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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

Model Ward Programme and dedicated ward pharmacists

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

MPT long-term ward round

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.



East Sussex Healthcare NHS Trust

Therapy led rehabilitation board round

The team developed a daily board round in their intermediate care facilities, underpinned by their intermediate care database. The round is attended by key representatives of the MDT and provides a consistent review of the status of the patient within the unit. This includes:

- ▶ confirming length of stay (LOS)
- ▶ 'rehab complete' status – when rehabilitation no longer requires bedded care but can be delivered within the community
- ▶ confirming length of stay (LOS)
- ▶ 'rehab complete' status – when rehabilitation no longer requires bedded care but can be delivered within the community identifying the pathway of care, eg rehabilitation, disability management, end-of-life care or pre-habilitation
- ▶ measure of complexity
- ▶ measure of disability
- ▶ daily intermediate care coding, ie reasons why the patient is still in intermediate care

Daily board round discussion is captured directly onto the intermediate care database and is available for review at any point by the MDT. From the database, those patients required for the weekly rehabilitation review round (led by an AHP consultant with a nurse and therapy worker) are identified. Patients who are over the target LOS, who have a rehab complexity score >11 or a high disability score are automatically scheduled for review. These reviews focus on key areas, such as tone management, disability management, mood and cognition, and discharge planning. The aim of these ward rounds is to ensure that the MDT is objectively reviewing patients to ensure they are still suitable for the unit. As a result, LOS has been reduced by 10 days.

1Unit. www.1unit.com

Structured Interdisciplinary Bedside Rounds (SIBR) and accountable care units (ACUs)

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 worked with over 100 teams worldwide.

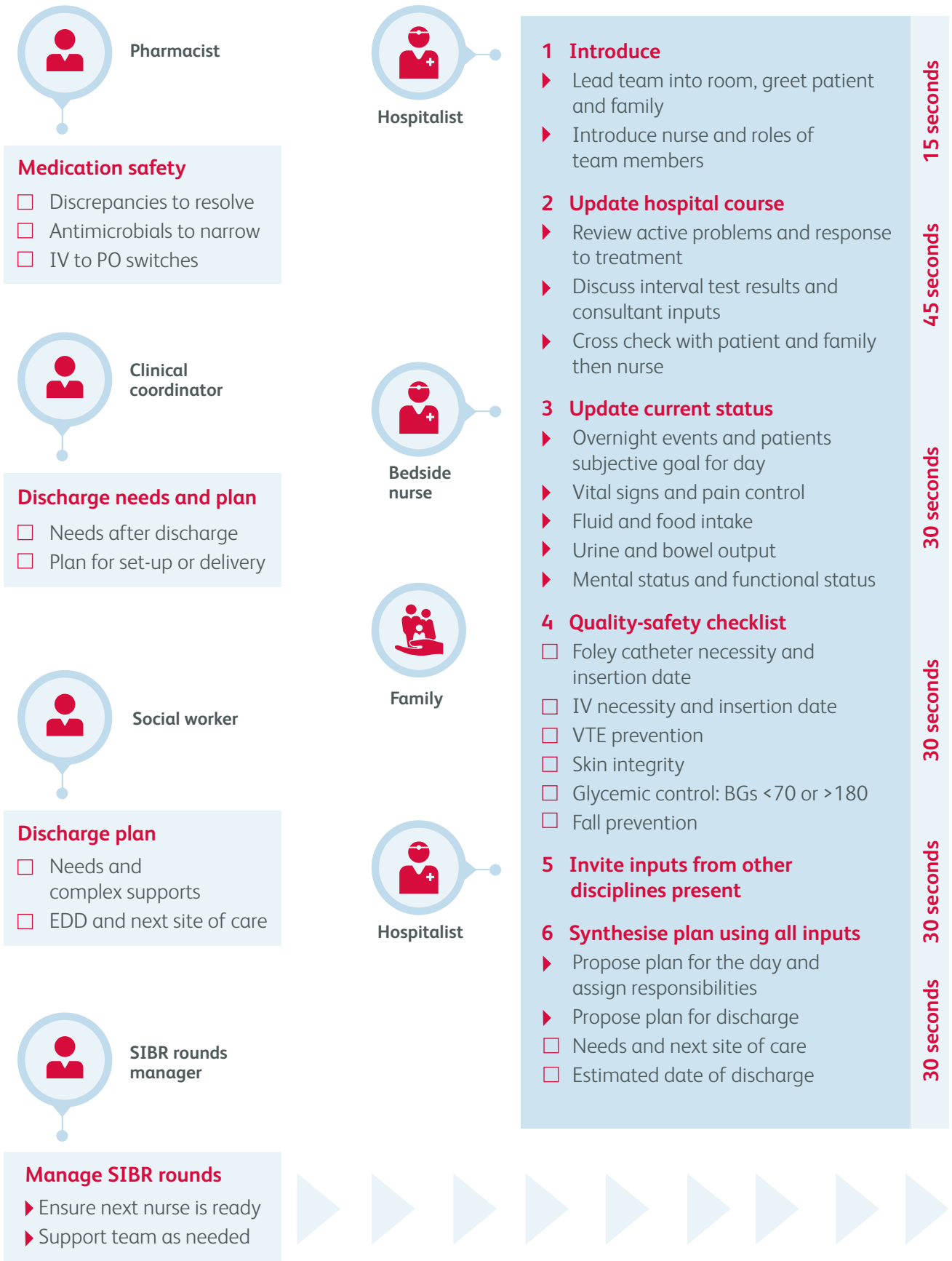
SIBR follows a six-step communication protocol that enables teams to review patients together at the bedside. The inputs from individual professionals is key to SIBR, and the bedside review brings this information together with the patient in order to agree a management plan. Nurse and allied health professional (AHP) prep sheets have been developed that enable a consistent approach. Structured input from the shift handover is key, and a prerequisite to implementing SIBR.

