2013

National Guideline on Ward Rounds

Ministry of Health

Quality Assurance Section (QAS)

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Foreword

The Ministry of Healthplaces great emphasis on ensuring that the health care services provided to Maldivians are safe and are of high quality. Well-developed standards of care including necessary protocols, practice guidelines and relevant training to health staff are all important in achieving our goals.

I am pleased that we are publishing the first *National Guideline on Ward Rounds* which would be utilized as a benchmark documentin the Maldives.

I would like to convey my sincere gratitude to Ms.ThasleemaUsman, for taking the initiative to develop this*National Guideline on Ward Rounds* and gearing the whole process of consultation, compilation, draft evaluation and finalization. I would also like to congratulate the stakeholders for their valuable input and the dedication in developing the guideline. I highly appreciate the dedicated efforts of the staff of Quality Assurance Section and Health Services Division of Ministry of Health in compiling this publication and the senior management of Ministry of Health for giving valuable insight to this document.

I hope the health care professionals and administrators of both public and private health care facilities will use this guideline on ward rounds in order to improve the quality and efficiency of their services.

Dr.Sheeza Ali
Director General of Health Services
Ministry of Health
26th September 2013

Acknowledgement

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Ms.ThasleemaUsman
Director
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26th September 2013

Part I:Ward rounds

Introduction

Ward rounds are complex clinical activities, critical to providing high-quality, safe care for patients in a timely, relevant manner. They provide an opportunity for a coordinated plan of care, while facilitating full engagement of the patient and/or carers in making shared decisions about care. It offers opportunities for effective communication, information sharing and joint learning through active participation of all members of the multidisciplinary team.
Ward rounds need to be restored to a position of central importance in how we collectively care for and communicate with patients. Doctors and nurses need to understand the wider impact of their approaches to ward care, whilst managers and the executive board bear a responsibility to protect time and resources, enabling all members of the multi-professional team to prioritise the ward round.

Identifying principles for best practice in ward rounds can improve patient safety, patient experience, shared learning, collaborative working and efficient use of resources.

The process includes:

1. Establishing, refining or changing the clinical diagnoses
2. Reviewing the patient's progress against the anticipated course on the basis of history, examination, results of investigations and other observations
3. Making decisions about future investigations and options for treatment, including DNAR (do not attempt resuscitation) and any ceilings of care
4. Formulating arrangements for discharge
5. Communicating all of the above with the multidisciplinary team, patient, relatives and carers
6. Active safety checks to mitigate against avoidable harm
7. Training and development of healthcare professionals.

Types of ward rounds

1. **Teaching round**

   Interns, registrars and specialists go from patient to patient to test the knowledge of the more junior doctors and train them in how to identify particular conditions and determine treatment.

2. **Traditional ward round**

   Ward rounds attended by different health professionals caring for the patient to discuss how the patient is progressing and future plans for care ***(Annex 1)***

3. **Working round**

   The medical team visits patients to review their condition and plan their care. ***(Annex 1)***

Multidisciplinary involvement

Medical ward rounds require the coordinated collaboration of several health care professionals and have multiple challenges and barriers to effective team working that must be negotiated. The delivery of high-quality, patient-centered care improves patient outcomes and organizations should have processes in place for ensuring effective team working. Nurses have a crucial role on sharing information, supporting patients in articulating their views and preferences. Absence of a nurse at the bedside has clear consequences for communications, ward-round efficiency and patient safety. Although time pressures have grown for all professionals, the responsibility to set-aside time for ward rounds should be a collective effort for all professionals concerned.

Effective team working

Ward round require strong leadership and good working relationships among all members of the team and individuals are made aware of their respective roles and responsibilities to engage in the ward round process. All members of the team should have the opportunity to actively interact as part of the ward round process

Responsibilities of a Doctor
leading the round, provides and update on current problem, responses to treatment, test results, medications, clinical examination and review of patients and drug chart etc. Also anticipated discharge planning and follow up arrangements.

Responsibilities of a Nurse
providing updates on vital sign, pain control, nutrition, hydration, elimination, neurological assessment, quality and safety checks on urinary catheter, IV lines, pressure ulcers, falls, infection control etc.

