Royal College of Physicians

Royal College of Nursing

Modern ward rounds

Good practice for multidisciplinary inpatient review

Endorsed by NHS

Endorsed by Chartered Society of Physiotherapy

Endorsed by Royal Pharmaceutical Society

Endorsed by GIRFT Getting It Right First Time

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Foreword

Sarah Clarke
Clinical vice president,
Royal College of Physicians

The ward round remains a cornerstone of medical and nursing practice, underpinning the quality of daily care for inpatients in our hospitals. More than that, it provides unique opportunities for sharing knowledge and promoting effective communication between the multidisciplinary team and patients – and with relatives and carers.

Although there is no agreed national guidance for ward rounds, many of our dedicated and experienced NHS staff have developed innovative and cohesive practice in their own hospitals. We have been able to draw on this best practice to inform these guidelines, and I am grateful to colleagues in many NHS trusts who submitted supportive case studies, available as an appendix to this document.

The RCP and RCN first published guidance on ward rounds in 2012. This update offers a more detailed and thorough reworking of the principles, preparation and processes necessary for a successful ward round. Much has changed in the intervening years, with greater participation of other members of the multidisciplinary team who have increasingly extended roles, and the emphasis on true patient involvement and shared decision-making. Accordingly, this guidance was developed by a wider range of professional healthcare organisations and NHS England, in partnership with patients and carers.

Guidance is nothing without implementation, and in an NHS that receives a constant stream of guidance on all aspects of medical practice, our focus is to encourage adoption by setting out a clear vision of the modern ward round and a straightforward road map of how to realise it – while recognising that the obstacles faced by each NHS trust will be different. The five fundamental principles, each with three recommendations, offer a simple but effective template for any trust to map against their current practice and, if necessary, redesign their ward round processes.
Although the guidance is for use regardless of the clinical situation, we recognised earlier in the year a need for specific guidance on ward rounds and patient assessment during COVID-19, and produced a supplementary document.

Importantly, the Getting It Right First Time (GIRFT) NHS improvement programme, led by frontline clinicians, has endorsed the guidance and will ensure it is embedded into NHS practice. With 7 days ward rounds, streamlined decisions can be made to optimise patient care, the patient pathway and inpatient bed resources. New digital healthcare solutions should be adopted to facilitate the ward round and subsequent administration, inpatient care and discharge.

I would like extend my personal thanks to members of the working party for their leadership and commitment in producing the guidance, and in particular the RCP's John Dean and the RCN's Nicky Ashby for steering the guidance to publication in this extremely difficult year for the NHS, when all attention was focused elsewhere. With a brighter post-vaccine future to come, we can improve the inpatient experience for healthcare professionals and patients alike.

Foreword

Dame Donna Kinnair
Chief executive and general secretary,
Royal College of Nursing

It has been extremely satisfying to witness the huge amount of cross-organisational and cross-disciplinary collaboration that has gone into creating this report.

That work reflects, of course, the approach which must be taken in order to carry out effective ward rounds: it takes a multidisciplinary team, where the experience and expertise of individuals – no matter which branch of healthcare they represent – to contribute to the best outcome for each patient.

The patients, their families and carers are a crucial part of the ward rounds process too – they have a unique insight into the background, history and general health and wellbeing of the patient themselves. And that's why I'm particularly pleased to see patients, families and carers at the heart of this report.

Ward rounds are an essential component of clinical practice. Healthcare professionals need a framework not only to achieve the best possible outcomes for their patients, but also as a tool to help them deal with the increasing demands and pressures placed upon their resources. Patients, their families and carers see ward rounds as a chance for clarity, reassurance and advice from all those charged with their care. As one RCP Patient and Carer Network member put it: 'Explain and agree the plan for my care – and let me know how it's going.'

Effective multidisciplinary teams are wholly dependent on there being the right number of professionals, with the right skills, in the right place at the right time. It is paramount that governments invest in our healthcare system to ensure our patients get the safest and best care they need and deserve.

I welcome this report, and the RCN commits to doing everything it can to embed the practices it sets out as widely as possible.

Executive summary

Ward rounds are the focal point for a hospital's multidisciplinary teams to undertake assessments and care planning with their patients. Coordination of assessments, plans and communication is essential for effective and efficient care.

There are many examples of good, exemplary and innovative practice related to ward rounds in the UK. These show what is possible helping to achieve the best outcomes for patients.

The delivery of high quality and effective ward rounds are challenged by a number of factors including completing clinical priorities of staff, workforce gaps, inadequate planning, unwarranted variation in practice and an absence of training in the skills required to deliver complex multidisciplinary team care.

This can lead to frustration for staff and patients, and can lead to errors in care, longer stays in hospital and readmissions.

This report:

- brings together the good practice currently being delivered in the NHS.
- enables clinical teams to self-assess against good practice and identify priorities for improvement.
- offers organisational leaders a template for a standardised approach to multidisciplinary team inpatient assessment, which can be delivered through hospital-wide improvement programmes.
- describes how care can be delivered in hospital in partnership with patients, families and carers.
- reiterates and updates the guidance published in *Ward rounds in medicine: principles for best practice* (2012). While that guidance was welcomed, it has not been widely implemented.

This guidance has been developed by UK healthcare professional leaders, along with patients, and has the potential to revitalise care to improve outcomes. It describes best practice for multidisciplinary patient review in hospital wards which teams should work towards. Adaptation of the recommendations to specific patient groups and care settings would be expected.

Preparation

The purpose of ward rounds is to monitor the patient's progress, clarify diagnoses and relevant problems, and for the clinical team to work with the patient to coordinate, document and communicate a management plan. This should include goals and discharge plans. Ward rounds should also incorporate clinical safety checks and education.

Effective ward rounds can only be delivered in a well-organised ward by a team that is likely to include new and extended roles of healthcare professionals and other staff. Ward teams must agree roles and responsibilities, and necessary equipment must be available and maintained. The scheduling of ward activities, including ward rounds, is key to ensuring that staff and patients are available to participate in a calm environment.

Patients and families must be prepared for ward rounds and need to understand when they will happen, who will be involved and how they can maximise the opportunities presented by ward rounds. This will include written and verbal information for patients. Mechanisms for patients, families and carers to develop questions and communicate their priorities and needs should be in place.

Ward rounds should happen daily in acute hospitals, led by senior clinicians, though not all patients will require review every day.

The shift handover should gather information on the patient's condition, which then feeds into multidisciplinary team planning by all members of the team prior to the ward round in a board round or huddle. This will provide an overview of all patients on the ward, prioritises those who require early review, and identifies actions for team members to take.

The board round should particularly highlight delays in care that can be addressed, as well as discharge planning. Patients requiring specific infection prevention and control measures should be highlighted. Information that will affect decision-making should be collated before the round's bedside review. This may affect the planned timing of ward activities, including the rounds.

The ward round process and team

The ward round should review the most unwell patients first, followed by those who could be discharged that day, before completing reviews of the remaining patients. The ward round lead should clarify team members' roles and set the tone for participation and learning for each round. It is particularly important to begin the round at the agreed time, in order to ensure efficiency and maximise teamworking. There should be mechanisms in place that allow all professional staff to input into ward round discussions and decisions. The continual presence on the ward round by all multidisciplinary team members is not necessary, but input and involvement from the staff who know the patient best – usually the nurse directly caring for the patient – is essential. For patients receiving rehabilitation, this may be a therapist. Without this involvement, it is unlikely that the best clinical decisions will be made. Pharmacy input is also essential for most patients and, where resources allow, there are demonstrable benefits to the ward pharmacist being part of the ward round.

Ward round team members should be introduced to patients individually. Communication with the patient should take place at eye level, in as private an environment as possible, and this is particularly important at the start and end of the assessment.

