Case Studies

Modern ward rounds

Good practice for multidisciplinary inpatient review

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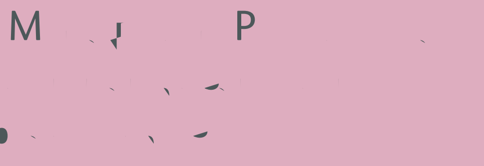
Case studies

Modern multidisciplinary ward teams

East Lancashire Hospitals NHS Trust



East Lancashire Hospitals NHS Trust is a large provider of hospital and community services to a population of around 550,000 people. It comprises five hospitals with one main acute site, the Royal Blackburn Teaching Hospital (RBH). Wards at RBH had variable practice across acute wards, which had changed over a number of years, including changes in staffing. There were many elements of good practice, but these were isolated in individual wards or individual professions. Case note review on long length of stay patients had shown a lack of multidisciplinary decision-making.

The trust developed the Model Ward Programme, which began with a value stream mapping week and led to a programme of work including standardising processes, improving the environment and multidisciplinary working. Key roles have been defined for multidisciplinary ward staff including their roles in standard processes of board rounds, ward rounds, multidisciplinary discussions and decisions, and discharge processes. The Dedicated Ward Pharmacist Programme was developed in parallel, with a full-time pharmacist, supported by a pharmacy technician, dedicated to one ward. This has demonstrated cost savings and reduced length of stay, as well as improvements in discharge communication. The trust has now recruited a dedicated pharmacist for each adult acute ward at RBH, with clear and extended roles in the ward team including medicines reconciliation, participation in ward rounds and other clinical discussions, and preparing discharge communications. This has demonstrated reductions in medicines waste, improved medicines reconciliation, and more timely transfer of care documentation.

Nottingham University Hospitals NHS Trust

A weekly multi-professional team (MPT) 'long-term' ward round for critical care patients who have a length of stay over ≥10 days has been established. The ward round includes the patient, their relatives (if appropriate) a critical care consultant with a special interest in rehabilitation, nursing staff, pharmacist, speech and language therapist, physiotherapist, dietician, occupational therapist, psychologist and family liaison officer (if involved in the patient's care). The team attend the patient's bedside to review the current situation, notes, charts and care plan.

Bringing together all the professionals involved in the patient's care at the same time, with the patient present, helps to:

- improve multi-professional shared decision making, eg weaning plans, liaising with dieticians when physical rehabilitation is increasing
- manage and identify issues such as delirium more efficiently
- involve patients to plan weekly goals and be involved in decisions about their care, by getting to know their personal preferences and needs
- involve relatives and care givers in planning care/management
- setting daily rehabilitation timetables for longer term patients to suit their individual needs, eg when they like to get up, when they like to be left alone for periods of time etc.

1Unit is a worldwide network of nurses, physicians and allied health professionals, who have developed the approach of Structured Interdisciplinary Bedside Rounds (SIBR) and accountable care units (ACUs). They have also developed Nurses First, a structured approach to shift huddle and bedside handover. They have now

Structured interdisciplinary bedside rounds (SIBR)

Pharmacist

- ☐ Discrepancies to resolve
- ☐ Antimicrobials to narrow
- ☐ IV to PO switches

Clinical coordinator

- ☐ Needs after discharge
- ☐ Plan for set-up or delivery

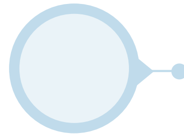
Social worker

- ☐ Needs and complex supports
- ☐ EDD and next site of care

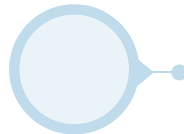
SIBR rounds manager

Manage SIBR rounds

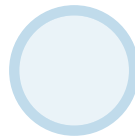
- Ensure next nurse is ready
- Support team as needed



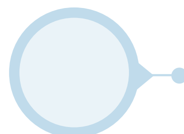
Hospitalist



Bedside nurse



Family



Hospitalist

1 Introduce

Lead team into room, greet patient and family

Introduce nurse and roles of team members

2 Update hospital course

Review active problems and response to treatment

Discuss interval test results and consultant inputs

Cross check with patient and family then nurse

3 Update current status

Overnight events and patients subjective goal for day

Vital signs and pain control

Fluid and food intake

Urine and bowel output

Mental status and functional status

4 Quality-safety checklist

Foley catheter necessity and insertion date

IV necessity and insertion date

VTE prevention

Skin integrity

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Before the ward round

Barnet Hospital, Royal Free London NHS Foundation Trust

An initiative was designed to help improve the early identification of unwell patients, new admissions and potential discharges.