Responsibilities of patient and carer*providing updates on current concerns, arrangement for discharge.*

Royal College of Physicians, Royal College of Nursing (2012)

Board rounds

Medical staff are now increasingly using ‘board rounds’ away from bed-side, which provides an opportunity to prioritise bedside reviews and deal with non-medical issues like discharge planning, issues related to communication between staff and relatives. Board rounds conducted at the end of the ward rounds provides an opportunity for the team to summarize all issues related to patient care, identify and prioritize tasks and delegate responsibilities. Board rounds should address specific needs of patient, maximize effectiveness of time spend by the bedside and minimize disruption to the process of daily patient reviews.

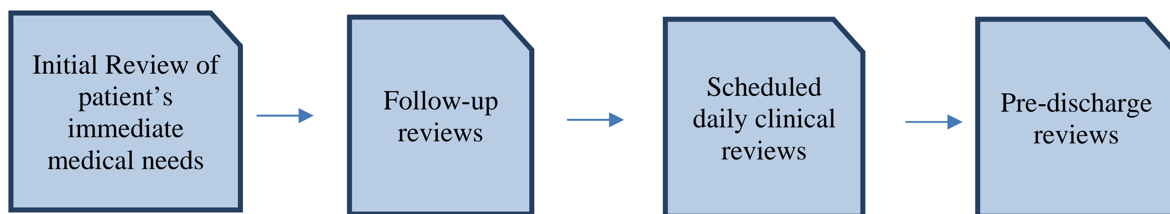
Intentional Rounds

Intentional rounds are “proactive patient rounds’ done by the nursing staff especially in the acute care setting. This is a structured, evidence-based processes for nurses to carry out regular checks with individual patients at set intervals which addresses essential care needs and patient experiences and help organize their workloads on the ward. The key aspects checked during these rounds are ‘Positioning’, ‘Personnel needs’, ‘Pain’ and ‘Placement’.

Ward-round preparations, planning and carrying out orders

Ward rounds has to be structured in such a way that maximum benefit is taken with limited available time, during the rounds. All required items should be made available during the rounds. Nurses should familiarize themselves with cases and be aware of the issues that need to be raised on the round. Pre-round preparations have to be done wherever possible and necessary especially for grand and multidisciplinary rounds. Post round decision-making and delegation of necessary tasks should be carried out for attaining effective patient outcomes.

Structured inpatient bedside reviews includes:-



Royal College of Physicians, Royal College of Nursing (2012)

Scheduling

Appropriate timing for ward rounds are crucial to ensure that clashes does not occur with other scheduled activities, especially with necessary investigations, patient transfersetc. It is common for a single round to involve visits to different wards and different medical teams conducting simultaneous ward rounds in the same ward creating resource and efficiency issues.

Resourcing

Ward rounds are to be started after determining the number of patients and where they are located. Additionally; the workload should be prioritised, identifying unwell patients who may need to be seen first or other patients awaiting imminent discharged.

The ward-round team should have a designated area to discuss patient care away from the bedside. Additionally desk space, patient notes and access to IT facilities should be made available if the need arise.

Training, education and audit

Ward rounds present a vital opportunity for all healthcare professionals to participate in education, training and clinical audit. Responsibilities lies with the consultant and senior nurses to structure the ward round to make the maximum benefit by providing educational opportunities for all involved.

Communicating with patients#

Ward rounds presents a vital opportunity to build trust and rapport with patients.Healthcare professionals should not underestimate the importance of interactions on the ward round from the patient's perspective. It is also important to understand that patient anxiety is usually subjected to information that is not given rather than what is communicated. Patients should also be informed of who will be seeing them in the rounds and also communicate a point of contact (e.g. Ward Sister/ allocated nurse), with whom they can raise questions after the ward round.

Dedicating time at bed-side and answering simplest questions will remove fear and anxiety and aid recovery. Opportunity should be provided to discuss the patient's care (with consent) with relatives or carers in a confidential setting away from the bedside. Allowing relatives and carers to book to see consultants at mutually agreeable timings can facilitate good communications and mitigate potential disputes, particularly when such individuals are unable to attend the ward rounds.

Protecting vulnerable patients

Inpatient populations increasingly consist of frail older people and it is important that healthcare workers are aware of their capacity and context. Patients with dementia and learning disabilities should be supported as far as possible in making decisions about their care. Nurses and junior doctors are well positioned to endure that their patient's need are identified and articulated during ward rounds.Family/carers should be involved as far as possible on behalf of such patients.

Protecting confidentiality and dignity

Confidentiality and dignity are much influenced by the ward layout and available space. All members of the ward round team should be aware of the immediate environment when discussing patient information.