The ward round's review and decision-making processes collate all relevant information for discussion on the patient's condition and progress. Providing and assimilating this information should be delegated to clearly defined team members. Dialogue scripts for the leader and professional members provide structure and have demonstrated benefit. Clinical reasoning and decision-making should be documented.

The team should use structured documentation that incorporates safety checklists and key elements of plans, such as escalation plans and details of what has been communicated with patients. This must incorporate medication and monitoring chart review. Written summaries for patients are helpful.

More detailed discussions with patients, families and carers around difficult decisions should take place outside the ward round to allow adequate time and an appropriate environment. Other more complex assessments should also take place outside the ward round.

Interruptions during the ward rounds are frequent, but can be minimised by careful scheduling of activities and staff roles. Ward coordination is a key role, and the individual responsible for this should not have other competing responsibilities, particularly when many ward activities are happening, but the coordinator does not have to attend the whole round, and they are likely to be interrupted. The coordinator provides vital input to pre- and post-ward round board rounds/huddles, as well as receiving regular updates during the round so that care can be progressed.

Ward rounds should not last longer than 120–150 minutes, in order to prevent cognitive fatigue. If a longer round is necessary, then adequate breaks should be planned. Team roles should be divided to ensure that tasks, such as ordering investigations or completing transfer documents, can be done during the ward round, and are not delayed until the end. This should be planned whenever possible.

The ward round team lead should update the multidisciplinary team after the ward round to ensure that plans are agreed and actioned within agreed time frames. It is also important to agree who will update patients on the progress of the plans during the day. A further check on progress of plans should occur in the late afternoon. Friday rounds must plan for the weekend and may need to be extended.

Education is an important part of ward rounds and should be considered for all participating professionals. Key learning points, and actions for further learning, should be summarised at the end of the round. The training of staff in ward round practice and functions should be part of professional training, including simulation.

Electronic patient records (EPRs) bring together patient information and help with structured documentation and decision support. However, they can distract the team's focus from people to screens. Ensuring direct communication at eye level with patients, and eye contact amongst team members, reduces this. A nominated scribe will also help. Mobile devices can help share information between staff and patients. Training in their use, and hardware availability and maintenance, must be planned.

Improving ward rounds

Most ward rounds in UK hospitals require considerable improvement, and research and quality improvement is necessary to inform effective practice. Some elements of best practice may be more difficult to implement until current persistent staffing deficiencies have been addressed. However this should not prevent teams and hospitals developing improvement plans for ward rounds using the best practice guidance in this report. Ward leads should meet regularly to review quality measures related to ward rounds, and adapt approaches where needed, using both this guidance and emergent new evidence.

The continual presence on the ward round by all multidisciplinary team members is not necessary, but input and involvement from the staff who know the patient best – usually the nurse directly caring for the patient – is essential.

An effective ward round

Shift handover

Board round

- Patient symptoms and care needs
- Patient and family questions
- Uniprofessional reviews
- Physiological monitoring
- Investigation results
- Prioritisation from board round

Briefing

Ward round

Team

Lead
Note keeper
Patient advocate
Communicator
MDT members
(as appropriate and available)

Actions

Confirm diagnosis and problems
Address patient's questions
Review progress against plan
Check safety measures
Teach and learn
Revise plan with patient
Complete structured documentation
Assign actions

Debrief

MDT handover

- Agreed next reviews
- Liaise with external teams
- Implement management plan
- Feedback progress to patient

Ward round fundamentals

Key principles	Summary recommendations
Well led	Protect and dedicate time for consultant* led delivery. Create an environment for active participation of all team members in care planning. Agree roles for multidisciplinary team members and their input to ward rounds.
Structured	Schedule a pre-ward round board round, to be attended by the multidisciplinary team. Review patients in priority order on ward rounds. Use standardised documentation including safety checklists.
Effective teams	Schedule ward rounds to prevent conflicts with other ward activities. Structure and plan shift handovers to inform board and ward rounds. Debrief and handover multidisciplinary plans after the ward round.
Patient involvement	Actively involve patients in ward rounds, with family and carers as required or requested. Agree communication with the patient on progress of their plan following the ward round. Plan complex and difficult conversations or assessments outside of the ward round.
Education, learning and improvement	Use each ward round as an opportunity for learning. Continue to develop the skills required for all staff to actively participate in ward rounds. Assess ward round quality against best practice.

* In some settings this may be senior nurses or therapists (see report case studies)

Introduction

Multidisciplinary assessment for care planning is essential for the safe, effective and personalised care of patients admitted to hospital.

This report provides updated best practice guidance for multidisciplinary teams and clinical and operational leaders caring for, or supporting patients in wards. The guidance can also be used by patients, their families and carers to recognise what good care looks like, and what patients should expect from ward rounds. It outlines key elements of patient- and family-centred multidisciplinary team review and care planning, and how this can be facilitated through the focus that ward rounds provide for staff and patients.

When we refer to patients, we also include family members, carers and significant people the patient wishes to be involved.

Ward rounds in medicine: principles for best practice was published in 2012 by the Royal College of Physicians (RCP) and Royal College of Nursing (RCN). While widely referenced, there is continued frustration among clinicians that multidisciplinary care planning and communication for patients in hospital is still far from optimal. This creates inefficiencies, increased risk, and care plans that are not appropriately agreed with patients, carers and families.

Ward rounds are a fundamental function of clinical practice. Acute care capacity pressures in hospitals across the UK – and demand and capacity pressures across the wider health and social care system – have led to a renewed focus on the importance of ward rounds for safe, effective and efficient communication and clinical decision-making.

The hospital working environment has changed since the 2012 guidance was published.

Key elements that have changed include:

- significant staffing shortages in doctors and nurses[1,2]
- clinical professionals undertaking extended roles
- the RCP's *Safe medical staffing guidance*,[3] and staffing guidance for other clinical professions[2]
- the increasing use of multiple electronic record systems
- increasing numbers of frail older people with potential cognitive impairment in hospitals
- hospital occupancy pressures, including patients being cared for by teams across multiple wards, sometimes called 'outliers' or 'boarders'
- national guidance on patient flow from the NHS Emergency Care Improvement Support Team endorsed by RCP and Society for Acute Medicine[4]
- other national guidance on care delivery, for example acute clinical deterioration or discharge[5,6]
- a better understanding of human factors that influence decision-making and teamworking
- a greater emphasis on shared decision-making and patient and family/carer involvement
- the need for better advance care planning and end-of-life decisions.[7]

*This report uses the terms 'ward' and 'ward round' extensively. In the UK, a ward is a physical space in which a group of patients receive care from a common nursing team. It can sometimes be called a unit. Ideally the other members of the multidisciplinary team will also be common to that ward's patients, but often have responsibilities across a number of wards. The processes described should occur in each ward or unit, and be replicated wherever possible within the organisation. Some members of the team may therefore be participating in multiple ward rounds in multiple wards or units.

While some of the recommendations may appear basic, our evidence† suggests that a consistent approach as described in this report is uncommon. Although it is rare for all recommendations to be fulfilled, the report draws from good practice that is happening in the UK or internationally. Current constraints make it challenging to deliver care as described, but all teams will find areas where they can improve practice. The recommendations are not proscriptive, as local context will determine how these principles can be applied and adapted to specific patient groups and settings.

The effectiveness of ward rounds should be monitored, their benefits maximised, and the processes, behaviours and skills required should be continuously improved.

Teams should self-assess their current practices against this guidance and identify priorities for improvement, and hospitals should set up improvement programmes to support these changes. We will be running implementation programmes to enable service changes by teams and hospitals.

