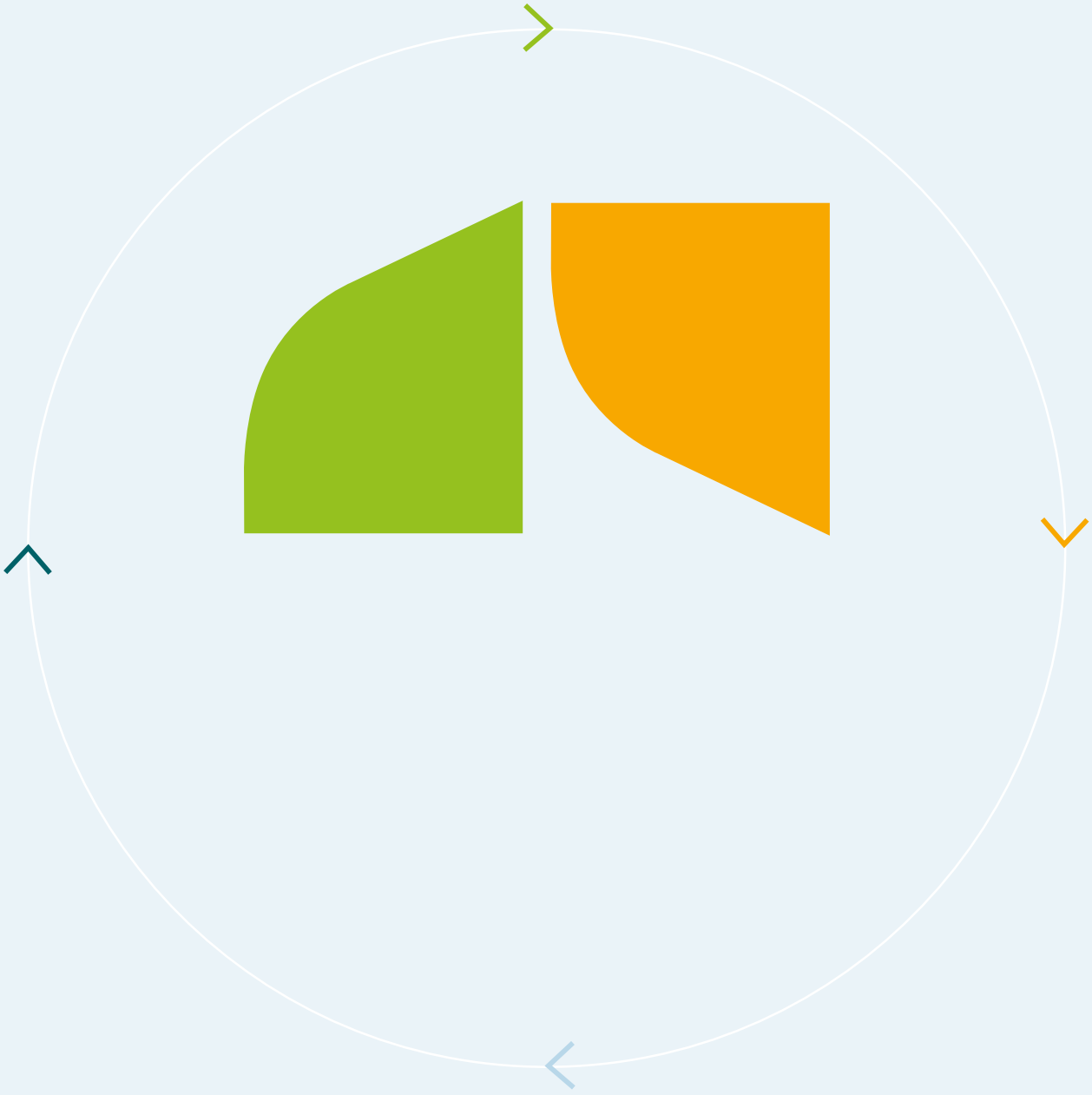


Modern ward rounds

Good practice for multidisciplinary inpatient review

Contents

Foreword

Dame Donna Kinnair
Chief executive and general secretary,
Royal College of Nursing

It has been extremely satisfying to witness the huge amount of cross-organisational and cross-disciplinary collaboration that has gone into creating this report.

That work re ects, of course, the approach which must be taken in order to carry out effective ward rounds: it takes a multidisciplinary team, where the experience and expertise of individuals – no matter which branch of healthcare they represent – to contribute to the best outcome for each patient.

The patients, their families and carers are a crucial part of the ward rounds process too – they have a unique insight into the background, history and general health and wellbeing of the patient themselves. And that's why I'm particularly pleased to see patients, families and carers at the heart of this report.

Ward rounds are an essential component of clinical practice. Healthcare professionals need a framework not only to achieve the best possible outcomes for their patients, but also as a tool to help them deal with the increasing demands and pressures placed upon their resources. Patients, their families and carers see ward rounds as a chance for clarity, reassurance and advice from all those charged with their care. As one RCP Patient and Carer Network member put it: 'Explain and agree the plan for my care – and let me know how it's going.'

