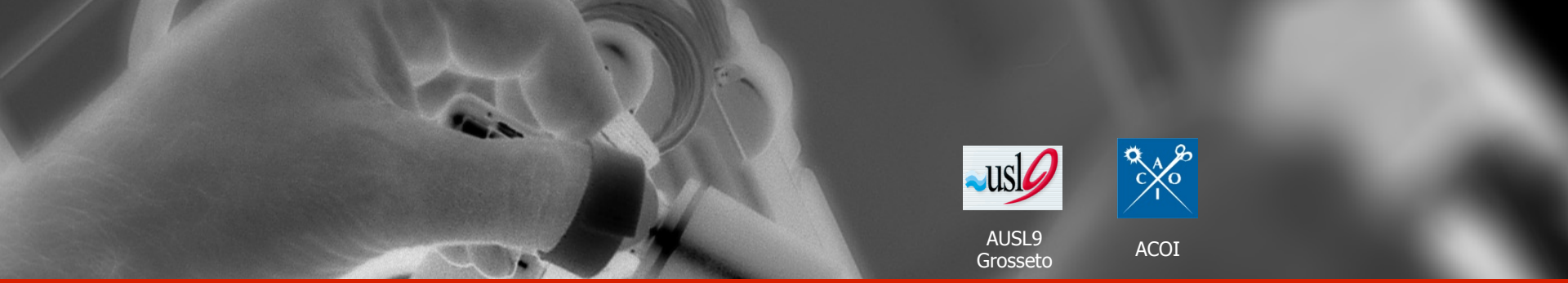

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Rinnovati modelli di presa in carico nell'organizzazione per intensità di cura
Ferrara 26 Marzo 2015

BRIEFING AND SURGICAL WARD ROUNDS:OUR EXPERIENCE

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EVIDENCES

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- The use of a multidisciplinary ward round increased their educational benefit whilst also reducing length of hospital stay

O'Mahony J Gen intern Med 2007

- The presence of registered nurses has been shown to reduce adverse events and mortality

Kane RL Med Care 2007

- Following the introduction of twice-daily consultant WRs in a large UK medical centre,average length of stay fell from 10.4 to 5.3 days ($p<0.01$) without increasing readmissions

Ahmad A Clin Med 2011

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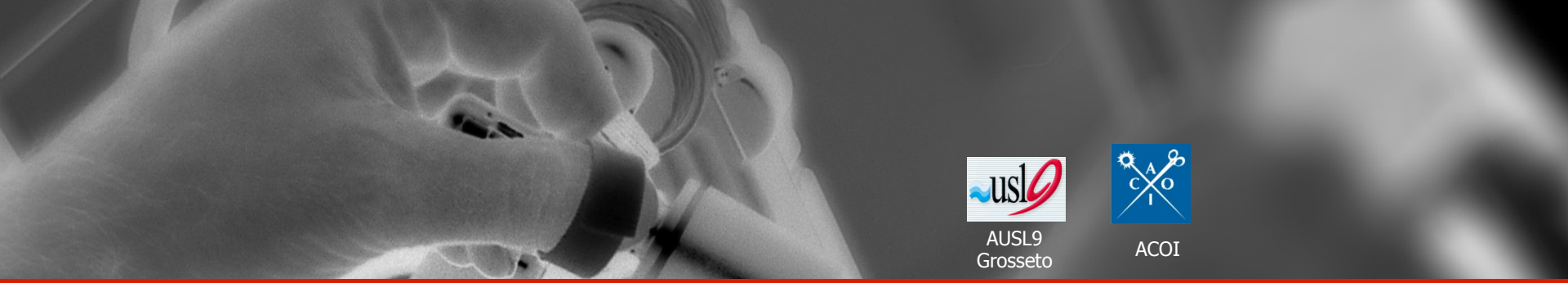
2012