What's important to patients: quotes from RCP Patient and Carer Network members

'It's important to see the clinical team focus on me, (or my family's)care and progress.'

'I want to be involved in discussions and decisions.'

'Give me confidence that you are an effective and efficient team.'

'Explain and agree the plan for my care – and let me know how it's going.'

There is continued frustration among clinicians that multidisciplinary care planning and communication for patients in hospital is still far from optimal.

In our surveys, nurses were sometimes perceived by medical staff to be too busy with nursing tasks for increasingly complex patients, however nurses expressed frustration at not being always involved in wards rounds.

'The junior staffing rotas are so fragmented that attendance on sequential ward rounds is poor and their learning opportunities reduced.'

† Evidence was gathered through member surveys, and through the committees, networks and forums of the participating professional and patient groups. Many examples of good practice were submitted.

Background and context

A

Background and context

The ward round was first noted in the 17th century, when the visiting physician would 'round' patients on a ward, or in a hospital, in the same way as they would 'round' patients in their homes. This practice has subsequently evolved into a multidisciplinary approach for communication, monitoring progress and planning.

Despite the necessity for organised, regular, clinical reviews of hospital inpatients, defined quality indicators and evidence to guide best practice for ward rounds was lacking until our 2012 guidance. There remains considerable variability in the organisation, efficiency, quality, delivery and patient experience of ward rounds. A summary of results from our surveys is shown in Appendix 1.

The purpose of ward rounds

Ward rounds are the focus of multidisciplinary care planning and review, and for each individual patient on a ward or unit under the care of a particular team. Traditionally, this occurred in a processional manner and encompassed all patients under one consultant's care, but the emergence of allied activities that assist care planning mean this will not always be appropriate.

These activities must be planned and coordinated by the whole care team alongside other components of inpatient care.

The purpose of ward rounds is to ensure:

- clarity of diagnosis(es) and relevant problems
- prioritisation of problems and treatments, and use of resources, eg medication and investigations
- coordination of a management plan, including goal setting and discharge planning
- monitoring of the patient's progress, including medical, functional, emotional and cognitive state
- management of clinical risk, eg venous thromboembolism (VTE) prophylaxis, severity of illness, drug interactions, level of care required
- clear documentation of clinical assessment, reasoning and plans
- communication with the patient and between staff
- opportunities for education and training.

There remains considerable variability in the organisation, efficiency, quality, delivery and patient experience of ward rounds.

The ward round reviews must be informed by patient, family/carer and multidisciplinary inputs. With the complexity of modern teams, it may not be possible to convene the whole multidisciplinary team at one location, eg the bedside, but the mechanism for each individual to offer their contributions and input must be planned for each ward and for each patient.

What patients should expect

Ward rounds present a focal point for sharing information between the patient and care team. Healthcare professionals must not underestimate the importance of the ward round to patients, relatives and carers. For patients this demonstrates the care team focusing on their condition and needs. Dedicating time by the bedside, or in another private location, to provide clear explanations about symptoms, diagnoses and disease severity, and to answer questions, can reduce a patient's fear and anxiety and can build confidence in the care that they receive. Healthcare professionals must take time to carefully listen to the patient and understand what is important to to them, and to answer questions and concerns.

The modern multidisciplinary team

Best practice: multidisciplinary teams

- Agree principles, standards, functions and structure for local ward teamworking.
- Clarify each team member's role.
- Include each tier of decision-makers as per the RCP's *Safe medical staffing*[3].
- Agree methods and times of communication.
- Keep membership of the ward's multidisciplinary team consistent wherever possible.
- Ensure opportunities for team education and development.
- Regularly review team performance.

Care in hospitals is delivered by multidisciplinary teams. The members and functions of these teams have evolved over recent years and differ between clinical environments. Individual clinical assessments by team members must be coordinated, as they all contribute to care planning and decision-making. Care delivered through an agreed team function and structure will ensure timely and well-planned care, and will enable effective ward rounds. The RCP has summarised many key aspects of how modern teams should function, develop and learn, and the evidence of the impact of effective teams.[8] Features of such teams include clear roles, good communication, common goals, a flattened hierarchy, and team-based education and development. These are dependent on many factors including how well a workplace enshrines and values these themes.[9] Keeping consistent team members at the ward or unit level helps teams function well and should be planned across professional groups.

Ward team members will include consultants, doctors in training or non-training grades, advanced practitioners (nursing and AHP), nurses, physician associates, pharmacists, physiotherapists, occupational therapists, speech and language therapists, dieticians, social workers and healthcare students. Non-medical professionals commonly take advanced roles extending beyond what is seen as their traditional role, and may be part of the tiers described in *Safe medical staffing*. For example, nurse or therapy consultants may lead and coordinate clinical decision-making, and advanced nurse practitioner and advanced practice therapist roles may include many elements traditionally performed by doctors. Many professions also have assistants or technicians to perform key functions on wards and who might work across professions, eg therapy or pharmacy assistants/technicians. Some areas have also developed administrative assistants to support clinical roles.

Other ward staff also play a role in ward rounds. Nursing support workers are often the most closely involved with patients, and understand their needs and concerns. Clerical and administrative staff, such as ward clerks, offer support to the functionality of ward rounds. Additional roles to help the smooth running of hospitals, such as clinical flow facilitators, must be seen as part of the team and their role should be clearly defined. Links to key clinical professionals outside the hospital, eg case managers, also need to be clearly defined with agreed communication mechanisms.

Figure 1. One possible healthcare team. Taken from the RCP's *Improving teams in healthcare*.

Three tiers of decision-making skills by clinical professionals are described in the RCP's *Safe medical staffing*.[3] This should be included in planning and coordinating the ward team.

Table 1: Tiers of clinicians

Tier 1: Competent clinical decision-makers	Clinicians who are capable of making an initial assessment of a patient.
Tier 2: Senior clinical decision-makers	The 'medical registrars' – clinicians who are capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatment.
Tier 3: Expert clinical decision-makers	Clinicians who have overall responsibility for patient care.

▲ From the RCP's *Guidance on safe medical staffing*.

The expansion of modern teams has an impact on the patient and their perspective of ward rounds. The purpose, identity and make-up of the ward round team may be clear to hospital staff, but not necessarily to patients.

Stein *et al* have developed the concept of accountable care units and Structured Inderdisciplinary Bedside Rounds (SIBR) (See case study document.) [10] This approach describes key patient care and assessment roles that are coordinated through ward 'team huddles' and interdisciplinary bedside reviews.

The process

B

The process

Scheduling ward rounds and considering allied activities

Best practice: scheduling

- Schedule ward rounds, board round and associated activities to prevent conflicts.
- Include before, during and after ward round activities in the schedule.
- Scheduling should maximise patient flow. Shift times may need to be adjusted to accommodate this.
- The ward round lead should ensure the round adheres to the agreed schedule.
- Ward rounds should not last more than 120–150 minutes, or have agreed breaks, to prevent cognitive fatigue.
- Dialogue scripts can help to correctly pace ward rounds.
- Agree mechanisms to prevent unnecessary interruptions.
- Include the review of possible outliers or boarders in the schedule.

Ward rounds require joint multidisciplinary and profession-specific assessments, care and plans. To be effective, they must be scheduled to incorporate the input of all team members. They should be timed not to clash with other activities, such as medication rounds, meal times, visiting hours, or ward rounds being conducted by other teams. Maximising the use of handovers, huddles and board rounds, as well as ward rounds, ensures consistent communication, but must not create duplication. It is not uncommon for a single ward round to involve visits to several wards, but this should be minimised.