Effective multidisciplinary teams are wholly dependent on there being the right number of professionals, with the right skills, in the right place at the right time. It is paramount that governments invest in our healthcare system to ensure our patients get the safest and best care they need and deserve.

I welcome this report, and the RCN commits to doing everything it can to embed the practices it sets out as widely as possible.

There are many examples of good, exemplary and innovative practice related to ward rounds in the UK. These show what is possible helping to achieve the best outcomes for patients.

The delivery of high quality and effective ward rounds are challenged by a number of

The shift handover should gather information on the patient's condition, which then feeds into multidisciplinary team planning by all members of the team prior to the ward round in a board round or huddle. This will provide an overview of all patients on the ward, prioritises those who require early review, and identi es actions for team members to take.

The board round should particularly highlight delays in care that can be addressed, as well as discharge planning. Patients requiring speci c infection prevention and control measures should be highlighted. Information that will affect decision-making should be collated before the round's bedside review. This may affect the planned timing of ward activities, including the rounds.

The ward round process and team

The ward round should review the most unwell patients rst, followed by those who could be discharged that day, before completing reviews of the remaining patients. The ward round lead should clarify team members' roles and set the tone for participation and learning for each round. It is particularly important to begin the round at the agreed time, in order to ensure ef ciency and maximise teamworking. There should be mechanisms in place that allow all professional staff to input into ward round discussions and decisions. The continual presence on the ward round by all multidisciplinary team members is not necessary, but input and involvement from the staff who know the patient best – usually the nurse directly caring for the patient – is essential. For patients receiving rehabilitation, this may be a therapist. Without this involvement, it is unlikely that the best clinical decisions will be made. Pharmacy input is also essential for most patients and, where resources allow, there are demonstrable bene ts to the ward pharmacist being part of the ward round.

Ward round team members should be introduced to patients individually. Communication with the patient should take place at eye level, in as private an environment as possible, and this is particularly important at the start and end of the assessment.

The ward round's review and decision-making processes collate all relevant information for discussion on the patient's condition and progress. Providing and assimilating this information should be delegated to clearly de ned team members. Dialogue scripts for the leader and professional members provide structure and have demonstrated bene t. Clinical reasoning and decision-making should be documented.

The team should use structured documentation that incorporates safety checklists and key

Ward rounds should not last longer than 120–150 minutes, in order to prevent cognitive fatigue. If a longer round is necessary, then adequate breaks should be planned. Team roles should be divided to ensure that tasks, such as ordering investigations or completing transfer documents, can be done during the ward round and are not delayed until the end. This should be planned whenever possible.

The ward round team lead should update the multidisciplinary team after the ward round to ensure that plans are agreed and actioned within agreed time frames. It is also important to agree who will update patients on the progress of the plans during the day. A further check on progress of plans should occur in the late afternoon. Friday rounds must plan for the weekend and may need to be extended.

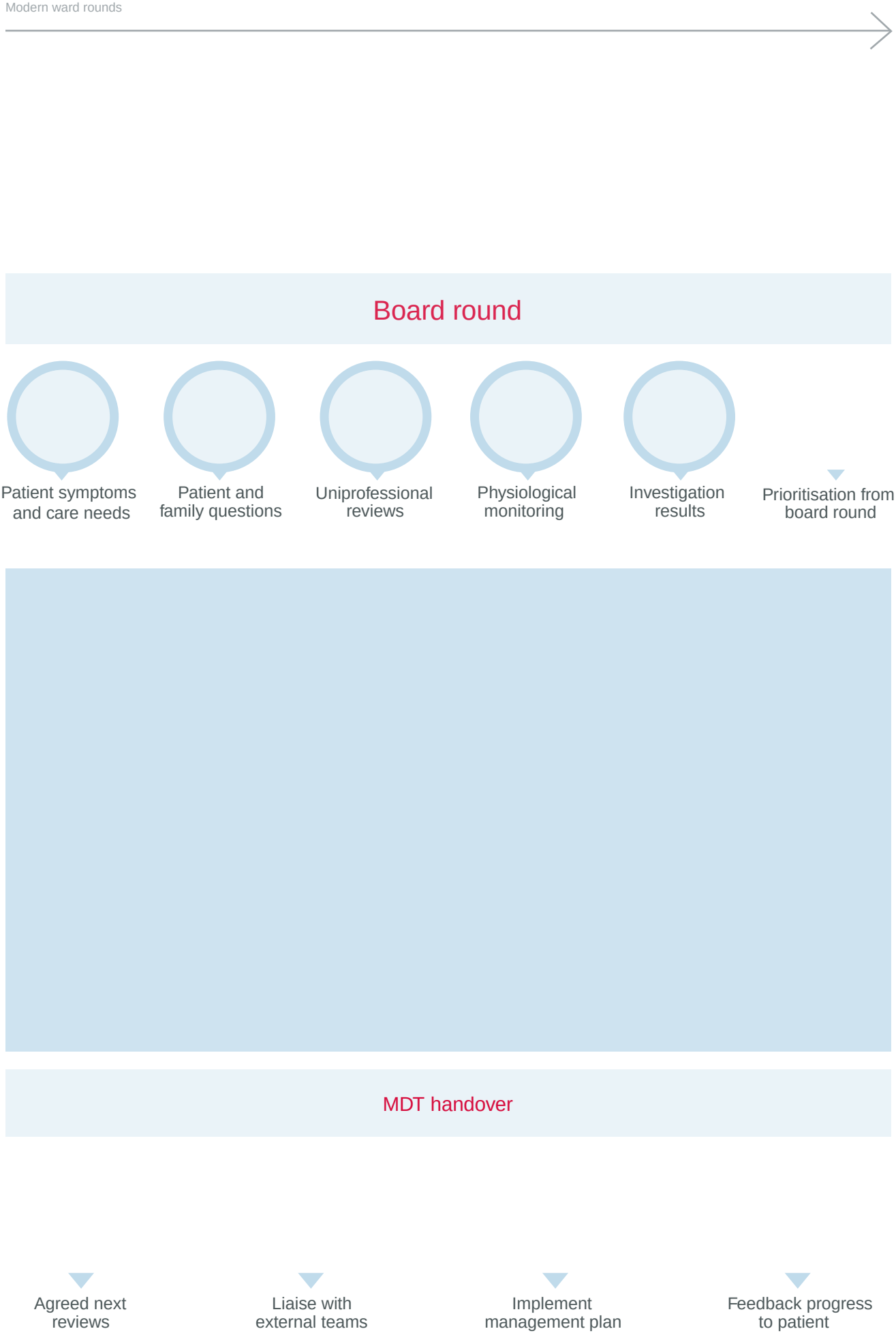
Education is an important part of ward rounds and should be considered for all participating professionals. Key learning points, and actions for further learning, should be summarised at the end of the round. The training of staff in ward round practice and functions should be part of professional training, including simulation.