In order to be successful, SIBR requires structured training of the team in gathering the information and in the process of bedside review.

ACUs are clinical teams with unit co-leaders, and ongoing performance assessments and improvement plans. These replicate well-run wards in the NHS and incorporate key principles that teams can follow.

The implementation of ACUs incorporating SIBR and Nurses First has reduced length of hospital stay, medication errors, readmission and mortality, as well as improving the reliability of key elements on inpatient care and improving staff morale. This has been demonstrated in the USA, Canada and Australia.

Structured interdisciplinary bedside rounds (SIBR)





**Cambridge University
Hospital NHS Foundation
Trust and George Eliot
Hospital NHS Trust**
Advanced clinical practitioners

Both trusts aimed to maximise the benefits of advanced clinical practitioners (ACPs) in acute medical care to complement the traditional workforce and meet increasing clinical demands.

Cambridge have ACPs in acute medicine working at tier 2, as per RCP recommendations in *Safe medical staffing*. These clinicians do not replace doctors but support the whole multidisciplinary ward team. ACPs are on the medical rota and are expected to undertake many duties junior doctors undertake in addition to providing leadership, education and research. The ACPs work across the whole of acute medicine including in the Emergency Department, take team, ambulatory care, medical decisions unit and short stay medicine. Senior ACPs undertake independent ward rounds making complex clinical decisions and see patients independently on ambulatory care. The ACPs regularly support and supervise the junior doctors during their rotation through the service with clinical, communication and procedural skills.

George Elliot Hospital employs a nurse consultant for acute, emergency and ambulatory care. The role includes acting as an autonomous advanced practitioner with responsibility to be a senior clinical decision-maker across a wide range of acute and ambulatory pathways. Part of the nurse consultant role provides tier 2 and tier 3 leadership for ward rounds and board rounds.

**University Hospital
Southampton
Foundation Trust**
Doctor's administrators

It was noted that the administrative tasks required of doctors in training and the wider team were increasing and causing time constraints for clinical care. A lack of time to recruit and train other clinical team members, such as physician associates or ACPs, was inhibiting the development of solutions.

The role of doctor's administrator (DAs) was developed. These team members were employed to work on the Acute Medical Unit (AMU) seven days a week from 8am to 6pm. They are paid at Band 3 (NHS Agenda for Change). They come from a variety of backgrounds including ward clerks and healthcare assistants. They have an initial 6-week training period, including a competency framework that includes medical terminology. During this time they are closely supervised in completing electronic discharge summaries and other elements of the role. They have become integral and valued members of the multiprofessional team on AMU and enable junior doctors to focus on their clinical duties and training opportunities.