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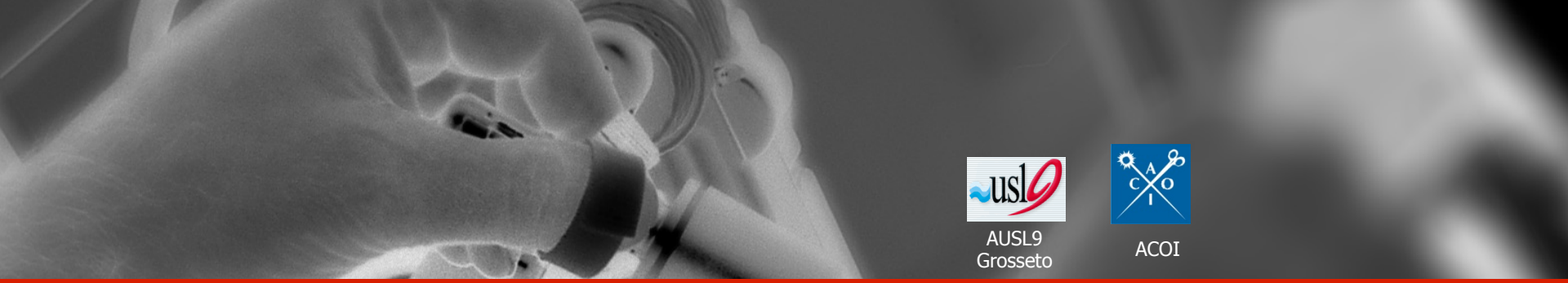
There is no single agreed definition of a 'medical ward round'. However, it can be described as a complex clinical process during which the clinical care of hospital inpatients is reviewed.[1] This process includes:

1. establishing, refining or changing the clinical diagnoses
2. reviewing the patient's progress against the anticipated trajectory on the basis of history, examination, NEWS (national early warning score)[2] and other observations, and results of investigations
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 checking to mitigate against avoidable harm
7. training and development of healthcare professionals.



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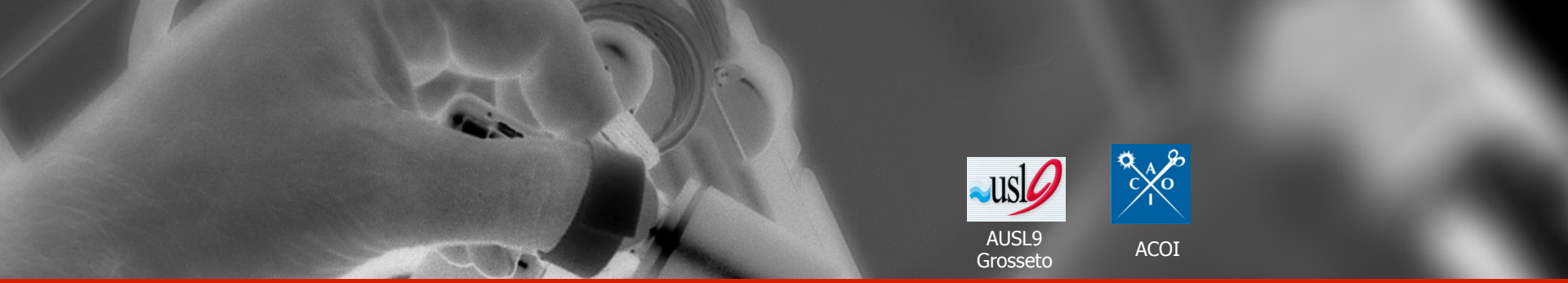
Key points

- Ward rounds are complex clinical processes that extend beyond a bedside review of care.
- They present a key opportunity to involve patients in their care, building trust and rapport.
- There is still significant variability in the conduct and purpose of ward rounds.
- Nurses provide the hub of patient care, and their involvement in the daily bedside clinical review is central to the effectiveness of the ward round.
- An organised and disciplined approach to ward rounds, with appropriate preparation, scheduling and review, improves patient safety and experience, while promoting efficient use of time and resources.
- Safety checklists reduce omissions and variation in practice, while strengthening team communication, performance and patient experience.
- Engendering and sustaining improvements to traditional ward round practices require strong clinical leadership, with all healthcare professionals fully engaged in improving patient care and effecting culture change.



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Recommendations for multidisciplinary involvement

- Ward rounds should be seen as a priority by all members of the multiprofessional team.
- A senior nurse should be present at every bedside patient review as part of the ward round.
- The senior nursing team should be informed of all key decisions made on the ward round.
- Planned, dedicated time should be set aside for multidisciplinary ward rounds.

Recommendations for effective team working

- Staffing issues and other adverse factors should be identified before the ward round.
- 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.