Electronic patient records (EPRs) bring together patient information and help with structured documentation and decision support. However, they can distract the team's focus from people to screens. Ensuring direct communication at eye level with patients, and eye contact amongst team members, reduces this. A nominated scribe will also help. Mobile devices can help share information between staff and patients. Training in their use, and hardware availability and maintenance, must be planned.

Improving ward rounds

Most ward rounds in UK hospitals require considerable improvement, and research and quality improvement is necessary to inform effective practice. Some elements of best practice may be more dif cult to implement until current persistent staf ng de ciencies have been addressed. However this should not prevent teams and hospitals developing improvement plans for ward rounds using the best practice guidance in this report. Ward leads should meet regularly to review quality measures related to ward rounds, and adapt approaches where needed, using both this guidance and emergent new evidence.

The continual presence on the ward round by all multidisciplinary team members is not necessary, but input and involvement from the staff who know the patient best – usually the nurse directly caring for the patient – is essential.


Board round
Patient symptoms and care needs
Patient and family questions
Uniprofessional reviews
Physiological monitoring
Investigation results
Prioritisation from board round
MDT handover
Agreed next reviews
Liaise with external teams
Implement management plan
Feedback progress to patient

Ward round fundamentals

Key principles	Summary recommendations
Well led	Protect and dedicate time for consultant* led delivery. Create an environment for active participation of all team members in care planning. Agree roles for multidisciplinary team members and their input to ward rounds.
Structured	Schedule a pre-ward round board round, to be attended by the multidisciplinary team. Review patients in priority order on ward rounds. Use standardised documentation including safety checklists.
Effective teams	Schedule ward rounds to prevent con icts with other ward activities. Structure and plan shift handovers to inform board and ward rounds. Debrief and handover multidisciplinary plans after the ward round.
Patient involvement	Actively involve patients in ward rounds, with family and carers as required or requested. Agree communication with the patient on progress of their plan following the ward round. Plan complex and dif cult conversations or assessments outside of the ward round.
Education, learning and improvement	Use each ward round as an opportunity for learning. Continue to develop the skills required for all staff to actively participate in ward rounds. Assess ward round quality against best practice.

* In some settings this may be senior nurses or therapists (see report case studies)

This report provides updated best practice guidance for multidisciplinary teams and clinical and operational leaders caring for, or supporting patients in wards. The guidance can also be used by patients, their families and carers to recognise what good care looks like, and what patients should expect from ward rounds. It outlines key elements of patient- and family-centred multidisciplinary team review and care planning, and how this can be facilitated through the focus that ward rounds provide for staff and patients.

When we refer to patients, we also include family members, carers and signi cant people the patient wishes to be involved.

Ward rounds in medicine: principles for best practice was published in 2012 by the Royal College of Physicians (RCP) and Royal College of Nursing (RCN). While widely referenced, there is continued frustration among clinicians that multidisciplinary care planning and communication for patients in hospital is still far from optimal. This creates inef ciencies, increased risk, and care plans that are not appropriately agreed with patients, carers and families.

Ward rounds are a fundamental function of clinical practice. Acute care capacity pressures in hospitals across the UK – and demand and capacity pressures across the wider health and

While some of the recommendations may appear basic, our evidence† suggests that a consistent approach as described in this report is uncommon. Although it is rare for all recommendations to be fulfilled, the report draws from good practice that is happening in the UK or internationally. Current constraints make it challenging to deliver care as described, but all teams will find areas where they can improve practice. The recommendations are not proscriptive, as local context will determine how these principles can be applied and adapted to specific patient groups and settings.