Record keeping

Ward rounds must include a holistic assessment of the patient's needs. Reviews and decisions need to be properly recorded for continuity of care. Proper recording ensures completeness in case of medico-legal issues that may arise. Records should be kept in wards or Medical records room. All documents should be legible including name and signature of the person writing.

Ward-round safety

Ward rounds should prioritise quality, patient experience and patient safety. Mistake are more likely in a complex, chaotic environment such as a hospital ward, but a systematic human factor approach to identifying omissions and mistakes can reduce errors. All bedside reviews should address common safety aspects.Specific documents of previous 24 hours should be checked by doctors during the ward rounds.

Discharge planning

This is an integral part of the ward round and patient involvement should be encouraged. This includes setting an estimated date for discharge, with appropriate multidisciplinary input. Taking a planned approach to discharge helps prevent readmissions. (***Annex2***)

Conclusion

Ward rounds are an integral part of inpatient care which presents a key opportunity for the multi-disciplinary team carers to coordinate care for on-going care planning. It also builds trust and rapport between the patient and the team taking care. Establishing, promoting and sustaining culture change in relation to ward rounds require strong clinical leadership and commitment from all healthcare professionals.

Till date there are significant variability in the conduct and purpose of ward rounds. An organized and disciplined approach to ward rounds, with appropriate preparation, scheduling and review improves patient safety, quality and experience, while promoting efficient use of time and resources, strengthening team communication, performance and patient experiences.

Part II: Recommendations

1. **Multidisciplinary Involvement**
    1.1. Ward rounds should be seen as a priority by all members of the multi professional team.
    1.2. A senior nurse should be present at every bedside patient review as part of the ward round.
    1.3. The senior nursing team should be informed of all key decisions made on the ward round.
    1.4. Planned, dedicated time should be set aside for multidisciplinary ward rounds.

2. **Effective Team Working**
    2.1. Staffing issues and other adverse factors should be identified before the ward round.
    2.2. To engage all members of the ward-round team in the process, individual roles and responsibilities should be allocated at the start of the ward round.

3. **Board Rounds**
    3.1. Board rounds should be used to facilitate multidisciplinary input and prioritize bedside reviews.
    3.2. Board rounds should not replace face-to-face clinical reviews with patients

4. **Intentional Rounds**
    4.1. Assess patient comfort, pain levels and risk of pressure ulcers
    4.2. Assess personal needs and schedule care timings
    4.3. Arrange patient unit making sure items including medicines needed are available
    4.4. Attend to patient complaints

5. **Scheduling**
    5.1. Consultants and senior nursing staff should negotiate appropriate scheduling of ward rounds.
    5.2. The allocation of beds should minimize the number of ‘outlier’ patients for any given team.

5.3. Where possible, ward rounds should not occur simultaneously on the same ward.

5.4. Consultant-led ward rounds should be conducted in the morning to facilitate timely completion of tasks during the working day.

6. Training, Education and Audit

6.1. Ward-round organization should be included in the local induction for all new healthcare staff.

6.2. Training and education needs should be identified and promoted on ward rounds.

6.3. Facilitating access to local outcome data will promote improvements to care from clinical audit.

7. Communicating with Patients

7.1. Patients should be encouraged to prepare in advance for ward rounds.

7.2. Patient, carers and relatives should be provided with a ‘summary sheet’, detailing in a clear manner information discussed on the ward round that can be revisited at a later point.

7.3. Consultants should allow relatives to arrange to see them at mutually convenient times.

8. Vulnerable Patients

8.1. All members of the ward-round team should be introduced to the patient.

8.2. Nurses and doctors should ensure that all patient needs are identified and articulated during ward rounds and subsequent actions recorded and communicated back to the team as well as to the patient and their family/carers.

8.3. Patients with dementia and learning disabilities should be supported to make decisions about their care as far as possible.

9. Confidentiality and Dignity

9.1. Bedside curtains must be fully drawn before any physical examination of the patient.

9.2. Patients should be appropriately exposed only for the duration of a physical examination.

9.3. Organizations should ensure that clinical teams have appropriate facilities to ensure patient confidentiality; do not assume that discussions behind curtains remain private.

10. Record Keeping

10.1. Patient's records should be kept centrally to promote effective communication and team working.

10.2. All key decisions and actions made on the ward round should be clearly documented.

11. Ward-round and Safety

11.1. Drug charts must be reviewed by doctors for each patient during the ward round.

11.2. Ward-round teams should utilize locally adapted checklists to reduce omission, improve patient safety and strengthen multidisciplinary communication.