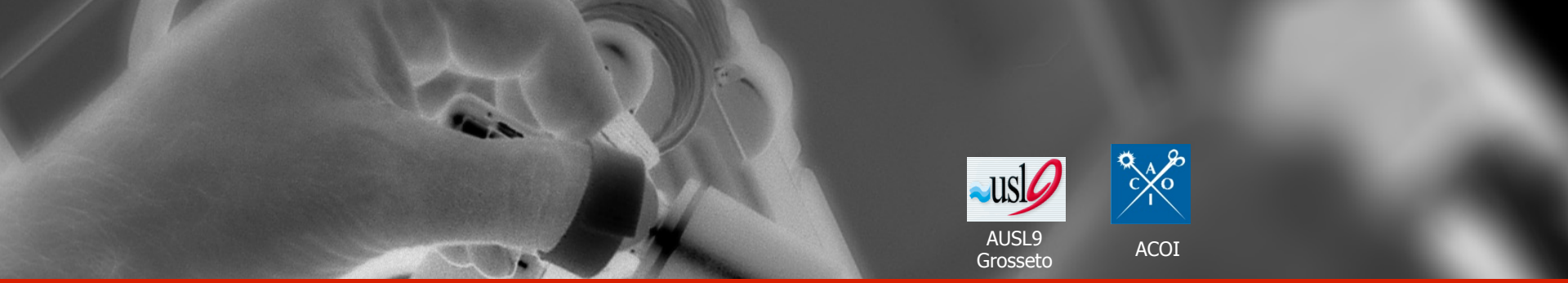

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Fig 1 Example of team roles on a multidisciplinary ward round. AHP = allied health professional; iv = intravenous; VTE = venous thromboembolism.

Doctor

- **Leads the round and introduces the team to the patient**
- **Provides an update of recent history, clinical examination and review of patient**
- **Reviews drug chart**
- **Provides update:**
  - + current problems
  - + responses to treatment
  - + test results
  - + medication
  - + information from patient and/or family and nurses

Nurse

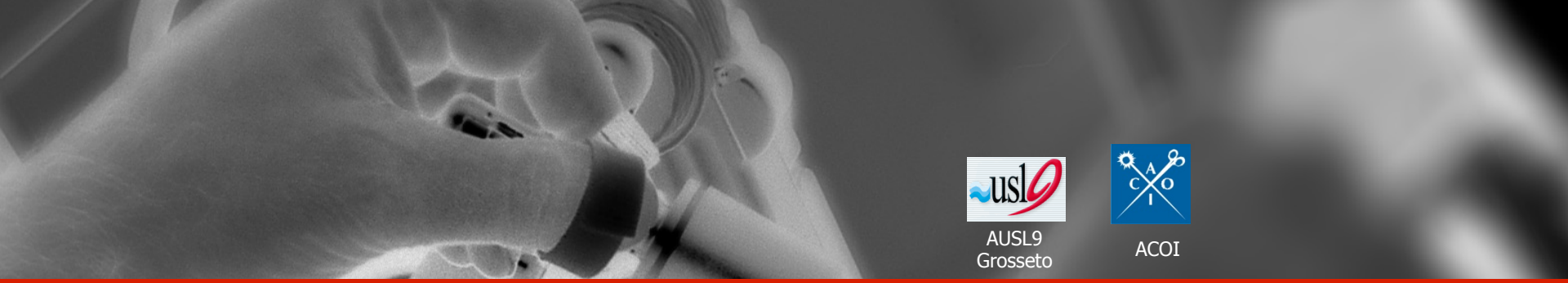
- **Provides update:**
  - + vital signs
  - + pain control
  - + nutrition and hydration
  - + elimination (urine and bowels)
  - + mobility
  - + confusion or delirium
- **Quality and safety checks:**
  - + urinary catheter
  - + review of iv lines
  - + VTE prophylaxis
  - + pressure ulcers and category
  - + falls
  - + infection control

Pharmacist and AHPs

- **Pharmacist:**
  - + reviews patient's medications
  - + checks VTE prescription
  - + drug chart review
- **AHPs:**
  - + update of care provided
  - + discharge and follow-up arrangements

Patient and carers

- **Provide updates:**
  - + current concerns
  - + discussions with other health professionals
  - + information from carers/family
  - + arrangements for discharge



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Recommendations for board rounds