Different medical teams conducting simultaneous ward rounds in the same ward creates difficulties for many members of the team. If this is likely, then timing should be agreed to minimise conflicting requirements. Scheduled planning of ward rounds should consider the before, during and after phases aligned with internal and external activities in order to deliver the agreed care, and also take into account the team members' other professional duties. Timings should allow preparatory work to take place before the ward round, and this may require adjustment or alignment of shift times; recognition that some team members work across a number of wards may influence agreed times. It must also consider the impact of multidisciplinary decisions, so that subsequent discharge plans, involvement of other teams, or further treatments and investigations can flow smoothly from decisions made on the round. An agreed and adhered schedule optimises attendance, communication and effective planning, and enables efficient care delivery.

Timing is also important for patients, so they know when to expect an update and can offer input into their care plan.

Interruptions prolong the round, and disrupt the concentration of the multidisciplinary team, and so should be avoided where possible. To assist this, teams should put mechanisms in place for non-urgent messages to be 'held' until the end of the ward round. For prolonged ward rounds regular 'pauses' may be required in order to ensure adequate input and delivery of actions, eg at the end or beginning of each bay of patients. Cognitive and physical fatigue will occur after 120–150 minutes[13,14] and ward rounds should be planned to be completed within this time. If more time is required, the team should agree to take breaks as necessary. The ward round lead must ensure that commencement and completion schedules are followed. Debriefing and multidisciplinary feedback should be used to prevent delays or disruptions for team members in the future.

A dialogue script can be used to provide the opportunity for all multidisciplinary team members to contribute to the ward round. The ward round leader should follow this to ensure contributions from all team members, patients, carers and family members as necessary. (See 1Unit in case studies document).

The SAFER flow bundle[15] has been developed as a structured approach to reduce delays for patients in adult inpatient wards (excluding maternity). It is a guiding set of principles (similar to a care bundle) to help reduce variation by standardising ward and board round processes to ensure that all patients receive an effective senior clinical review and have a clinical plan agreed by the multidisciplinary team, including clinical criteria for discharge and an expected date of discharge.

The five core components of the SAFER care bundle are:

S — **senior** review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A — **all** patients will have an expected discharge date (EDD) and clinical criteria for discharge (CCD), set by assuming ideal recovery and assuming no unnecessary waiting.

F — **flow** of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am.

E — **early** discharge. Thirty-three per cent of patients will be discharged from base inpatient wards before midday.

R — **review**. A systematic multidisciplinary team review of patients with extended lengths of stay, with a clear 'home first' mind set.

There are many activities that require multidisciplinary input to care planning on wards.

These elements include:

- shift handover
- handover on patient transfer of location
- initial clinical patient assessment
- medicines reconciliation
- board rounds/huddles
- multidisciplinary team care planning meetings
- discharge communications
- daily clinical assessments, including multidisciplinary bedside review.

The key to successful care planning and communication is that these elements are planned, structured and integrated. Each ward team should agree its approach to all of these components, and particularly the times when healthcare professionals need to be together for key interactions and communications.

Different medical teams conducting simultaneous ward rounds in the same ward creates difficulties for many members of the team.

Before the ward round

Best practice: before the ward round

- Structured information from shift handovers should be available.
- Results of investigations should be available and prepared.
- Ensure patient questions and concerns are gathered.
- Board round or huddle to prioritise patients and highlight issues from the whole team.
- Undertake individual professional reviews to inform multidisciplinary bedside review.
- Put in place arrangements for patients with translation needs or other communication difficulties.

The common approach is to begin the day with nursing handovers. Teams should agree the elements of a structured handover that feed into ongoing care planning. This includes patient status, changes during the shift, and patients', relatives' and carers' concerns.

The multidisciplinary team should convene for a board round or huddle at the start of the shift. Board rounds provide an opportunity for multidisciplinary teams not only to prioritise bedside reviews, but also ensure discharge planning momentum and communication, and highlight delays and actions. These rounds enable the team to quickly review any outstanding issues, eg results of investigations, communications with relatives / parents / carers and advocates, input from other healthcare professionals etc. They can also highlight key contextual issues, such as staffing gaps, operational incidents etc. They should take place around patient summary boards, for instance a 'white board' (which are increasingly electronic). The round should take place in a space that can accommodate the team, ensure confidentiality, and prevent interruptions.

Patients are discussed in a structured format to identify key actions and priorities for clinical team members, eg the physiotherapist may plan a mobility assessment that will then complement medical and nursing assessments for a multidisciplinary plan.

The 'Sick, Out today, Rest, To come in' or SORT approach[16] to the ward round promotes review of the sickest patients first, followed next by those who are likely to be discharged, thus balancing individual clinical urgency and essential system flow. These patients are identified at the board round / huddle. Patients requiring specific infection prevention and control measures should be highlighted.

The team should aim to prepare the input from each professional before the ward round, so that the information, eg investigation results or therapy assessment, is not 'hunted for' at the ward round, but is readily available to share with the patient and team for decision-making. The work on structured interdisciplinary bedside review (SIBR)[10] emphasises the importance of structured information from handovers, and from uniprofessional assessment that feeds into multidisciplinary assessment with the patient. Office-based ward rounds have been used to ensure all information is collated away from the bedside before the bedside interaction.

It is equally important to prepare the patient, relative or carer for any exchange with the team. Providing adequate information about the purpose of the ward round and, if appropriate, leaflets on diagnostic tests, medicines[17] and other procedures can help prepare patients for ward round discussions. This gives them time to consider questions and reflect on information that the round team may need to agree the right management plan. If the patient is not going to be seen on this particular ward round, this should be explained to them. Patients should be informed of who will be seeing them on the ward round and provided with a point of contact (a specific named member of the ward team), with whom they can raise questions afterwards. Expectations may be different for individual patients and families in relation to family/carer presence for the ward round and the sharing of information. Formal arrangements for these communications will help save time and reduce any potential miscommunication.

Pre-ward round discussions with relatives or carers are particularly important for patients with learning disabilities or cognitive impairment, in order to establish changes in behavioural traits which otherwise might be attributed to their underlying condition. Additional support should be arranged for those patients with specific needs, eg translation, communication difficulties, those experiencing confusion, and patients with mental health needs

During the ward round

Best practice: during the ward round

- Begin by assigning roles and setting expectation of learning.
- Confirm diagnosis and problems.
- Address patients' questions and concerns.
- Review patients' progress against plan.
- Confirm or revise escalation plans.
- Check safety measures, including medication review.
- Summarise a revised plan, goals and actions with the team.
- Progress actions during ward round when possible.
- Teach and learn.
- Revise plan with patient.
- Communicate and document the review and plan, assigning key actions.

The ward round should begin with a briefing, in which a nominated lead, usually the senior clinician, should:

- brief the team on the purpose and context of the round
- allocate roles and tasks to team members (see Table 2)
- set expectations about learning
- create the environment for an open forum for the team to discuss and familiarise themselves with patients' cases and issues that need to be raised during the round
- confirms priorities and context eg staffing.

The central component of the review is the assimilation of the information on the patient's condition and progress (Figure 3). This leads to clinical reasoning around active diagnoses and problems, prioritisation of interventions (including which to start and which to stop), the day's goals, and planning the next stage of care towards discharge. Ensuring all team members have a common understanding of this is vital. Clinical criteria for discharge must be agreed and documented, so that these can be followed by the appropriate team member, and may not need to wait until the next ward round if met. It is essential to agree follow up, including communication of actions and time of next review.

