability to order their workload. Eight of the staff mentioned that they felt that PPR had become part of the ward routine, that it was becoming ingrained in practice. The documentation was seen as straightforward, though some viewed it as additional work and believed that it was not always completed. The staff nurses felt that the health care support workers were not as committed to PPR as the staff nurses.

Staff also spoke about the project itself. They were generally positive about the process in particular the education sessions and staff discussions prior to implementation. They were also positive about the reflection sessions during the Implementation Phase. The auditing process was generally seen favourably, as an opportunity to receive feedback from patients and from the senior orthopaedic nursing staff.

5.6 Conclusion

The project aimed to introduce two hourly PPR on the Orthopaedic Unit at Whipps Cross University Hospital NHS Trust in order to improve nursing staff proactiveness with regards to anticipating patients' care needs.

PPR was introduced following a five month Exploratory and Education Phase. This allowed exploration of the current situation from a patient and staff perspective and the education of staff on the patient experience and how PPR might improve this.

The evidence suggests that PPR was successfully introduced to some extent with benefits for both patients and staff. Pre and post implementation data indicated that staff were more proactively approaching patients, introducing themselves and asking whether patients had any care needs. This was occurring not only through specific rounds but also because staff were checking patients' needs when attending to them for other reasons such as the recording of vital signs observations. The evidence suggests that consistency in PPR was not achieved and it appeared that some staff were not always carrying it out. More work is needed on achieving consistent relative/carer rounding. This should take place in the context of the Trust-wide 'Patient Experience Revolution' which continues to be on-going.

5.7 Recommendations

A number of recommendations can be made as a result of the project:

1. Patient rounding should only be introduced after a preparation period which involves auditing of the current situation and education of staff about the process. Consideration should be made of the aims of the implementation, which will inform the auditing necessary. Aims may focus on staff's relationship with patients or on aspects of care such as pressure ulcer incidence.
2. The introduction of Patient Rounding should be considered as one aspect of improving the patient experience and the learning from it should be integrated into wider initiatives, such as the Trust's Patient Experience Revolution.'
3. Staff need the opportunity to reflect during the implementation of patient rounding.
4. For the practicalities of rounding:

- a. All patients should be included as staff decisions about those who do not 'need' rounding may mean that patients who do not want to 'bother' busy staff may still feel neglected.
 - b. Rounding should follow a 'script' as simply asking patients if they want anything may lead to patients not verbalising needs, as opposed to specific questions which patients may find easier to answer.
 - c. Rounding should be built into current nursing activities; for example when a nurse is recording a patient's blood pressure. In this way rounding is not an additional activity.
 - d. Documentation of rounding should be as simple as possible and minimise the duplication of documentation.
 - e. Rounding can be undertaken by staff nurses or health care support workers; this would work better if staff discussed in advance who would undertake rounding during a shift.
 - f. Visitor rounding should be considered but appears to require additional staff education/reflection and the issue of auditing its use in practice needs consideration.
 - g. Rounding at night appears to be more problematic than during the daytime, possibly due to lower staffing numbers or staff perceptions of 'work' at night.
5. Ongoing auditing of rounding should be considered as it provides feedback to staff; however there are implications in terms of resources to carry out and record the audits. Weekly or monthly audits may be more realistic.

References

- Castledine, G. (2002) Patient comfort rounds: a new initiative in nursing. *British Journal of Nursing*. Vol. 11. No. 6. p 407.
- Castledine, G., Grainger, M., Close, A. (2005) Clinical nursing rounds part 3: patient comfort rounds. *British Journal of Nursing*. Vol. 14. No. 17. pp 928-930.
- Garratt, E. (2009) *The key findings for the 2008 inpatient survey*. Oxford: The Picker Institute Europe.
- Guba, E.G. and Lincoln, Y.S. (1989) *Fourth Generation Evaluation*. Newbury Park, California: Sage Publications.
- Leighty, J. (2006) You called? Hourly rounding cuts call lights. <http://www.studergroup.com/dotCMS/knowledgeAssetDetail?inode=323256> (last accessed 14th November 2010).
- Meade, C.M., Bursell, L.K. (2006) Effects of Nursing Rounds on patients' call light use, satisfaction and safety. *American Journal of Nursing*. Vol. 106. No. 9. pp 58-70.
- Tea, C., Ellison, M., Feghali, F. (2008) Proactive Patient Rounding to increase customer service and satisfaction on an Orthopaedic Unit. *Orthopaedic Nursing*. Vol. 27. No. 4. pp 233-240.