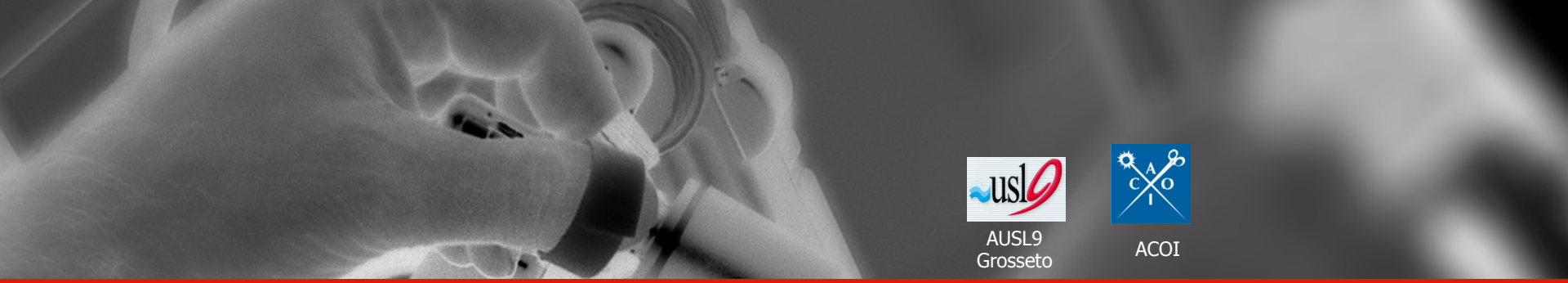
> Board rounds should be used to facilitate multidisciplinary input and prioritise bedside reviews.
> Consultant-led afternoon board rounds can help facilitate planning for next-day discharge.
> Board rounds should not replace face-to-face clinical reviews with patients.

Recommendations for ward-round briefings

> Preparation for the ward round should include a pre-round briefing.
> All members of the ward-round team should be debriefed after the ward round.

Recommendations for scheduling

> Consultants and senior nursing staff should negotiate appropriate scheduling of ward rounds.
> The allocation of beds should minimise the number of 'outlier' patients for any given team.
> Where possible, ward rounds should not occur simultaneously on the same ward.
> Consultant-led ward rounds should be conducted in the morning to facilitate timely completion of tasks during the working day.



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Recommendations for training, education and audit

> Ward-round organisation should be included in the local induction for all new healthcare staff.
> Training and education needs should be identified and promoted on ward rounds.
> Facilitating access to local outcome data will promote improvements to care from clinical audit.