With current staffing levels and multiple priorities, the 'presence' on the ward round of multidisciplinary team members is less important than the inputs, joint discussions when needed, and agreed action being well communicated by the whole team. However, it is essential that the staff who know the patient best are able to contribute to discussions and decisions at the patient's bedside. This is usually the bay nurse or named nurse, but may be a therapist in patients receiving rehabilitation. Their input is also essential to any discussion or information gathering that happens away from the bedside, and in ongoing communication. It is also particularly beneficial for pharmacists to attend the ward round, particularly in medical wards, as their presence has been shown to double the number of impactful interventions.[18] Therapists should be present when rehabilitation is a component of care. Any of these inputs being relayed second- or third-hand reduces their accuracy, and prevents any potentially unnecessary discussions. Team members physically convening at these times not only increases the quality of decision-making, but also builds teamworking, and displays these qualities to patients.

Table 2. Ward round core roles

Each team member may perform a number of these roles.

Ward round lead	▸ Coordinates and takes responsibility for decision-making ▸ Sets the culture of collective input to decision-making ▸ Agrees roles of other team members ▸ Ensures the correct priorities and pace of the ward round ▸ Checks accuracy of documentation ▸ Facilitates and/or delivers multidisciplinary education
Summariser	▸ Summarises key elements of the input for decisions and the agreed decisions for documentation and communication
Note keeper	▸ Completes structured ward round documentation
Patient and family advocate	▸ Ensures input of patient, family and carer questions, goals and priorities ▸ Summarises the answers to the patient's questions and decision for the patient, ensuring their agreement ▸ Ensures follow-up communication around progress of plans to the patient
Safety checker	▸ Ensures completion of safety checklist
Staff member who knows the patient best – usually nurse directly caring for patient	▸ Updates the team on patient's current state, including relevant physiological observations and monitoring ▸ Updates the team on any changes in the patient's condition since the last review
Other multidisciplinary team members, eg doctor, physician associate, pharmacist, therapist etc	▸ Ensures medication review ▸ Ensures update on functional status in hospital and at home ▸ Manages emergent issues to prevent delays

Figure 3. Individual patient review during ward round

Introduction

Preparation of information

Confirm patient identity

Introductions to patient

Explanation of process

Checking patient questions, concerns and symptoms

Document

Reviews completed

Clinical reasoning

Working diagnosis and problems

Assigned actions, including discharge preparations

Planned next review and escalation plan and triggers

Discharge plans and objectives

Communication with patient

Clinical criteria for discharge

Discussion and decisions

Confirm team understanding of*:

- Current working diagnosis and problems
- Progress on plans since last review
- Changes in patient status or events since last review
- Emotional, psychological and cognitive status
- Observation chart / triggers / NEWS2
- Fluid balance, nutrition and bowel function
- Speech and swallow assessment
- Infection control status
- Investigation schedule, results and trends
- VTE risk assessment and plan
- Medicines chart review, including allergies and antibiotics
- IV cannulas, lines, infusions, drains and catheters
- Falls risk, skin care, pain, mobility
- Social care status and effect on discharge planning

Pause

- Agree diagnosis, and problems, progress, daily goal and plan with team and patient

Agree

- Communications of actions and timescales
- Next time of review

*** Many of these items should have been reviewed by team members before the ward round and as part of ongoing care so only that those that require attention can be highlighted in the round.**

Ward coordinators are key to effective care, and their time should be protected from other duties during peak activity times on the ward. The role of the ward coordinator and their interactions with ward rounds needs careful planning. If the staff member who knows the patient best contributes their input to the patient's care plan, a coordinator attending the ward round may not be the most effective use of their time. A ward coordinator is also likely to be interrupted, and it may be more efficient to provide regular updates to the coordinator instead. It is also helpful to agree which team member will deal with emergent issues to prevent delay or interruptions.

Medication review is a key component of ward rounds. This will include:

- reviewing and completing medication reconciliation
- route of administration
- dosing, side effects and interactions
- clinical effectiveness
- identifying administration omissions (and reasons)
- optimisation and deprescribing
- update of prescription.

The seven steps to appropriate polypharmacy should be followed.[20]

If it is necessary to conduct a physical examination of the patient, this should be done by the examining clinician with appropriate assistance, and other members of the team should be outside the room or curtained area to preserve the patient's dignity and privacy, unless team members are being taught (with the patient's consent).

Determining which tasks can wait until after the ward round, and which should occur immediately (as the ward round takes place) requires careful consideration. This will be partly determined by the number of team members in the round and should be clarified by the lead. For example, tier 1 staff may take the lead on summarising and documenting information on alternate patients, and then complete tasks while the next patient is being reviewed. Another example would be to share patient summaries and plans with the ward coordinator after every few patients (and certainly after priority patients have been reviewed), so that elements of care can be progressed by the wider team while the ward round continues.

The team should identify opportunities for recognising patients who may be in their last year of life, and commence conversations around advance care planning, but the more detailed conversations should take place after or outside the ward round. Escalation plans and 'Do not attempt resuscitation' (DNAR) orders should be reviewed and documented and shared with patients as appropriate.

Documentation and clinical records

Best practice: documentation and clinical records

- Clear documentation of diagnosis, problems, assessments, goals, progress and plans is essential.
- Structured records help to organise documentation to act as prompts to ensure that no important component is missed.
- Checklists are helpful when incorporated into structured records and should be used for key safety risks.
- Information recorded at the ward round should make clear the thinking around the clinical decisions, and include clinical criteria for discharge.
- Records form the basis for clinical coding, clinical audit and for the production of the discharge summaries, and should be structured to aid this.
- Clearly documenting discussion with patients, families and colleagues is a high priority.
- A written summary for patients and relatives is encouraged.

Good record keeping underpins communication and aids clear thinking about the clinical situation. It is essential to clearly document diagnoses, problems, assessments, goals, progress and plans, including the relevant clinical reasoning. Ward rounds provide an opportunity to pull together the different strands of documentation from paper or electronic patient records (EPRs) into a summary of the patient's current state and plan. Structured documentation improves outcomes[19] and helps to organise documentation. It acts as a prompt to ensure that no important part is missed. Authorship of ward round entries must be clear and all entries should be overseen by the ward round lead. While a scribe may be used to document on behalf of the team, the ward round lead is accountable for what is written and its accuracy. The composition of the team constituting the ward round, and allocation of tasks following the round, should also be documented.

Evidence-based structured approaches such as Situation, Background, Assessment, Recommendation, Review (SBARR)[23] or Subjective, Objective, Assessment, Plan (SOAP)[24] should be incorporated. A consistent core format within an organisation is necessary (and ideally in the NHS) given the movement of staff and patients across wards and specialty boundaries. Checklists are effective, particularly when incorporated into structured records.[23] They should be structured so that they do not 'take over', create duplication, or obscure the core clinical information. As more documentation becomes electronic, the use of cut-and-paste (or automated carrying forward of information) will bring opportunities, but also the hazard of replicating inaccuracies.

Prescribing and administration charts, as well as the documentation of physiological observations and notes from nursing and other colleagues, are an essential part of ward round review. Care should be taken to ensure high standards of documentation. Ward rounds are an opportunity for teaching and role modelling on this, as well as providing assurance by review of records. Drug chart reviews and reviews of observations can be noted, either electronically or otherwise, without the need to copy every item of information into every ward round note. Particular items of interest that are copied are thus able to attract the attention they deserve.

Clear documentation of discussion with patients, families and colleagues should be a high priority.

Ward round entries should be designed and made with their future utility in mind. A key recipient is the clinician who did not attend the ward round, but will be reviewing the patient later. Records also form the basis for clinical coding, clinical audit and the production of the discharge summaries.

A written summary of important information discussed on the ward round can be produced for the patient, family or carer, and is also helpful to relatives and carers not present at the time of the round. This can reduce the time spent by ward staff answering questions from relatives and is particularly helpful for relatives and carers of patients with communication difficulties.