The effectiveness of ward rounds should be monitored, their benefits maximised, and the processes, behaviours and skills required should be continuously improved.

Teams should self-assess their current practices against this guidance and identify priorities for improvement, and hospitals should set up improvement programmes to support these changes. We will be running implementation programmes to enable service changes by teams and hospitals.

What's important to patients: quotes from RCP Patient and Carer Network members

'It's important to see the clinical team focus on me, (or my family's)care and progress.'

'I want to be involved in discussions and decisions.'

'Give me confidence that you are an effective and efficient team.'

'Explain and agree the plan for my care – and let me know how it's going.'

There is continued frustration among clinicians that multidisciplinary care planning and communication for patients in hospital is still far from optimal.

In our surveys, nurses were sometimes perceived by medical staff to be too busy with nursing tasks for increasingly complex patients, however nurses expressed frustration at not being always involved in wards rounds.

'The junior staffing rotas are so fragmented that attendance on sequential ward rounds is poor and their learning opportunities reduced.'

† Evidence was gathered through member surveys, and through the committees, networks and forums of the participating professional and patient groups. Many examples of good practice were submitted.

Background and context

The ward round was first noted in the 17th century, when the visiting physician would ‘round’ patients on a ward, or in a hospital, in the same way as they would ‘round’ patients in their homes. This practice has subsequently evolved into a multidisciplinary approach for communication, monitoring progress and planning.

Despite the necessity for organised, regular, clinical reviews of hospital inpatients, de ned quality indicators and evidence to guide best practice for ward rounds was lacking until our 2012 guidance. There remains considerable variability in the organisation, ef ciency, quality, delivery and patient experience of ward rounds. A summary of results from our surveys is shown in Appendix 1.

The purpose of ward rounds

Ward rounds are the focus of multidisciplinary care planning and review, and for each individual patient on a ward or unit under the care of a particular team. Traditionally, this occurred in a processional manner and encompassed all patients under one consultant’s care, but the emergence of allied activities that assist care planning mean this will not always be appropriate.

These activities must be planned and coordinated by the whole care team alongside other components of inpatient care.

The purpose of ward rounds is to ensure:

- clarity of diagnosis(es) and relevant problems
- prioritisation of problems and treatments, and use of resources, eg medication and investigations
- coordination of a management plan, including goal setting and discharge planning
- monitoring of the patient’s progress, including medical, functional, emotional and cognitive state
- management of clinical risk, eg venous thromboembolism (VTE) prophylaxis, severity of illness, drug interactions, level of care required
- clear documentation of clinical assessment, reasoning and plans
- communication with the patient and between staff
- opportunities for education and training.

There remains considerable variability in the organisation, efficiency, quality, delivery and patient experience of ward rounds.

The ward round reviews must be informed by patient, family/carer and multidisciplinary inputs. With the complexity of modern teams, it may not be possible to convene the whole multidisciplinary team at one location, eg the bedside, but the mechanism for each individual to offer their contributions and input must be planned for each ward and for each patient.

What patients should expect

Ward rounds present a focal point for sharing information between the patient and care team. Healthcare professionals must not underestimate the importance of the ward round to patients, relatives and carers. For patients this demonstrates the care team focusing on their condition and needs. Dedicating time by the bedside, or in another private location, to provide clear explanations about symptoms, diagnoses and disease severity, and to answer questions, can reduce a patient's fear and anxiety and can build con dence in the care that they receive. Healthcare professionals must take time to carefully listen to the patient and understand what is important to to them, and to answer questions and concerns.

The modern multidisciplinary team

Best practice: multidisciplinary teams

- Agree principles, standards, functions and structure for local ward teamworking.
- Clarify each team member's role.
- Include each tier of decision-makers as per the RCP's *Safe medical staffing*[3]
- Agree methods and times of communication.
- Keep membership of the ward's multidisciplinary team consistent wherever possible.
- Ensure opportunities for team education and development.
- Regularly review team performance.

Care in hospitals is delivered by multidisciplinary teams. The members and functions of these teams have evolved over recent years and differ between clinical environments. Individual clinical assessments by team members must be coordinated, as they all contribute to care planning and decision-making. Care delivered through an agreed team function and structure will ensure timely and well-planned care, and will enable effective ward rounds. The RCP has summarised many key aspects of how modern teams should function, develop and learn, and the evidence of the impact of effective teams.[8] Features of such teams include clear roles, good communication, common goals, a attened hierarchy, and team-based education and development. These are dependent on many factors including how well a workplace enshrines and values these themes.[8] Keeping consistent team members at the ward or unit level helps teams function well and should be planned across professional groups.

Ward team members will include consultants, doctors in training or non-training grades, advanced practitioners (nursing and AHP), nurses, physician associates, pharmacists, physiotherapists, occupational therapists, speech and language therapists, dieticians, social workers and healthcare students. Non-medical professionals commonly take advanced roles extending beyond what is seen as their traditional role, and may be part of the tiers described in *Safe medical staffing*. For example, nurse or therapy consultants may lead and coordinate clinical decision-making, and advanced nurse practitioner and advanced practice therapist roles may include many elements traditionally performed by doctors. Many professions also have assistants or technicians to perform key functions on wards and who might work across professions, eg therapy or pharmacy assistants/technicians. Some areas have also developed administrative assistants to support clinical roles.