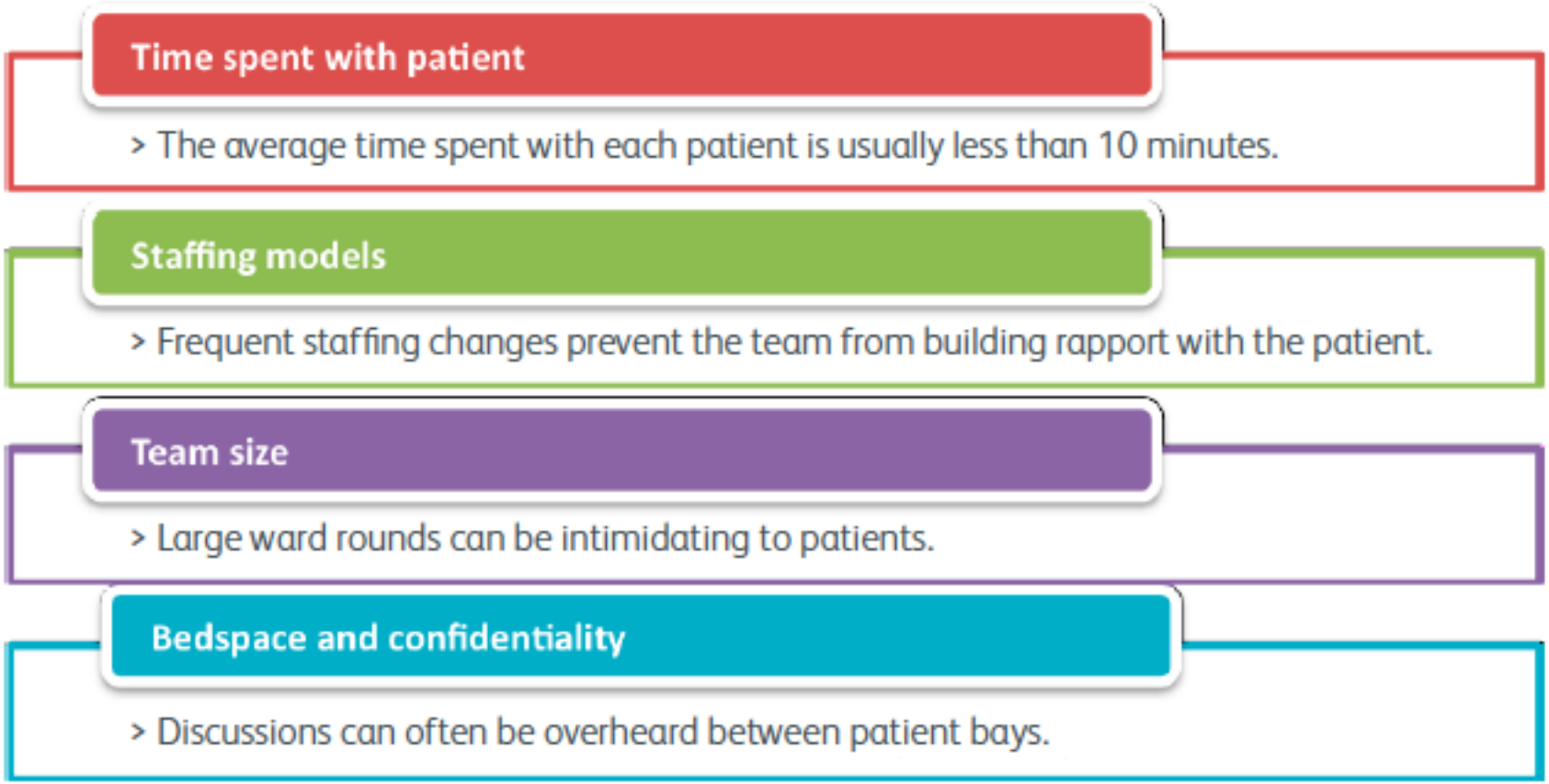
Recommendations for record keeping

> Patients' records should be kept centrally to promote effective communication and team working.
> All key decisions and actions made on the ward round should be clearly documented.

Recommendations for ward-round safety

> Drug charts must be reviewed by doctors for each patient during the ward round.
> Ward-round teams should utilise locally adapted checklists to reduce omissions, improve patient safety and strengthen multidisciplinary communication.

Fig 3 Barriers to communicating with patients.[8]



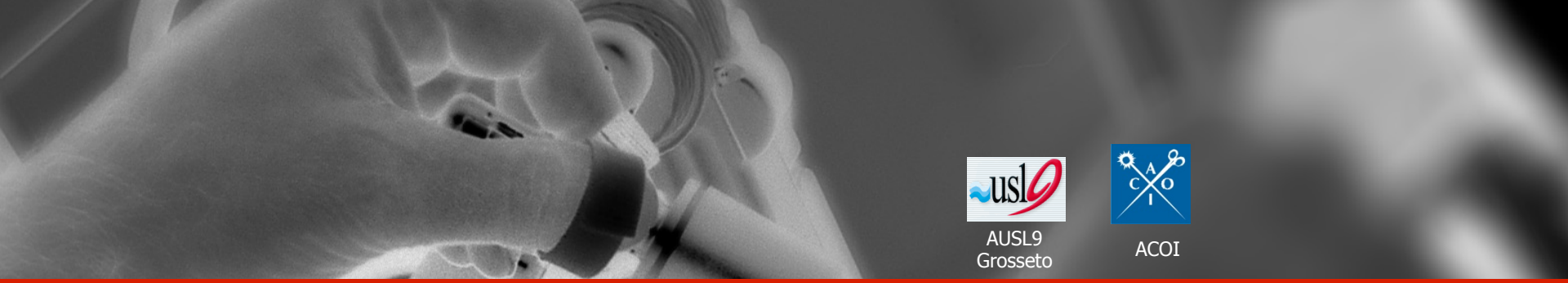


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Fig 4 Ward safety checklist by University College London Hospitals.[15] MRSA = methicillin resistant *Staphylococcus aureus*; TTA = to take away (medication).