Before the ward round

Barnet Hospital, Royal Free London NHS Foundation Trust

Who to see first

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

Preparing the information

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

New patient office-based electronic record review

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 more thorough review of the notes and medications, in less time, with fewer interruptions
- ▶ higher rates of completion of VTE, oxygen prescribing and, MRSA prophylaxis
- ▶ increased ability to order blood tests before the phlebotomists arrive, so fewer bloods left for junior doctors to take
- ▶ opportunity for quick bite-size teaching
- ▶ less nursing time needed for ward rounds, while still able to benefit from the MDT approach
- ▶ the ability to focus on the patient when at the bedside
- ▶ conservation of team members' energy.

Royal Glamorgan Hospital, Llantrisant, South Wales

Multidisciplinary board rounds

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 communication, improved risk management and a reduction in complaints.



South Tyneside and Sunderland Foundation Trust
Brief/debrief model ward

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.



During the ward round

Barnet Hospital, Royal Free London NHS Foundation Trust

Managing complex cases – setting an example

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 discussing the cases to verify factual materials and clear didactic thinking steps in evaluating and managing patients. As a result of this new approach:

- ▶ Junior team members are exposed to a structured approach of conducting a ward round. This allows them to appreciate the complexities of decision-making.
- ▶ Greater attention to detail is promoted and a better understanding of the patient’s disease and issues can be achieved. This allows the team to appreciate the long-term outcome and the treatment goals of the patient.

- ▶ With a clear treatment goal, junior members of the medical team feel more confident in their management plans.
- ▶ A cohesive approach by the multidisciplinary team then improves efficiency and quality of care, resulting in higher confidence levels among patients and relatives about the care provided.
- ▶ Confidential space for data sharing from all colleagues in an MDT ward round with flat hierarchy structure and shows workload sharing equitably.

Yeovil Foundation Hospital Reducing the effects of noise

Changes were introduced to the ward environment in order to counteract barriers to effective ward rounds, namely loud noise, a lack of relevant available information, and a lack of record keeping.

Staff now use an app to record the decibels on the ward round, encouraging staff to keep noise levels to 30–40 db. This encourages clearer thinking and decision-making and makes it less likely that information will be missed. To ensure smooth running of the round, team members are encouraged to meet an hour before the beginning of the round, to allow ample time to prepare, which has resulted in a quicker round overall, and rounds finishing on time. Finally, a process is now under way to implement a digital record of ward rounds, which can be accessed by any team member at any time, with the aim of informing on-call doctors about patients.



University of Nottingham and Nottingham University Hospitals NHS Trust

Creating the culture by incorporating reverse role rounds

The team set out to address three issues:

- ▶ the lack of formal opportunities for junior medical staff to take ownership and responsibility for the ward round under direct observation
- ▶ a lack of time and ‘space’ for senior medical staff to step back, complete safety checklists, use clinical decision support tools and consider the impact of human factors on team performance and patient safety
- ▶ changing the mindset of patients and healthcare professionals from one that believes the ward round can only be led and completed by senior medical staff, to one where there is acceptance that flattening the medical hierarchy on the ‘traditional’ ward round can be an improvement from a patient safety perspective when done properly – with benefits also including giving others the opportunity to other staff members to explain care plans to others.

The team implemented reverse role rounds, with the addition of pre- and post-consultation patient notes workups (digitally recorded where appropriate) alongside ‘ward round feedback clinics’ where performance on task was micro-analysed and workplace-based assessments completed. As a result, the following benefits were noted:

- ▶ greater insight and reflective practice on the part of junior medical staff into their clinical reasoning and diagnostic decision-making skills, as well as greater self-awareness among this staff group about the need for verifying information written in the notes given patient safety implications of errors.

- ▶ greater awareness by senior staff members around the tendency for ward rounds to propagate certain types of cognitive biases, eg commission bias, bandwagon effect, and base-rate neglect, which could lead to error, but also the new awareness by these staff, as well as around the opportunity for ward rounds to prevent errors in thinking, prescribing and communicating from causing avoidable harm to patients.

- ▶ greater appreciation of the purpose of ward round by all staff, management and patients as the key daily clinical activity that can unlock problems with ‘flow’ through a hospital, miscommunication between different clinical teams as well as reduce wastage from poor or delayed clinical decision-making.