Other ward staff also play a role in ward rounds. Nursing support workers are often the most closely involved with patients, and understand their needs and concerns. Clerical and administrative staff, such as ward clerks, offer support to the functionality of ward rounds. Additional roles to help the smooth running of hospitals, such as clinical ow facilitators, must be seen as part of the team and their role should be clearly de ned. Links to key clinical professionals outside the hospital, eg case managers, also need to be clearly de ned with agreed communication mechanisms.

Figure 1. One possible healthcare team. Taken from the RCP's ***Improving teams in healthcare***.

Three tiers of decision-making skills by clinical professionals are described in the RCP's *Safe medical staffing*.[3] This should be included in planning and coordinating the ward team.

Table 1: Tiers of clinicians

Tier 1: Competent clinical decision-makers	Clinicians who are capable of making an initial assessment of a patient.
Tier 2: Senior clinical decision-makers	The 'medical registrars' – clinicians who are capable of making a prompt clinical diagnosis and deciding the need for speci c investigations and treatment.
Tier 3: Expert clinical decision-makers	Clinicians who have overall responsibility for patient care.

▲ From the RCP's *Guidance on safe medical staffing*.

The expansion of modern teams has an impact on the patient and their perspective of ward rounds. The purpose, identity and make-up of the ward round team may be clear to hospital staff, but not necessarily to patients.

Stein*et al* have developed the concept of accountable care units and Structured Inderdisciplinary Bedside Rounds (SIBR) (See case study document).[10] This approach describes key patient care and assessment roles that are coordinated through ward 'team huddles' and interdisciplinary bedside reviews.

The process

B

The process

Scheduling ward rounds and considering allied activities

Schedule ward rounds, board round and associated activities to prevent con icts.

Include before, during and after ward round activities in the schedule.

Scheduling should maximise patient ow. Shift times may need to be adjusted to accommodate this.

The ward round lead should ensure the round adheres to the agreed schedule.

Ward rounds should not last more than 120–150 minutes, or have agreed breaks, to prevent cognitive fatigue.

Dialogue scripts can help to correctly pace ward rounds.

Agree mechanisms to prevent unnecessary interruptions.

Include the review of possible outliers or boarders

A dialogue script can be used to provide the opportunity for all multidisciplinary team members to

The common approach is to begin the day with nursing handovers. Teams should agree the elements of a structured handover that feed into ongoing care planning. This includes patient status, changes during the shift, and patients', relatives' and carers'concerns.

The multidisciplinary team should convene for a board round or huddle at the start of the shift. Board rounds provide an opportunity for multidisciplinary teams not only to prioritise bedside reviews, but also ensure discharge planning momentum and communication, and highlight delays and actions. These

Pre-ward round discussions with relatives or carers are particularly important for patients with learning disabilities or cognitive impairment, in order to establish changes in behavioural traits which otherwise might be attributed to their underlying condition. Additional support should be arranged for those patients with speci c needs, eg translation, communication dif culties, those experiencing confusion, and patients with mental health needs

Begin by assigning roles and setting expectation of learning.

Table 2. Ward round core roles

Each team member may perform a number of these roles.

Ward round lead	▸ Coordinates and takes responsibility for decision-making ▸ Sets the culture of collective input to decision-making ▸ Agrees roles of other team members ▸ Ensures the correct priorities and pace of the ward round ▸ Checks accuracy of documentation ▸ Facilitates and/or delivers multidisciplinary education
Summariser	▸ Summarises key elements of the input for decisions and the agreed decisions for documentation and communication
Note keeper	▸ Completes structured ward round documentation
Patient and family advocate	▸ Ensures input of patient, family and carer questions, goals and priorities ▸ Summarises the answers to the patient's questions and decision for the patient, ensuring their agreement ▸ Ensures follow-up communication around progress of plans to the patient
Safety checker	▸ Ensures completion of safety checklist
Staff member who knows the patient best – usually nurse directly caring for patient	▸ Updates the team on patient's current state, including relevant physiological observations and monitoring ▸ Updates the team on any changes in the patient's condition since the last review
Other multidisciplinary team members, eg doctor, physician associate, pharmacist, therapist etc	▸ Ensures medication review ▸ Ensures update on functional status in hospital and at home ▸ Manages emergent issues to prevent delays

Introduction

Preparation of information

Con rm patient identity

Introductions to patient

Explanation of process

Checking patient questions, concerns and symptoms

Document

Reviews completed

Clinical reasoning

Working diagnosis and problems

Assigned actions, including discharge preparations

Planned next review

Ward coordinators are key to effective care, and their time should be protected from other duties during peak activity times on the ward. The role of the ward coordinator and their interactions with ward rounds needs careful planning. If the staff member who knows the patient best contributes their input to the patient's care plan, a coordinator attending the ward round may not be the most effective use of their time. A ward coordinator is also likely to be interrupted, and it may be more ef cient to provide regular updates to the coordinator instead. It is also helpful to agree which team member will deal with emergent issues to prevent delay or interruptions.