Introduction

> Preparation

> Introductions

> Confirm patient identity

Continue your round >

Introduction

Time out

> Pause

> Confirm team understanding

+ observation chart/triggers
+ fluid balance and nutrition
+ speech and swallow assessment
+ MRSA status and treatment
+ infection control/antibiotics
+ scans and results
+ allergies
+ drugs chart review
+ VTE risk assessment and plan
+ drips and catheters/needed?
+ falls, skin care, pain, mobility

> Pause

Confirm patient understanding

Time out

Actions

> Documentation complete

> Actions assigned

> Discharge plans and objectives

> TTAs completed

> Communicate actions and timescales

Actions

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Rowlands et al. Patient Safety in Surgery 2014, 8:11
http://www.pssjournal.com/content/8/1/11

PATIENT SAFETY IN SURGERY

RESEARCH Open Access

Surgical ward rounds in England: a trainee-led multi-centre study of current practice

Ceri Rowlands[1], Shelly N Griffiths[2], Natalie S Blencowe[1,3], Alexander Brown[4], Andrew Hollowood[1], Steve T Hornby[5], Sarah K Richards[6*], Jennifer Smith[7] and Sean Strong[1,3] on behalf of the Severn and Peninsula Audit and Research Collaborative for Surgeons (SPARCS) and the Northwest Research Collaborative

Abstract

Background: Recent guidance advocates daily consultant-led ward rounds, conducted in the morning with the presence of senior nursing staff and minimising patients on outlying wards. These recommendations aim to improve patient management through timely investigations, treatment and discharge. This study sought to evaluate the current surgical ward round practices in England.

Methods: Information regarding timing and staffing levels of surgical ward rounds was collected prospectively over a one-week period. The location of each patient was also documented. Two surgical trainee research collaboratives coordinated data collection from 19 hospitals and 13 surgical subspecialties.

Results: Data from 471 ward rounds involving 5622 patient encounters was obtained. 367 (77.9%) ward rounds commenced before 9am. Of 422 weekday rounds, 190 (45%) were consultant-led compared with 33 of the 49 (67%) weekend rounds. 2474 (44%) patients were seen with a nurse present. 1518 patients (27%) were classified as outliers, with 361 ward rounds (67%) reporting at least one outlying patient.

Conclusion: Recommendations for daily consultant-led multi disciplinary ward rounds are poorly implemented in surgical practice, and patients continue to be managed on outlying wards. Although strategies may be employed to improve nursing attendance on ward rounds, substantial changes to workforce planning would be required to deliver daily consultant-led care. An increasing political focus on patient outcomes at weekends may prompt changes in these areas.

Keywords: Health manpower, Ward rounds, Seven day working, Consultant

Introduction

Ward rounds (WRs) represent a complex interaction between clinical staff and patients and are crucial to providing safe, high-quality care in a timely and efficient manner. They allow opportunities to review diagnoses in light of clinical findings and investigations, formulate on-going management or discharge plans and facilitate information sharing between patients, relatives, and healthcare professionals whilst also playing an important role in training [1,2]. Despite these accepted merits, it has been suggested that they remain a much-neglected part of inpatient care [1,3].

Recently, best practice guidelines for this important clinical activity have been published [1,2]. These include ensuring the presence of a senior nurse during every bedside review and that rounds should take place early in the day to facilitate timely completion of tasks, such as requesting investigations and discharging patients. The importance of senior leadership on WRs has also been highlighted, recommending that a consultant should review patients at least once, every 24 hours [2]. This issue may be of particular relevance to surgical specialties, as a recently well-publicised study has suggested that outcomes amongst patients admitted during weekends, or undergoing elective procedures towards the end of the week, may be less favourable [4]. One proposed cause for this 'weekend effect' is the perceived lack of consultant input into patient management outside of routine working