Case studies

- Daily consultant-led board rounds at Royal Glamorgan Hospital have resulted in improved patient flow, communication, risk management and reduced complaints.
- East Lancashire Hospitals developed a Model Ward Programme to standardise roles and processes on wards. They also have Dedicated Ward Pharmacists programme with a full-time pharmacist on each ward who contributes to ward rounds.
- At Northampton General Hospital, ward round documentation is structured under 3 Rs: review of diagnosis, record of progress and revised plan. Where adopted, this has resulted in shorter ward rounds.

For details, please refer to the full case studies document that accompanies this report.

Communicating with patients, relatives and carers

Best practice: communicating with patients, relatives, and carers

In advance of the ward round

- Healthcare professionals should ensure that patients have a clear understanding of the purpose of the ward round, when it is likely to take place and what is likely to happen.
- Anyone identified by the patient as being important to them who is present at the time of the ward round should also be included in the conversation and communication.
- Wards should have an explanatory leaflet to give to patients and those identified as being important to them that includes details of ward rounds.
- Arrangements should be made for patients with translation needs of or other communication difficulties.

During the ward round

- At least one healthcare professional, preferably the person leading the round, should be at eye level with the patient.
- While healthcare professionals may be sharing more complex information between the team, they should ensure that the patient and any relatives or carers present have understood the situation and have been able to ask questions before moving on to the next patient.
- The patient should be left with a short note explaining the outcome of the ward round, providing the information most important to patients.
- The information should be available to people identified by the patient as important to them and with whom they want to share information.

Outside the ward round

- More complex discussions around escalation and end-of-life plans should happen outside the ward round.
- Carers and family members should have the opportunity to 'book' to see relevant team members at an agreed time.

Effective information sharing enhances self-management in hospital and following discharge. Although there are pockets of good practice in the UK, the lack of structured communication causes frustration and confusion for patients and those important to them.

It is important that team members introduce themselves and explain their roles. Patients, carers and relatives experience ward rounds in a very different way to healthcare professionals. It is not always clear to them who is leading the ward round, and the role and identity of all the team members. The sheer number of people – particularly on a student or junior doctor teaching round – can be a barrier or deterrent to a patient engaging or asking questions. The lead should use the 'Hello: My name is…' approach and briefly introduce the team. Ensure there is a team member at eye level with the patient to prevent the patient feeling that they are being 'talked over'. Ask the patient in advance with whom they want to share information about their care. Staff should be aware of cultural differences in expectations of involvement and sharing of information.

Cognitive and communication difficulties must be considered both as part of the assessment, and in how communication with the patient, family and carers is undertaken. Key documents including 'This is me' for patients with dementia or learning disability passports should be reviewed.

Information considered the most important by patients and relatives

While in hospital:

- What is wrong with me?
- Am I getting better or worse?
- What is going to happen today?
- What treatment am I having, and what are its benefits and disbenefits?
- When can I expect to be going home?
- Is there anything that I or my family / friends / carers can do to help?

On discharge:

- What will happen when I leave hospital; will I need further treatment/support?
- How will this be organised?
- Is there anything my family / friends / carers can do to help?

Involving the patient in decisions is fundamental practice, and the approach outlined in shared decision-making[21] including Ask me 3[12], should be used. When confirming the information and plan in communication with patients, the teachback[22] technique can be used to ensure understanding.

Protecting vulnerable patients

Inpatient populations include an increasing proportion of frail older patients, with estimates of the prevalence of dementia as high as 25 % within this cohort.

Healthcare professionals should be aware that capacity is context specific. Patients with cognitive impairment, mental health problems, dementia and learning disabilities should be supported to make decisions about their care, with dedicated time provided to communicate information to carers/advocates and relatives/parents. This is likely to be necessary before and after the ward round, to give adequate time. If a patient lacks capacity to make specific decisions about his or her care, multidisciplinary team meetings and careful discussions with carers/advocates and relatives/parents should guide the team to make decisions in the patient's best interests.

Agreed team members should gain as much information as possible about these patient before the ward round, including background history from the patient's usual residence and key worker, care passport or disability assessment.

After the ward round

Best practice: after the ward round

- Debrief the team to discuss the ward round and for learning points.
- Multidisciplinary team board round should confirm plans, actions and prioritisation.
- Continue to update the patient on progress.
- White boards should be updated with progress and goals.
- Afternoon huddle to check progress and people who can be discharged before that day and the next day. Includes weekend handover plans on a Friday.

There should be a debrief at the end of the ward round, covering what went well, what could have been improved, and important areas of learning that the team have encountered. As part of the debrief, the team should also prioritise tasks arising from the ward round.

Compiled from RCP Patient and Carer Network, Ask me 3 [11] and ECIST best practice[12]

◊In the previous report, barriers to communication with patients were briefly acknowledged, and recommendations were made to support better communication. In updating this report, the RCP's Patient and Carer Network held a workshop on communication between healthcare professionals, patients and relatives/carers to draw out key issues relating to ward rounds and to make positive recommendations for change.

Board rounds or multidisciplinary team huddles conducted at the end of the ward round provide an opportunity for the team to summarise all issues relating to patient care, identify and prioritise tasks, confirm plans with the wider team, and assign responsibilities appropriately. Further white board meetings should be held later in the day to ensure progress is being made, and identify any challenges or delays. This is particularly important on a Friday, to ensure that handover plans are up to date. The team should remember to continually update boards that display patients' status 'at a glance'.

Priority should be given to patients being discharged that day, or the next day, as well as the sicker patients. This ensures that patients who would benefit from the care of that team can be admitted to the ward in a timely manner, and do not wait in a less appropriate area for their care.

Continuing to update the patient around progress with plans is important, and this task should be assigned to a specific team member.

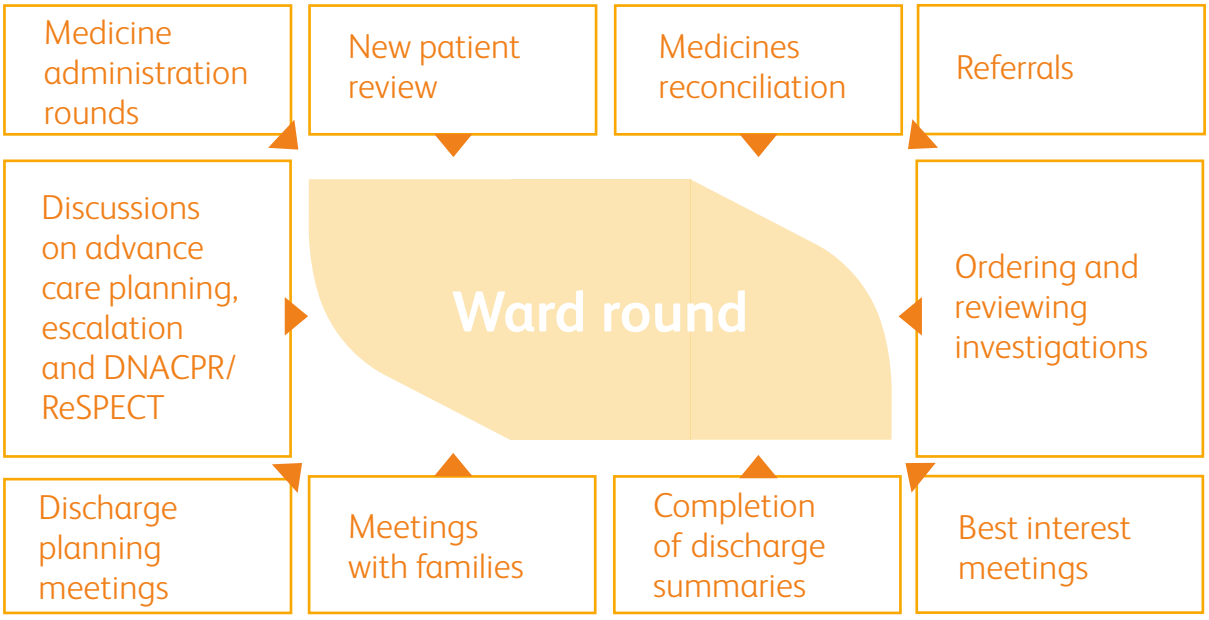
Outside the ward round

There are multiple processes of care that occur outside the ward round, but that nevertheless inform the ward round, or will be informed by the assessment and plans of the ward round. These are shown in Figure 4.

