Ward round Improvement work

Medicine for Older People-NBT

Summary

- Older people in hospital are more vulnerable to adverse events e.g., falls and associated injuries, medication errors, thrombotic events, nutritional deficiencies, inappropriate treatments, and hospital-acquired infections.
- Within the healthcare system, omission errors are twice as common as commission errors.
- Mortality rates in the year following admission to the medical directorate are 39% at NBT.
- Ward rounds are highly complex, with multiple decisions made for each patient, including risks/benefit assessments.
- Effective older patient care is critically dependent on effective interdisciplinary communication at verbal and written levels.
- Establishing systems such as multifactorial changes in ward rounds using board rounds, ward round check, and implementation lists, post-round huddles, reduces omissions, clarifies decisions, and improves communication, leading to safer patient care.

Background

How do I make a ward round system reliable and safe with a rapidly changing junior doctor and nursing workforce? Education of junior doctors at induction seemed to have a limited effect. The ward-based medical team changes formally every four months and often daily.

Methods

Following the publication of Gordon Caldwell’s article in clinical medicine and the joint RCP/RCN publication on ward rounds, a multidisciplinary team based on a medicine for
older people ward at North Bristol Trust have developed a ward round checklist customised to older patients (attached). Regular board rounds and post round huddles were started to improve communication. This ward round checklist has evolved using PDSA methodology over the last twenty four months to its current version. All new patients admitted to the ward are assessed and the ward round checklist filled in. Twice weekly on consultant/registrar ward rounds the list is completed. This often prompts a number of questions such as ceilings of treatment, is this patient frail? is this patient in the last year of life. Methodical falls risk review included.

**Benefits** Measurements of ceilings of care decisions, risk/benefit of LMWH for DVT, proactive discussions and involvement of carers/relatives, systematic checks of IV and catheter lines have all improved. Junior doctors like the systematic approach of the ward round check and implementation list and have taken the concepts to other wards in the hospital customising the lists for the different specialities. It prompts discussions about risks and benefits of treatments on a daily basis. Nursing staff (who contributed to the design) like the checklist as they say they know exactly where to look when they want to see the senior review, there is clarity over the decision making, ceilings of treatment decisions are clear, there is a task list for them. The consultants feel more confident that they are providing more reliable, consistent and effective patient centred care.

**Drawbacks** time taken to fill in checklist or attend board round, pedantic, some doctors irritated by a list, not always reliably filled in, potential for routine aspects to distract from the underlying diagnoses. Human behaviour factors important to recognise along with culture on ward.

**References**
1. Quality and safety at the point of care: how long should a ward round take? Roselle Herring, Tejal Desai and Gordon Caldwell *Clinical Medicine* 2011, Vol 11, No 1: 20–2
2. Ward rounds in Medicine Principles of best practice *Royal College of Physicians. Royal College of Nursing* Joint publication October 2012