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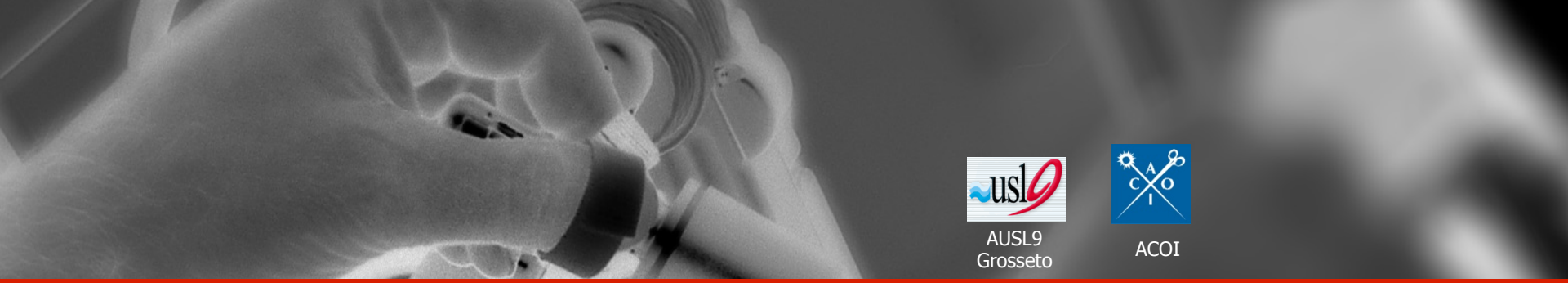

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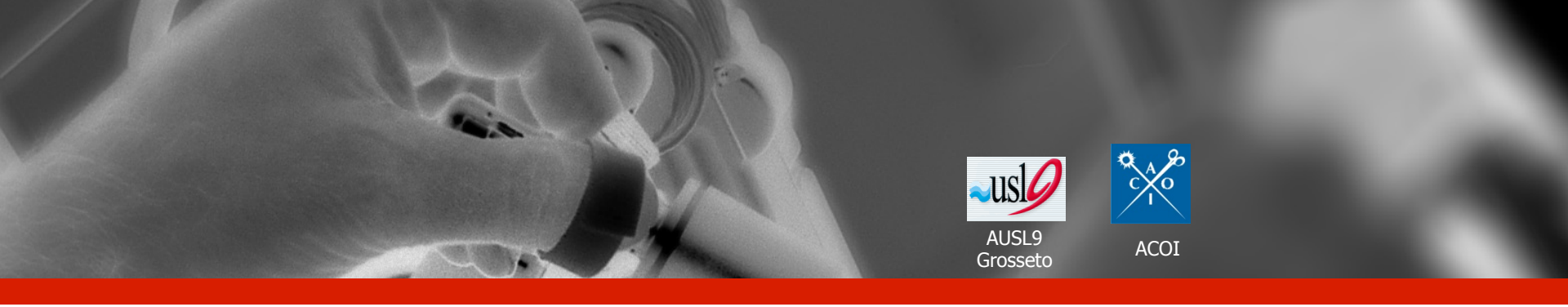
Table 1 Definitions of ward round categories

Ward round type	Definition
Acute admissions	Review of emergency admissions during the course of a 24 hour take period, often undertaken in the evening, distinct from the post-take ward round.
Post-take	Formal post-take round of emergency admissions, following completion of a 24 hour take period
Post-operative	Review of patients in the immediate post-operative period, often on an ad-hoc basis at the end of an operating list
Daily working round	Daily ward round of current inpatients under the care of a surgical firm
Other	Any round taking place not defined within a preceding category

Table 4 Nursing presence on ward rounds

Grade of doctor leading patient encounter		Number of weekday encounters n = 4915	Number of weekday encounters with nurse present n = 2169 (%)	Number of weekend encounters n = 707	Number of weekend encounters with nurse present n = 305 (%)
Consultant		2126	1106 (52.0)	550	229 (41.6)
Non-consultant	Staff grade	151	104 (68.9)	42	36 (85.7)
	Clinical fellow	86	59 (68.6)	15	10 (66.7)
	ST3+	1781	806 (43.6)	56	30 (53.6)
	CT1-3	572	30 (5.2)	34	0 (0)
	FY1-2	185	58 (36.3)	4	0
Unknown		14	6 (42.9)	6	0

(ST3+ = Specialist Trainee, CT1-3 = Core Trainee, FY1-2 = Foundation Year Doctor).



<50% WRs were led by consultant
<44%the level of nursing presence on WRs

“we have found that compliance with recent recommendations for WR practice is poor. The current drive within the NHS is toward twice daily consultant-delivered care with patients nursed in appropiate ward settings and improved nursing attendance at bed side reviews.”