Any barriers related to changing the purpose of the ward round in terms of moving from a ‘silo-ed’ and chaotic ‘medic-only’ activity towards a more structured and consistent team-based activity were addressed by engaging the medical director, chief nurse and Trust Patient Safety Team.

Any tribalism related to the different perceptions about the purpose of the ward round were overcome by engaging the nursing ward manager and senior medical team (consultants) in the department, and agreeing their mandate to implement the change.

Any suspicion held at the frontline by junior medical staff, junior nursing staff or healthcare assistants was dispelled by delivering regular and rolling lunchtime teaching sessions to these staff about the ward round and the interconnectedness with all ward activity performed by them – ie handover, board rounds, asking for senior help and acting on results.



Sheffield Teaching Hospitals – geriatric and stroke medicine

Maintaining high-quality training while ensuring patient care remains excellent

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 identifying 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

Meeting with the patient and team away from the bed

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.



Southend University Hospitals NHS Trust

Criteria-led discharge

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.

Northampton General Hospital

Clinical documentation using 3 Rs

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:

- 1** Review of diagnosis: beginning with the current working diagnosis followed by a review of the evidence for or against this.
- 2** Record of progress: reintroducing a sense of narrative into the notes, and a record of what has changed since the last entry – not just a snapshot of the current physiological parameters.
- 3** Revised plan.

This new system has made ward rounds quicker, and anecdotally trainees have fed back that reviewing patients out of hours has been easier. Although discussed with consultant colleagues prior to implementation and presented to trainees in a teaching session, getting others to engage with the project and promote the methodology to trainees has been extremely difficult. It takes slightly longer for the first entry to be completed and it is not just ‘business as usual’, which has put people off. In the relatively small numbers who have adopted it, the time savings on subsequent reviews have persuaded them to continue with it. This is still very much a work in progress.



Wirral University Teaching Hospitals (WUTH)

Connected electronic information and templates

WUTH went live with electronic noting for all inpatients in November 2016. Working with the Cerner team, Wirral have created specific ward round templates for different functions including first consultant post-take ward round and daily ward review.

Embedding consistent document templates has enabled integration of checklists, which encourage actions including consultant-led VTE prophylaxis, endorsement of test results, and ceiling of care documentation. Details such as specialty triage and estimated discharge date are automatically pulled through to electronic white boards that inform local board rounds and trust-wide flow dashboards.

Key information from primary care records can be accessed quickly during patient review and discharge letters emailed to GPs even before rounds have finished. In a rapidly digitising health service, handwritten ward round noting will not be a feasible option for long. WUTH's experience shows how embracing technology can improve the quality and accuracy of the care record. However, more work is needed to make this process more efficient and understand the effects of this digital focus on team cognition, patient interaction and professional training.

East Lancashire Hospitals NHS Trust

Connecting electronic information across the healthcare system

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 support clinical assessment and decisions for ward rounds.



Patient partnership

Emerson Green

What are your questions?

Emerson Green is an independent elective surgery treatment centre in Bristol run by Care UK. It specialises in planned NHS and private surgery for NHS, private and insured patients. The services cover a wide range of treatments and also provides diagnostic services.

On admission, patients are provided with a folder and sheets of paper to write down any questions they may have, and are then given an opportunity to ask the questions during the ward round. The ward manager ensures that all members of the multidisciplinary team have enough time for this, and has reassured patients that they can also ask questions outside of the ward round.

Norfolk Community Health and Care NHS Trust

Maintaining confidentiality

Norfolk Community Health and Care NHS Trust serves a population of nearly 900,000 people in Norfolk with community health and care services, as well as providing a specialist early supported discharge service to stroke patients in Norfolk and Suffolk. On the amputee rehabilitation ward round the team were unable to maintain confidentiality due to shared bays, and elderly patients felt intimidated when surrounded by the team that could include a consultant, junior doctor, nurse, physiotherapist, occupational therapist and occasionally students.

The team found a room dedicated for the ward rounds and all team members sat in the room – patients were brought to the room for review and a confidential discussion. Patients felt more in control, as those in wheelchairs were able to leave when they wished. Patients were enabled to bring a family member with them, which gave them the opportunity to ask questions to the team and reduced the need for separate family meetings.