Medication review is a key component of ward rounds. This will include:

- reviewing and completing medication reconciliation
- route of administration
- dosing, side effects and interactions
- clinical effectiveness
- identifying administration omissions (and reasons)
- optimisation and deprescribing
- update of prescription.

The seven steps to appropriate polypharmacy should be followed[20].

If it is necessary to conduct a physical examination of the patient, this should be done by the examining clinician with appropriate assistance, and other members of the team should be outside the room or curtained area to preserve the patient's dignity and privacy, unless team members are being taught (with the patient's consent).

Determining which tasks can wait until after the ward round, and which should occur immediately (as the ward round takes place) requires careful consideration. This will be partly determined by the number of team members in the round and should be clari ed by the lead. For example, tier 1 staff may take the lead on summarising and documenting information on alternate patients, and then complete tasks while the next patient is being reviewed. Another example would be to share patient summaries and plans with the ward coordinator after every few patients (and certainly after priority patients have been reviewed), so that elements of care can be progressed by the wider team while the ward round continues.

The team should identify opportunities for recognising patients who may be in their last year of life, and commence conversations around advance care planning, but the more detailed conversations should take place after or outside the ward round. Escalation plans and 'Do not attempt resuscitation' (DNAR) orders should be reviewed and documented and shared with patients as appropriate.

Documentation and clinical records

Best practice: documentation and clinical records

- Clear documentation of diagnosis, problems, assessments, goals, progress and plans is essential.
- Structured records help to organise documentation to act as prompts to ensure that no important component is missed.
- Checklists are helpful when incorporated into structured records and should be used for key safety risks.
- Information recorded at the ward round should make clear the thinking around the clinical decisions, and include clinical criteria for discharge.
- Records form the basis for clinical coding, clinical audit and for the production of the discharge summaries, and should be structured to aid this.
- Clearly documenting discussion with patients, families and colleagues is a high priority.
- A written summary for patients and relatives is encouraged.

Good record keeping underpins communication and aids clear thinking about the clinical situation. It is essential to clearly document diagnoses, problems, assessments, goals, progress and plans, including the relevant clinical reasoning. Ward rounds provide an opportunity to pull together the different strands of documentation from paper or electronic patient records (EPRs) into a summary of the patient's current state and plan. Structured documentation improves outcomes[19] and helps to organise documentation. It acts as a prompt to ensure that no important part is missed. Authorship of ward round entries must be clear and all entries should be overseen by the ward round lead. While a scribe may be used to document on behalf of the team, the ward round lead is accountable for what is written and its accuracy. The composition of the team constituting the ward round, and allocation of tasks following the round, should also be documented.

Evidence-based structured approaches

Communicating with patients, relatives and carers

Effective information sharing enhances self-management in hospital and following discharge.

On discharge:

- What will happen when I leave hospital; will I need further treatment/support?
- How will this be organised?
- Is there anything my family / friends / carers can do to help?

Involving the patient in decisions is fundamental practice, and the approach outlined in shared decision-making[21] including Ask me 3[12], should be used. When con rming the information and plan in communication with patients, the teachback[22] technique can be used to ensure understanding.

Protecting vulnerable patients

Inpatient populations include an increasing proportion of frail older patients, with estimates of the prevalence of dementia as high as 25% within this cohort.

Healthcare professionals should be aware that capacity is context speci c. Patients with cognitive impairment, mental health problems, dementia and learning disabilities should be supported to make decisions about their care, with dedicated time provided to communicate information to carers/advocates and relatives/parents. This is likely to be necessary before and after the ward round, to give adequate time. If a patient lacks capacity to make speci c decisions about his or her care, multidisciplinary team meetings and careful discussions with carers/advocates and relatives/parents should guide the team to make decisions in the patient's best interests.

Compiled from RCP Patient and Carer Network, Ask me 3[12] and ECIST best practice[21]

◊In the previous report, barriers to communication with patients were brie y acknowledged, and recommendations were made to support better communication. In updating this report, the RCP's Patient and Carer Network held a workshop on communication between healthcare professionals, patients and relatives/carers to draw out key issues relating to ward rounds and to make positive recommendations for change.

Board rounds or multidisciplinary team huddles conducted at the end of the ward round provide an opportunity for the team to summarise all issues relating to patient care, identify and prioritise tasks, con rm plans with the wider team, and assign responsibilities appropriately. Further white board meetings should be held later in the day to ensure progress is being made, and identify any challenges or delays. This is particularly important on a Friday, to ensure that handover plans are up to date. The team should remember to continually update boards that

Education and learning should take place across professions on the ward round.

Simulation of ward rounds should be used to train staff in important skills.

Learning points should be summarised at the end of ward rounds with opportunities for further learning.

Patients should be informed that teaching and learning are part of ward rounds and

Ward rounds present a major opportunity for education and training. The RCP's *Acute care toolkit 5: Teaching on the acute medical unit*[25] and *Never too busy to learn*[9] provide guidance and best practice. Creating a culture of learning during board rounds and ward rounds is a key role for both senior and junior staff of all professions. The board round (or brie ng) can serve to emphasise the expectation of learning, and identify key learning opportunities.