Rowlands C ,Patient Safety in Surgery 2014

AREA CHIRURGICA “MISERICORDIA”GR

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Medico tutor
Infermiere referente
Cartella integrata
Briefing
Debriefing
Lettera dimissione medica
Lettera dimissione infermieristica

Chirurgiagenerale,vascolare,urologia
Ginecologia,urologia

Intensità medioalta elezione 34pz

9 — 13

Briefing 1:1 — Debriefing 1:1

Intensità medioalta urgenza 24pz

Week surgery 21 pz

chirurgia generale, chirurgia vascolare,urologia
orl,oculistica,ortopedia
ginecologia,ostetricia (194)

Day surgery 10+2 pz

CONCLUSIONI

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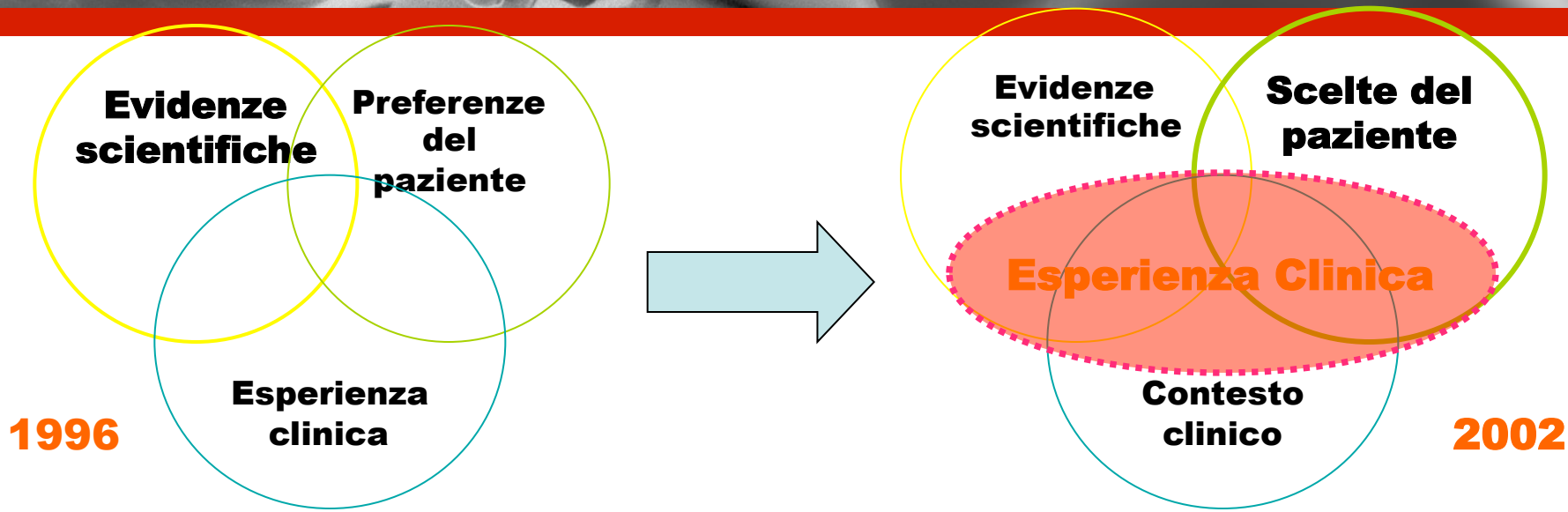
L'introduzione del modello per "intensità di cura" con aree omogenee di cura e team multidisciplinari ha introdotto di necessità la visita di reparto "disgiunta".Perchè questa risponda ai criteri di buona pratica già esaminati deve prevedere punti sostanziali di scambio tra le professioni:

- **Cartella clinica integrata**
- **Briefing**
- **Debriefing**
- **Lettera di dimissione integrata**
- **Presenza del medico tutor**
- **Presenza di infermiere referente**

Un nuovo modello di Evidence Based Medicine

Modello prescrittivo piuttosto che descrittivo



Ruolo centrale dell'esperienza clinica nell'integrare il contesto clinico, le migliori evidenze disponibili e le scelte dei pazienti.

Enfasi sulle scelte, non più solo preferenze, del paziente rispetto alle evidenze scientifiche

Haynes R.B. et al. EBM 2002 vol 8; 36-38