12. Discharge Planning

12.1. Patients and carers should be involved in discharge planning at an early stage.

12.2. Team should use a structured approach to discharge

12.3. Medications and outstanding issues should be carefully reviewed, using a checklist method.

12.4. Hospital team should ensure dear verbal and written communication of the discharge plan.

12.5. Post-discharge follow-up arrangements should be dearly communicated to the patient.

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Annex

Annex: 1
SCHEDULE AND GUIDANCE FOR WARD ROUNDS AT SECONDARY AND PRIMARY CARE LEVELS

MANAGEMENT SCHEDULE

Below mentioned schedule and guidance is to be followed by all Secondary and Primary care level institutions;

Round time:

Weekdays: -	**Morning:**	**8:00- 9:00**
	Evening:	**7:00 - 7:30**
Weekends: -	**Morning:**	**9:00 - 10:00**
	Evening:	**7:00 - 7:30**

Ramazan time:

Weekdays: -	**Morning:**	**9:00 - 10:00**
	Evening:	**9:00 - 9:30**
Weekends: -	**Morning:**	**9:00 - 10:00**
	Evening:	**9:00 - 9:30**

Duration of ward round depends on the number of cases and seriousness of the cases, any deviations from the given timing should be noted and informed to the management

1. Doctors on duty can spend a maximum of 45 minutes on each round. Over time must be noted accordingly of the time spent on each round only.
2. Maximum time for ward rounds should not exceed more than ONEhour. Wherever extra time is deemed necessary for ward rounds it has to be justified to claim overtime
3. Overtime could ONLY be claimed for ward rounds done during off hours and on holidays.
4. All ward rounds are monitored by doctors in charge.
5. Doctor's In-charge will be answerable to the management regarding overtime claim for ward rounds.

Guidance

1. Ward rounds should be conducted DAILY for ALL inpatients by the admitting Specialist / Medical Officer
2. Ward rounds are to be structured, efficient and non-hierarchical.
3. Admitting doctor be accompanied by the Ward Medical Officer during ward rounds, wherever applicable
4. Findings, change in treatments, complains and any other relevant information be documented in the IP folder during ward rounds. All documentations should be accurate and legible.
5. On Duty medical Officer should visit ALL Inpatients Minimum ONCE every shift.
6. Critically ill patients should be routinely monitored by On-duty Medical officer and should be seen by admitting specialist minimum ONCE in each Shift and whenever the need arises.
7. Inpatient medications should ONLY be changed with consultation and advice from the Admitting Doctor. However; documented standing orders should be carried out and where necessary informed to admitting doctor.
8. Emergencies should be attended immediately and critical situation to be managed, informed and discussed with on-call physician wherever possible at the earliest. Priority should be given to stabilizing the patient
9. Case discussions should be conducted among doctors for ALL critically ill patients, However; these discussions should not exceed more than 30minutes and Doctors involved should be from relevant areas ONLY
10. All referrals be informed to Admitting doctor and to referral specialist and documented in IP folder

Annex 2
Steps for Discharge Planning

1. Start planning for discharge before or on admission.
2. Identify whether the patient has simple or complex discharge planning needsand the patient and carerto be involved in your decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.
6. Review the clinical management plan with the patient / carer each day, take any necessary action and update progress towards the discharge date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalized care pathway and maximize their independence.
8. Use a discharge checklist 24–48 hours prior to transfer.

Organizational Support

Monitor and evaluate the causes, length and types of delays that follow the patient through the system.

1. Review the reimbursement notification procedure to ensure that timescales are sufficiently flexible around assessment

2. Carry out a simple hourly flow diagnosis to understand patient flows in and out of hospital.

3. Ensure that the discharge policy is up to date, and includes inter-agency agreements on joint working protocols.

4. Provide written information for patients so that they have clear guidance on what to expect and what is expected of them while they are in hospital.

5. Schedule ward rounds in a way that allows, at least daily, a senior clinical review of all patients in acute hospitals.

6. Ensure that all tests and treatments continue seven days a week.
7. Support nurses and allied health professionals to take on more responsibility for the discharge process, including the decision to discharge based on the agreed clinical management plan.

8. Ensure that mechanisms are in place for assessing the needs of those who are approaching the end of their life