George Eliot Hospital NHS Trust

Shared decision-making

Based on the outskirts of Nuneaton, George Eliot NHS Trust serves a population of more than 300,000 people. On Mary Garth Ward, an 18-bed ward focusing on gastroenterology, the team wanted to improve communications between doctors, nurses, auxiliary staff and patients.

The team set up a shared decision-making council to make ward improvements for staff, patients and visitors' wellbeing. As part of this, they developed a communication tool to give a brief overview of the patient's clinical plan and care. Staff complete a form with open sections for Monday–Friday based on the answers to three simple questions:

- ▶ What is going to happen to me today?
- ▶ What are we waiting for?
- ▶ What is my discharge plan?

Encouraging staff to complete the tool took time, but it has proved successful – the number of complaints has reduced significantly, feedback from patients' friends and family has improved, staff retention and morale has improved and staff feel more invested in the service and empowered to make changes.



Education and learning

Surrey and Sussex Healthcare NHS Trust

Quality Ward Round Programme

In 2012 surveys identified that doctors have had little training in how to conduct rounds and lacked in confidence in both leading and participating in rounds.

A low technology, high fidelity simulation training in ward rounds, called the Quality Ward Round Programme, was developed. The training – initially designed for final year medical students and FY1 doctors – has now been adapted to include senior nurses, pre-registration pharmacists and physician associate students. The training takes 3 hours. Two groups of up to 20 learners attend two sessions: a group tutorial, with problem-based common ward scenarios and patient safety issues relevant to ward round activities, and a simulation session involving three ward round encounters with an actor in the role of the patient in a simulated ward environment. Learners not taking part in the scenario act as observers. A learner is nominated to be the ward round leader and to delegate role and responsibilities to the ‘ward round team’. Roles include a scribe, a checklist reviewer and a person to check the patient bedside folder containing observations and the drug chart.

Themed scenarios were developed for use in the simulation. The ‘debrief’ allows leaders, participants and observers to talk through the scenario, assess their performance and revise the key learning points. The focus for the debrief is on the demonstration of the need for structure, teamworking and organisational skills. Over 200 FY1 doctors, 400 final year medical students and 100 physician associate students have been trained. Almost unanimously, learners felt

that ward round training should form part of their training programmes and over 94% of all learners rated the session as excellent. Statistically significant improvement in confidence levels in both leading and documenting ward rounds has been demonstrated.

Nottingham University Hospitals

Online videos and simulation

The acquisition of administrative skills, including those employed on a ward rounds, are envisaged to be developed for FY1 doctors during a shadowing period prior to their starting in post. This was recognised as unlikely to happen by shadowing alone.

A course was developed for final year medical students prior to commencing FY1 posts. This incorporated online video presentations. These outline the role of FY1s, different phases of ward rounds, the principles of documentation, patient confidentiality, communication and negotiation with colleagues, and work–life balance. They also include examples of good and bad ward rounds. They are followed up by a simulated event in which the FY1 leads a senior decision-maker around three simulated patients. 85% of reported this approach as useful.



Imperial College Healthcare NHS Trust and Torbay and South Devon NHS Foundation Trust

Trainee leading ward round reviews

With twice daily consultant ward rounds, trainees may feel disempowered from decision-making by frequent consultant presence, and therefore unable to learn the skills of leading a ward round and the MDT interactions within this. This causes increasing difficulties in trainees obtaining supervised learning events (around post-take ward rounds).

Once a week, Imperial College Renal Unit allowed the doctor in training to lead the ward round within a 4-bed bay while the consultant observed, acted as scribe, and then provided feedback after the bay was completed. Trainees felt able to learn the art of managing a ward round, reviewing patients, making decisions, and fixing discharge dates. All stages of training found this very useful. It provides an excellent opportunity for feeding back on communication skills with nurses, pharmacists, therapists and patients.

In Torbay and South Devon NHS Foundation Trust medical registrars have a rota slot to attend ambulatory care on four half days per year. They then undertake directly observed post-take ward rounds of the patients on the ambulatory care unit. The consultant observes the interaction with the junior doctor as they present the case, the clinical encounter with the patient and offers real time feedback on their skills, followed by an supervised learning event at the end of the session.