Patients who are new to that team or ward should ideally be assessed outside the ward round. This ensures that important assessment for care planning and prioritisation does not kept waiting until the next scheduled ward round. These first assessments are also likely to take more time, and involve examination, review of previous records etc, and so potentially lengthen a ward round's more predictable timing. The work on SIBR rounds recommends that this happens between the board round and multidisciplinary ward round, alongside any other uniprofessional reviews. This might be difficult in receiving units or acute admission wards, depending on the level of senior staffing. Patients should have received an initial assessment before the ward round, however there will be times when further delays in a patient's assessment until after the ward round is not warranted, as it would further delay their care. This must be decided on an individual basis, but can be planned at the board round. The standard for all patients is to receive consultant review within 14 hours of admission to hospital, this should be considered in prioritisation.

Discussions with patients and families around end-of-life care planning or escalation plans require a suitable environment and adequate time, and should take place outside the ward round.

Figure 4. Activities outside the ward round



Education, training and learning

Best practice: education, training and learning

- Education and learning should take place across professions on the ward round.
- Simulation of ward rounds should be used to train staff in important skills.
- Learning points should be summarised at the end of ward rounds with opportunities for further learning.
- Patients should be informed that teaching and learning are part of ward rounds and consent requested when appropriate.

Ward rounds present a major opportunity for education and training. The RCP's *Acute care toolkit 5: Teaching on the acute medical unit*[25] and *Never too busy to learn*[9] provide guidance and best practice. Creating a culture of learning during board rounds and ward rounds is a key role for both senior and junior staff of all professions. The board round (or briefing) can serve to emphasise the expectation of learning, and identify key learning opportunities.

The following techniques can be used:[16]

- thinking aloud
- demonstrating
- generating questions for the team to research the answer
- swapping senior and junior roles for part of the ward round
- asking trainees to review a patient first, think about the problem(s), and present their management plan to the team
- giving feedback
- telling clinical stories to illustrate an evidence-based point
- encouraging 'noticing' (eg of clinical signs or consultation skills)
- having clinical conversations (eg explaining the rationale of a management plan when reviewing a case)
- asking team members to explain three things they have learned at the end of the round
- encouraging trainees to write up interesting cases, or present cases at meetings
- recommending specific further reading.

This learning should be multidisciplinary, and each professional attending the ward round should share their knowledge and experience to educate others. Debriefing should confirm learning points, and other educational activities that can be pursued for further learning.

Reverse role ward rounds, in which a trainee takes the role of leading the round, can educate and train trainees. Feedback is essential, both during the round, and at the end. Without this experience, senior trainees are unlikely to get adequate opportunity to develop these skills.

Explaining the educational role of ward rounds to patients is essential. This is particularly important when undertaking a reverse role ward round.

Teams should employ simulation for education and training of clinical professionals in ward round skills. This involves simulating the different roles, learning from interactions between learners and surrogate patients. Different scenarios can be used to challenge the team.

Case studies

- A Quality Ward Round Programme at Surrey and Sussex Healthcare NHS Trust uses simulation of common scenarios. Learners take assigned roles. 700 staff have participated.
- Nottingham University Hospitals deliver 'reverse ward rounds'. Junior doctors take the lead in patient assessment, with pre- and post-consultation digital notes review with the consultant and feedback clinics.

For details, please refer to the full case studies document that accompanies this report.

C

The environment

The environment

Physical environment

Best practice: physical environment

- The area around the ward round should be quiet to ensure clear, undisturbed thinking and communication.
- Key equipment must be available and maintained.
- Confidentiality must be considered in all communications.
- Privacy and dignity must be maintained.
- Space for confidential phone calls and uninterrupted record keeping is necessary.
- A private room for sensitive communication must be available.
- Planned physical changes to the ward must consider the effect on ward rounds.

A ward round's physical environment is important, and can be conducive to conducting effective ward rounds. The following key elements should be considered:

- A quiet environment to aid communication and cognition by the care team and patient
- Other activities in the vicinity should be minimised to prevent interruptions or distractions
- Seating should be available to allow a team member to communicate with the patient at eye level
- Charts that need reviewing as part of the care process should be available, preferably at the bedside, or taken to the office if an office-based discussion is incorporated into the process
- Handwashing and personal protective equipment materials must be available for infection prevention purposes.
- Patients' case records must be available, either in paper of electronic format.
- Paper records should be prepared before the ward round with relevant documents being available
- If computerised information is used then the equipment to review that information must be maintained, appropriate and available (see later section: 'The role of technology')
- Each ward area should keep up-to-date patient status 'at a glance' boards in a location that preserves patients' confidential information, in order to enable board rounds, a communication focus and progress updates for all team members
- Places must be made available for confidential conversations, and for the uninterrupted work of staff preparing or following up actions from the ward round.

Teams in Sweden have developed a ward round process that takes place away from the bedside for 80% of patients on a general medical ward.[26] The patient is brought from their bed to a calm, uninterrupted designated place, with all the information available for good communication and decision-making.

In wards with multiple teams it can increase efficiency and communication to practise 'zoning', so that patients under one team are placed next to each other.

Any planned changes to the physical environment must consider their effect on ward rounds and other key activities.

Teams in Sweden have developed a ward round process that takes place away from the bedside for 80% of patients on a general medical ward.

Dignity, privacy and confidentiality

The ability to maintain patient confidentiality and dignity should be considered at all times, and are influenced by the ward layout and available space. Bedside discussions with patients behind curtains do not always preserve confidentiality, particularly when ward round times coincide with visiting hours. Similarly, discussing patient information in open spaces, such as by the nurses' station, in the middle of a bay or next to the ward board (if near to patients) may result in breaches in confidentiality. All members of the ward round team should be aware of the immediate environment when discussing patient information, and ensure conversations are not overheard wherever possible. Displays of electronic information must also be considered with regards to confidentiality.

It is important that consent be sought from a patient before allowing their relatives / parents / carers / advocates to be present during ward rounds.

Patient dignity can be maximised by including patients in discussions, seeking consent where necessary, and ensuring physical examinations take place with only necessary persons present.

The role of technology

Best practice: using technology

The basics

- Adequate hardware must be available on the ward for all tasks requiring computer records, particularly at peak times.
- Staff must be trained in the use of hardware and software – using single sign on if there are multiple systems.
- Accessible secure WiFi for mobile devices.

Maximise the benefits

- Computerised records and information systems should be used to maximise availability of information for decision-making, and remote communication.
- Connectivity of individual systems with agreed methods of use will increase efficiency.
- Computers on wheels, mobile or bedside devices should be used when possible to increase visibility and decision making with patients.

Minimise the risk

- Vigilance is required around the accuracy of electronic records.
- Methods of electronic recording should be agreed and tested that reduce recording times.
- Bedside computer etiquette should be used so that the use of technology does not detract from human interactions.