The following techniques can be used:[16]

C

The environment

The environment

Physical environment

The area around the ward round should be quiet to ensure clear, undisturbed thinking and communication.

Key equipment must be available and maintained.

Dignity, privacy and con dentiality

The ability to maintain patient con dentiality and dignity should be considered at all times, and

Structured records with quick links to the tasks required during clinical decision-making and care planning can increase ef ciency and reliability if linked to good role allocation. Integrated clinical decision support and safety checks are good, but alert fatigue and overly extensive checklists can be problematic. The ability to show trends in clinical data is an important function, and should be included.

Audit and information trails of requests and progress of investigations can reduce missed investigations. AKI alerts are a good example of where better availability of information has improved clinical care linked to good practice guidance[27].

Although EPRs promise to improve safety and ef ciency through advancing data connectivity, it is also important to consider how the use of technology during ward rounds reshapes working practices, particularly regarding communication, documentation, and the effect of mobile computers. For some team members, computer keyboard entry will take longer than written notes, increasing the length of time of a review. Newer technologies for handwriting or voice recognition may prove more useful. Some organisations have employed scribes as additional team members to increase ef ciency[28]. The common nding that ward rounds take longer with electronic information systems may be partly due to poor training in the use of software and hardware, and the level of interoperability between systems.

Although it is essential to ensure adequate

EPR providers have varying ways of allowing information to be copied or pulled through from one ward round to the next. Where this feature is used, it is important that the information is regularly and carefully reviewed, as outdated and potentially incorrect data can accumulate with potential risk to patient safety[60].

The use of mobile computers on ward rounds is common. Where multiple mobile computers are being used to access different elements of the electronic record (for example, the prescription chart, investigation results, the ward round note), it is harder to get an 'at-a-glance' idea of who is doing what. The principles of good communication practice on ward rounds, including pauses for verbal summaries and decision-making, should be employed. The ward round lead, when con rming team members roles, must specify who will use the electronic systems and when to focus on human interactions. Task planning and 'glide slopes' to ensure complex processes are followed are becoming more widely available.

Teams should use computers to share information with patients wherever possible, particularly if tablet devices or other bedside access is available. These can also be used to record patients' questions. The EPR may also facilitate summaries for patients of agreed diagnoses and plans.

It is vital to organise the team with consideration to how technology will be used. The use of electronic information systems and other hardware on ward rounds can have unintended consequences for personal interactions with patients. Those attending the ward round can become focused on screens and keyboards, rather than interacting with each other and the patient. The height of equipment can in uence human interactions, increasing the likelihood that the team will 'talk over' the patient, or not interact with each other. Electronic recording of plans and tasks shouldn't stop verbal communications.

Training of individuals and teams in ward rounds should include the integration of the use of digital systems.

Different inpatient settings and scenarios

Best practice: other settings

- Admission unit ward rounds include more detailed assessment of new patients on the round.
- 'Rolling ward rounds' are appropriate on admission units.
- Friday ward rounds should be led by the senior staff, take longer, and include clear, documented plans for the weekend.
- Weekend ward rounds target those who most need review, informed by board rounds.
- 'Outliers' should be minimised but should not be disadvantaged. Continuity of team and timing will help.
- Senior handover should occur if consultant responsibility rotates.
- Specialty rounds should involve the ward-based team.

Although the purpose and principles of good practice on ward rounds apply wherever rounds are undertaken in hospitals, it is important to recognise that ward rounds at different stages of a patient's admission to hospital may have different requirements.

For instance, a signi cant proportion of patients on an admission unit will be assessed by a consultant for the rst time during a ward round. Depending on the function of the unit, there will also be follow-up reviews. While a patient is at a more active stage of management, more information will need to be gathered in advance of the ward round, and examination of the patient may also be required during the ward round. The need to ensure privacy and dignity as information is assimilated, and during examination, remain pertinent. More time must also be allocated for communication and history checking in cases where patients are being more actively managed. It is possible that some of the multidisciplinary team will not have completed their review at this stage.

The RCP guidance on safe medical staf ng recommends, from the tasks required, that a consultant could safely review ten new patients over a 4.5-hour period on an acute medical admissions unit. (This includes time during and after the ward round, including follow up and communication.) Many assessment units employ the concept of the ‘rolling ward round’ or reviews, where bedside team review happens when the information is ready during the day or night – not at a set time of day. This is likely to be necessary in order to consistently ensure patients receive consultant review as early as possible – and within 14 hours of admission.

Continuity is important, and if consultants spend periods of time with and without ward patient responsibilities, the period of ward responsibility should consider a patient’s length of stay, to try to reduce the number of consultants supervising a patient during their stay. A handover round

Quality management, research and innovation

There are many elements of quality planning outlined in this report. These include:

- scheduling
- consistent staf ng and shift patterns
- structured documentation availability and maintenance of technology

Staff and patient experience will be major measures of effectiveness, as ward rounds and associated activities are the major function in which multidisciplinary staff work together. This should include effective teamworking and educational experience. Patient experience is key, and should include measures of effective communication and con dence, including the key patient questions outlined earlier. The use of real-time electronic patient experience measurement can give immediate feedback at the end of a session or ward round.