A magnetic red warning triangle was introduced, and placed by at-risk patients on the acute medical ward whiteboard to aid identification of patients with an elevated early warning score. These patients are flagged up at the early morning board round, alongside new admissions and potential discharges.

Using this new system has made it easier to identify patients at risk, so that they can be a prioritised for review and – if required – early referral to the critical care outreach team or palliation. New patients can be prioritised for early consultant review and prompt decisions can be made for early discharges. There was some initial resistance from a few colleagues who have traditionally conducted a ward round sequentially from one bed to another. However, those who adopt the new system have seen the benefit, making it easier to persuade reluctant nursing staff and junior members of the team. The key to implementation is for the ward manager/senior staff nurses to lead the initiative, as they have a more consistent presence on the ward compared with the medical staff who rotate shift patterns.

Lister Hospital, Stevenage

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A consultant at the hospital wanted to improve relationships with junior doctors, decrease the length of ward rounds, avoid interruption on rounds, and get to grips with patient problems before ward rounds began.

With a new approach, the consultant no longer goes straight to the ward, but instead meets the junior doctors and students in an office to assess all the patients quietly and confidentially. The benefits of this have been significant:

- a reduction in interruptions, and a quiet environment allows easy access to a computer to look at bloods, radiology etc. This environment also facilitates speaking about patients confidentially. The team can discuss the emotional and social challenges of caring for patients, as on Schwartz Rounds
- relationship with junior team members has improved, and the discreet setting allows colleagues to behave in a more relaxed manner than would be appropriate on the ward
- when on the ward, the round goes quickly and is less tiring, and benefits from prior preparation.

Bradford Royal Infirmary

Teams undertaking ward rounds were faced with frequent interruptions and distractions when reviewing information on new patients. It was felt that the focus at the bedside was often on computers, rather than the patient, and this was compounded by a shortage of nursing time for ward rounds.

The team implemented a review of new patients' electronic records prior to going to seeing patients at the bedside. Consultants now work alongside junior doctors in the ward office – each has a computer with the patient's electronic record open. Benefits to this new approach have included:

A daily board round was introduced with the aim of improving communication between medical, nursing, physiotherapy and occupational therapy staff.

The responsible consultant introduced the daily board round, which can be conducted either before or after the ward round. The board round is used to discuss anticipated discharge date, any PT/OT referrals needed, any discharge barriers or concerns from the medical / nursing staff that the medical / nursing teams need to address or vice versa (eg DNRs, updating families / careful handling etc)

Although the effectiveness of the board round will depend on which staff are involved, they have resulted in better patient flow, better communical / nursing ten-GB(s.was introduced with the)TjETE

South Tyneside and Sunderland Foundation Trust

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Following feedback from junior doctors, ward performance metrics and clinical incidents, a number of issues were highlighted around ward base work. These included missed junior doctor teaching, junior doctors working beyond contracted hours, delayed completion of discharge letters, delayed completion of death certificates, failed handover of tasks to evening teams, and boarded patients not being noted until late in the day. The senior clinical team also felt that junior doctor morale was low, and that trainees didn't receive enough positive feedback on their performance. Daily changes in the clinical team could also mean doctors working together often didn't know each other particularly well.

To improve the situation, a daily schedule was instituted, incorporating a consultant-led brief / debrief model of care, inspired by the WHO surgical checklist. This included a 5-minute check at the start and end of each day:

Start of day (9.15am)	
Team introductions	Morale check
Commitments – any clinics or teaching	Senior availability (registrar / consultant)
Is staffing adequate?	Sick patients
Discharges	Boarders
Procedures	Investigations
	certification
Start of day (9.15am)	
Concerns?	Any other issues?

End of day close down (4.30pm)	
Any work to handover?	Any work for tomorrow?
Problems for tomorrow?	Investigations
Electronic discharge summaries	How did today go?
Concerns / other issues	Any required critical incident debrief

Junior doctors reported that this approach improved organisation and morale, and gave

opportunities to raise concerns. Tasks and teaching were more likely to happen, and no 'additional hours' reports were received.

The team felt that the working day was once again being led by the consultant, and the new system allowed the group to plan handover and work for the following day. Positive feedback on performance of each member of the medical team was given.