Appendix 1: PPR patient audit tool

Date and time:

Ward:

<i>Please tick for 'Yes' and cross for 'No' as appropriate</i>	Patient 1 (Bay A)	Patient 2 (Bay B)	Patient 3 (Bay C)	Patient 4 (Bay D)
1. Patient correctly identifies name of nurse (and HCSW) caring for patient that morning (or afternoon)				
2. Patient states that they have been kept informed by the nurse caring for them that morning (or afternoon) about the care and treatment planned for them.				
3. Patient states that nurse (or HCSW) came round at least every 2 hours during the morning (or afternoon) to ask if they needed anything (PRONE questions)				
4. Patient states that when nurse (or HCSW) attended to them (giving a bedpan, performing observations) he/she always asked if there is anything else the patient wants/needs (using PRONE questions)				
5. Did the patient need to use the call bell today?				
6. Are there any individual nurses/HCSWs the patient feels has been particularly helpful when caring for them during their stay? (FULL NAME OF NURSE)				
<i>Name of person carrying out audit</i>				

Appendix 2: PPR relative/carer audit tool

Date and time:

Ward:

<i>Please tick for 'Yes' and cross for 'No' as appropriate</i>	Patient 1 (Bay A)	Patient 2 (Bay B)	Patient 3 (Bay C)	Patient 4 (Bay D)
1. Relative correctly identifies name of nurse caring for patient that afternoon				
2. Relative states that the nurse asked them if they had any questions about their relatives care.				
3. Relative states that they were happy with the information they received about their relatives care and condition				
<i>Name of person carrying out audit</i>				

Appendix 3: PPR Script

PROACTIVE PATIENT ROUNDING

A. Beginning of shift

1. At handover – nurse handing over introduces the staff nurse and health care support worker who will be caring for patient during shift.
2. Staff nurse or health care support worker lets patient know that they will be back after handover to discuss care for shift
3. After handover – nurse or healthcare support worker go back and agree plan plus first PPR of shift.

B. Two hourly proactive patient rounding – daytime

Introduce yourself – Hello, my name is

ASK:

1. How are you? (at the beginning of the day shift/night shift start by asking 'How was your day (or night)')
2. Do you have any pain?
3. Can I pour some water for you?
4. Do you need to go to the toilet (unless independent)
5. Let me help you change position (unless independent)

CHECK:

Is everything in reach? (call bell, water, snacks etc)
Is environment tidy?

BEFORE LEAVING ASK:

Is there anything else you want whilst I'm here? Someone will come round again in a few hours but you can use your call bell if you need anything before this.

C. Two hourly proactive patient rounding – night shift

Check all patients two hourly. For patients who are awake, who need observations carried out or who need pressure area care – proactive ward rounding as in daytime.

D. Proactive patient rounding – visitors

CHECK WITH PATIENTS – do they agree you can talk with relatives, and which relative would they like you to discuss their care with.

ASK: Have you got any questions about your relative's care?

(Use the following prompts as appropriate – patient's general condition, expected date of discharge, discharge support arrangements, concerns about care).

Appendix 4: PPR record sheet for nursing notes

Ward:

Patient Name/Hosp. No.

Date:

Time	Please tick that you have asked the patient					Please tick if you have performed an intervention					Comments	Printed Name of Nurse/ HCSW / Student nurse
	P	R	O	N	E	P	R	O	N	E		
08.00												
10.00												
12.00												
14.00												
16.00												
18.00												
20.00												
22.00												
24.00												
02.00												
04.00												
06.00												

P = Pain control, R = Repositioning, O = Other, N = Nutrition/fluids, E = Elimination