Many hospitals have ward accreditation or quality schemes, and the functioning and effectiveness of ward rounds should be included in these. Speci c ward rounds accreditation schemes should be considered.

The implementation of all of the good practice features of ward rounds outlined in this report is rare. Ward rounds are therefore a very applicable area for quality improvement programmes and projects. These should take place in the context of a hospital-wide improvement programme, though individual projects should happen at an individual ward/team level, and the successful elements then spread across the hospital. We recommend that teams and hospitals self-assess against this guidance and develop quality improvement initiatives to address or improve areas identi ed.

There is considerable scope for research and innovation related to ward rounds. Areas for this would include:

- the roles of individual team members in ward rounds, maximising the use of new roles
- patient involvement
- use of technology – particularly voice or handwriting recognition, and remote involvement
- the role of arti cial intelligence to identify key trends or risks
- mechanisms for increasing con dentiality.

Elements such as the reliability of start time, attendance on ward round, and duration of ward round could be used as process measures for ef ciency.

Case studies

Ward round accreditation, against agreed standards, has been incorporated into nd d.seen iBFF00Ae ati1enu233if 0 ration,as actich [(mHecommendhat t.d agreed

Working party

Dr John Dean Co-chair. Clinical director for quality improvement and patient safety, Royal College of Physicians. Consultant physician and deputy medical director, East Lancashire Hospitals NHS Trust

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Appendix 1: surveys of professions

Ward rounds: summary of surveys

In order to inform the working group, the professional bodies conducted surveys of physicians, nurses, physiotherapists and pharmacists in May and June 2018. The main numerical findings of the surveys are reported here.

2,022 physicians, 2,000 nurses, 509 pharmacists and 185 physiotherapists took part in the surveys, providing quantitative answers and free text comments about their current practice, challenges and good practice. These responses have been used to inform the recommendations within the body of the report. Differences in cohorts for the surveys and perceptions of participation are likely to account for the differences between the professions.

Which professionals participate in ward rounds?

Nursing input to ward rounds:

9.3% of consultants on acute medical units and 17.7% on wards reported that the nurse looking after the patient was present on the ward round, with only 5.5% stating that this happened all of the time. However, nurses across different units stated that they participated in ward rounds 61% of
ofof

How many patients are seen on ward rounds?

Physicians across specialties reported that 55.5% see between 10 and 20 patients on a ward round, with 19.5% seeing less than 10 patients, 22.5% seeing 20–30 patients and 2.5% more than 30.

31% of consultants had their ward rounds con ned to one ward, with 55% seeing patients on between two and four wards. 78% reported seeing patients on ‘outlying’ wards, with 60% reporting that this happens all year round. 60% reported that there was more than one consultant ward round on their ward. 25% led a ward round ve days per week, 37.2% on two days a week, 31.8% on three or four days a week. Nurses report that 17.2% of ward rounds take longer than three hours. Only 11% always start on time; 40% sometimes, rarely or never start on time. 61% of the nurses responding said this disrupts other ward care. Variable start times were also seen as an impediment by other professions.

Board rounds, huddles and priorities

42% of consultant physicians report attending or leading board rounds of huddles, with 21.9% of these occurring both before and after the ward round, 48.2% only before the ward round, and 17.5 % only after the ward round. 69.5% report debrie ng at the end of the ward round.

95.6% of consultants reported seeing the sickest patients, and 76.1% reported prioritising patients who might be discharged that day. However 33% of nurses reported that their was no particular order to the ward round.

30% of physiotherapists reported attending some form of multidisciplinary team board round or huddle 3–5 times ag patients oient (orm _1 1 TfTidi6.1 (vod)10.7att)10 (ending some nding />0rome r

Appendix 2: Self-assessment template

Rate your current performance of ward rounds below, using a 0–4 scoring system.

0 – not in place, 1 – in development, 2 – in place but incomplete, 3 – in place but not consistently followed, 4 – in place and reliably followed

Plot scores on radar chart to identify priorities for improvement.

Preparation	Assessment	Score
Ward team members roles and functions agreed, documented and understood		
Ward rounds and other activities are scheduled to prevent con icts		
Shift handover is structured to feed information into ward round		
Pre ward round board round is scheduled, structured, attended by all MDT staff and well led		
IT equipment is maintained and adequately available for ward rounds		
Ward round process	**Assessment**	**Score**
Patients are reviewed in priority order on ward rounds		
Structured documentation including safety checklists are used		
Medication and monitoring charts are reviewed		
The staff who directly care for the patient input to the ward round		
The ward round leader creates an environment for active participation and involvement in care planning		
Interprofessional education occurs during the ward round		
Learning points are summarised and planned at the end of the ward round		
Debrie ng and multidisciplinary agreement and handover of plans occurs after the ward round		

Patient-centred	Assessment	Score
Patients, families and carers are actively involved in ward round decisions		
Communication with patients during the ward round is at5n420o Td C4Td l Sdes		
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References

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