Those involved with ward rounds reported an unstructured approach to rounds, with disjointed contributions from colleagues, doctors, nurses and pharmacists. The excessive length of ward rounds also encouraged team members to leave the round prematurely. It was also felt there was a lack of understanding and 'ownership' of patients among junior teams, manifested in not knowing relevant and important investigation results and comorbidities prior to the ward round. This can result from lack of specialty knowledge of crucial information helpful for decision-making.

The first four new complex patients in each ward round are now discussed as a teaching case, looking at all the data in one place with access to external sites eg NICE guidelines, BNF, British Cardiac Society and European Society Guidelines, Pubmed etc. This allows research to be done while B2 round.

Sheffield Teaching Hospitals – geriatric and stroke medicine

Over the past decade, changes to medicine, with a move towards increasingly consultant delivered care and daily reviews, have removed significant numbers of training opportunities from junior doctors. Often, even quite senior grades make fewer decisions than their counterparts at a similar stage a few years earlier.

Rather than consultants actively seeing every patient themselves every day, with juniors only scribing/completing jobs, the team now start the day by proactively indentifying patients each morning and deciding which team member will see them. For example, the consultant may see new or complex patients accompanied by an F2, while the F1 sees patients expected to be simpler or already medically ready for discharge. The IMT may review the patient who has deteriorated overnight, prior to discussion with the consultant. The following day, trainee allocation will be similar to allow continuity, but the consultant may see some patients from the day before and other identified patients. The team aim to see every patient prior to a half-hour multidisciplinary board round and either during, prior to, or following this any medical queries from the team are discussed. From a consultant's point of view time on the ward remains similar to if they were seeing everyone themselves. However, trainees maintain continuity of care and are able to make decisions for themselves in a supervised environment, allowing for timely feedback on decision-making.

Wardround.net

At the Department of Internal Medicine at Kungälv's Hospital in Sweden the institutional ward round no longer exists. They have developed a working model that narrows the gap between the patient and the professional and facilitates the collaboration between the different health professions. The ward team now meets the patient at the ward stations (rooms designed for multiprofessional discussions). The ward rounds have become more effectively run, resulting in better medical care, securing the patient's integrity and giving them a chance to participate in their own care. In the words of one staff members: We try to listen more carefully to the story of illness from the person who became a patient.'

Qualitative evaluation has shown this new approach makes a physician's relationship with the patient less hierarchical, combined with working in a multiprofessional team. This contributes to better informed clinical decisions, fewer follow-up questions from patients and increased professional fulfilment. However, physicians also report that their autonomy was being reduced, and there was uneasiness about exposing potential knowledge gaps in front of others.

Clinical criteria for discharge (CCD) are 1–4 medical objectives set by senior doctors that describe why a patient is not yet safe for discharge, and what will need to be in place for discharge to be appropriate. CCD are expressed in concise, specific and measurable language that can be understood by the most junior members of the medical and nursing teams and by the MDT.

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They provide a basis for explanation to patients and their relatives in response to the question: 'When can I go home?' and often enable differences in expectations to be explored. The teams aim to set or revise CCD each day on every patient, with the exception of those who have already been medically discharged and for whom a Last Days of Life care plan has been commenced. CCD sticker templates are inserted in patient notes at the beginning of the day on a Friday to enable weekend discharge. Twice-yearly teaching sessions on CCD for junior and senior medical staff has received favourable response. The trust are planning to make a library of sample CCDs available to increase confidence in formulating CCDs for some of the more common conditions/scenarios.

A consultant wanted to design a system whereby the most recent entry in a patient's notes would contain all that was needed to get a rapid understanding of the patient's issues: what is clearly known, what is yet to be found out and the progress they have – or have not – made to date. On every ward round being conducted at that time, trainees started presenting the patient by reading the admission clerking, even if the patient had been in hospital for several days. This process can reinforce what may have been an erroneous initial working diagnosis and is very time-consuming.

A new format for the record of a routine ward round was introduced, written under three headings:

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While not having electronic patient records, the trust used a clinical portal. This enabled clinicians to view all clinical systems including letters, investigations and the GP summary care record. Clinicians can also access the Lancashire Person Record Exchange Service (LPRES) Health Information Exchange from the portal. LPRES is an ever-expanding service on which more content and functionality is continually being rolled out. It includes transfer of care letters and clinic letters from the four acute trusts in the integrated care system and also access to the GP summary care record. Mental health documentation is available and documentation from social care will also be linked. It will also include joint end-of-life care plans. All of this information is available to