Quality management

Northumbria Healthcare NHS Foundation Trust

Measuring patient experience

Northumbria Healthcare have a strong emphasis on patient experience. They aimed to measure patient experience that could be fed back to teams within a shift at the ward level.

Structured patient questionnaires were developed and are administered with patients using volunteers. The questions cover a wide area of care, including patient involvement in decisions and understanding of care. As the data is captured on handheld devices, the data can be fed back within the shift to the ward. The ward team can use this data to reflect on their practice and improve patient experience.

Ysbyty Gwynedd – Betsi Cadwaladar University Health Board

Patient involvement in ward rounds – innovation programme

The role of patients in ward rounds and inpatient care is poorly defined and communication is highly variable.

An innovation programme on patient involvement in acute care has developed and tested a number of interventions. Following exploration of patients' understanding of care, two prototypes to enable patient involvement were tested. Patients were given a 'how to' hospital patient diary containing information, space to document information and prompts for questions.

A medically delivered diary card required clinicians to complete information during rounds. These were usable in practice. Further tests and adaptations are planned. The team also simulated patient scenarios where personal health records of patients were integrated into clinical workflows. This was shown to be feasible, but requires adaptation of technology and clinical routines.

Wrightington Wigan and Leigh NHS Foundation Trust

Ward based safety meeting

A number of issues were noted in the wards on the 56-bed cardio-respiratory unit. These included increasing inpatient complaints, high medical and pharmacy error rates (as noted by incident reporting), and medical and nursing staffing issues that left inadequate cover and poor collaborative working between various health professionals. This was leading to a detrimental effect on patient safety, quality of care and team working. In response, a weekly multidisciplinary safety meeting was established. Drug errors/omissions, medical and nursing staffing issues, patient complaints /concerns and all reported incidents are formally discussed. The meeting lasts approximately 30 minutes, and is conducted at the end of a ward round. These meetings are now an integral part of a routine ward round. All discussed items are formally minuted and distributed to all concerned, providing a supportive and non-confrontational environment to all involved, in which issues can be raised, discussed and resolved in a timely and cohesive fashion. Over 95 % of all issues raised are resolved within a week. Patient complaints have become rare events. Working relationships have been greatly improved between all staff.



Ward round accreditation scheme (Warrington and Halton)

Key standards to be met*

Well led teams	Record keeping
Leadership	All documentation standards met – legible, signed, dated etc
Learning environment	Summary of ward round assessment – patient and professional progress report, findings from physical examination
Team culture	Working diagnosis recorded
Appropriate attendance at ward round	Clear management plan documented – including tasks to be completed and discharge plan
Data, governance and improvement	Medication charts to be updated at ward round
Communication with MDT	
Safe and effective medical handovers	
Board round completed to standard	
Effective communication with relevant members of the MDT– before round	
Effective communication with relevant members of the MDT – after round	
Referrals made in relevant and timely manner	
Patient communication	
Team introductions	
Patient focused communication	
Patient involved in ward round	
Patient made aware of diagnosis, investigations, results and action plan	
Patients/carers/families are aware of and involved in their plan of care	
Patient flow	
Prioritise patients to be seen	
Ensure every patient has an EDD	
Social circumstances reviewed	
Effective task allocation and timely completion	
Discharge summaries and TTOs completed in a timely manner	
Care and processes	
Patient history and diagnosis discussed in confidential manner	
Review all investigations and charts	
Infection control standards maintained	
Complete relevant examination with privacy and dignity maintained	
Check on current patient needs eg pain, hydration etc.	

Warrington and Halton Teaching Hospitals NHS Trust

Ward Round Accreditation Scheme

Clinical leaders recognised the variability of ward round processes and practices across medical wards in the trust. They aimed to standardise practice and build on the ward accreditation scheme with a Ward Round Accreditation Scheme.

A rapid improvement event was held with multidisciplinary team members from six pilot wards to explore the application of the current ward accreditation process to ward rounds, and standard practice elements to include in the accreditation were agreed. Wards identified their own improvement areas through a PDSA approach, and piloted process and patient feedback measures, as well as a ward round registration document. A pilot ward round accreditation took place in September 2019. The accreditation process is now supported by electronic recording of data. A multiprofessional accreditation team observes one ward round and documents against the agreed standards, they also speak to staff and patients. A validation panel of senior trust staff signs off the accreditation. This programme is now being rolled out across the trust.