Computers and EPRs are increasingly a core part of the functioning of hospital wards, and their use on ward rounds will be central in the next few years. The use of such technology will therefore need to be tested, learned from and improved. EPRs have the potential to allow ward rounds to proceed more smoothly by providing readily accessible notes and results. They also offer the availability of patient data from other healthcare locations and sources, with the benefits of collating and integrating this information into one place.

In many hospitals, the use of systems is in transition from a number of standalone systems for monitoring, investigations, external and internal records to one integrated system. During this transition the use of multiple systems and logins can be time-consuming. Checking patient identification for the correct record remains paramount.

Structured records with quick links to the tasks required during clinical decision-making and care planning can increase efficiency and reliability if linked to good role allocation. Integrated clinical decision support and safety checks are good, but alert fatigue and overly extensive checklists can be problematic. The ability to show trends in clinical data is an important function, and should be included.

Audit and information trails of requests and progress of investigations can reduce missed investigations. AKI alerts are a good example of where better availability of information has improved clinical care linked to good practice guidance.[27]

Although EPRs promise to improve safety and efficiency through advancing data connectivity, it is also important to consider how the use of technology during ward rounds reshapes working practices, particularly regarding communication, documentation, and the effect of mobile computers. For some team members, computer keyboard entry will take longer than written notes, increasing the length of time of a review. Newer technologies for handwriting or voice recognition may prove more useful. Some organisations have employed scribes as additional team members to increase efficiency.[28] The common finding that ward rounds take longer with electronic information systems may be partly due to poor training in the use of software and hardware, and the level of interoperability between systems.

Although it is essential to ensure adequate hardware is available and well-maintained, this is commonly not done well. People have preferences for different types of hardware and may have training needs to adjust to the hardware available. Ethnographic studies should be done during EPR deployment to understand hardware requirements, particularly during times of peak and competing activities. Mobile devices are obviously needed, but maintenance of WiFi, charging and IT support need to be planned into job roles at the ward or unit, and available on a 24/7 basis. There is a tendency for staff to use their own hardware for associated tasks, ie mobile phones for task lists, decision tools etc. The risks, benefits and policy around this should examined, agreed and supported.

EPRs allow ward rounds to be conducted with greater locational freedom. This can enable teams to find quiet spaces with adequate computer access to review patient records and information. However, the resulting reduced visibility of the ward round can make it harder for staff to coordinate work, and needs explaining to patients. If the ward round is less visible because notes are being accessed remotely, opportunities for face-to-face communication, such as board rounds and debriefings, can ensure the multidisciplinary team is aware of the plan for the day and any key decisions.

The remote use of information, if used in isolation, can create inappropriate biases in clinical decision-making. More detailed information on the impact of EPR on communication is available.[29]

Case studies

- The electronic record at Wirral University Hospitals has ward round templates and direct links into primary care records.
- Office-based review of electronic records in Bradford Royal Infirmary enables more focus on the patient at the bedside by the MDT.

For details, please refer to the full case studies document that accompanies this report.

EPR providers have varying ways of allowing information to be copied or pulled through from one ward round to the next. Where this feature is used, it is important that the information is regularly and carefully reviewed, as outdated and potentially incorrect data can accumulate with potential risk to patient safety.[30]

The use of mobile computers on ward rounds is common. Where multiple mobile computers are being used to access different elements of the electronic record (for example, the prescription chart, investigation results, the ward round note), it is harder to get an 'at-a-glance' idea of who is doing what. The principles of good communication practice on ward rounds, including pauses for verbal summaries and decision-making, should be employed. The ward round lead, when confirming team members roles, must specify who will use the electronic systems and when to focus on human interactions. Task planning and 'glide slopes' to ensure complex processes are followed are becoming more widely available.

Teams should use computers to share information with patients wherever possible, particularly if tablet devices or other bedside access is available. These can also be used to record patients' questions. The EPR may also facilitate summaries for patients of agreed diagnoses and plans.

It is vital to organise the team with consideration to how technology will be used. The use of electronic information systems and other hardware on ward rounds can have unintended consequences for personal interactions with patients. Those attending the ward round can become focused on screens and keyboards, rather than interacting with each other and the patient. The height of equipment can influence human interactions, increasing the likelihood that the team will 'talk over' the patient, or not interact with each other. Electronic recording of plans and tasks shouldn't stop verbal communications.

Training of individuals and teams in ward rounds should include the integration of the use of digital systems.

Different inpatient settings and scenarios

Best practice: other settings

- Admission unit ward rounds include more detailed assessment of new patients on the round.
- 'Rolling ward rounds' are appropriate on admission units.
- Friday ward rounds should be led by the senior staff, take longer, and include clear, documented plans for the weekend.
- Weekend ward rounds target those who most need review, informed by board rounds.
- 'Outliers' should be minimised but should not be disadvantaged. Continuity of team and timing will help.
- Senior handover should occur if consultant responsibility rotates.
- Specialty rounds should involve the ward-based team.

Although the purpose and principles of good practice on ward rounds apply wherever rounds are undertaken in hospitals, it is important to recognise that ward rounds at different stages of a patient's admission to hospital may have different requirements.

For instance, a significant proportion of patients on an admission unit will be assessed by a consultant for the first time during a ward round. Depending on the function of the unit, there will also be follow-up reviews. While a patient is at a more active stage of management, more information will need to be gathered in advance of the ward round, and examination of the patient may also be required during the ward round. The need to ensure privacy and dignity as information is assimilated, and during examination, remain pertinent. More time must also be allocated for communication and history checking in cases where patients are being more actively managed. It is possible that some of the multidisciplinary team will not have completed their review at this stage.

The RCP guidance on safe medical staffing recommends, from the tasks required, that a consultant could safely review ten new patients over a 4.5-hour period on an acute medical admissions unit. (This includes time during and after the ward round, including follow up and communication.) Many assessment units employ the concept of the 'rolling ward round' or reviews, where bedside team review happens when the information is ready during the day or night – not at a set time of day. This is likely to be necessary in order to consistently ensure patients receive consultant review as early as possible – and within 14 hours of admission.

Continuity is important, and if consultants spend periods of time with and without ward patient responsibilities, the period of ward responsibility should consider a patient's length of stay, to try to reduce the number of consultants supervising a patient during their stay. A handover round is best practice when consultants rotate duties. The frequency of consultant-led rounds will depend on the availability of tier 2 staff. *Safe medical staffing* recommends daily consultant presence for board rounds, assessment of sick and new patients and important communication with patients, families and other staff. Tier 2 staff should lead the ward round in the absence of the consultant, but arrangements should be put in place to brief the consultant after the round.

Some patients are not situated on the same ward as the clinical team responsible for their care. These patients are often called 'outliers' or 'boarders'. The timing of these patients' reviews must be coordinated to ensure their care is not disadvantaged; the principles outlined in this report all apply. Clarity as to which staff comprise members of the care team for these patients is important, and most members of these teams must be located on the same ward as the patient. Buddy wards (the pairing of medical and surgical wards to ensure that medical patients on the surgical ward are cared for by a consistent team who know the staff) have been shown to help. This should be considered from a multidisciplinary perspective; continuity of care for these patients is potentially of greater importance. These patients must not feel disadvantaged by language used in communications, eg referred to as 'outliers' or 'not on the right ward'.

Patients are likely to stay longer on rehabilitation wards and their condition will change more slowly. Ward rounds will therefore be less frequent and specialist input to ward rounds can be done by video consultation.

Medical staffing at weekends and some public holidays is reduced in the UK, with the exception of admission wards. The guidance on safe medical staffing suggests that, for the best practicable care, one consultant is needed for 2 hours on every ward on each day of the weekend (or public holiday), even with up to 40% of patients identified as not requiring a review at the weekend. This would permit a board round, review of new patients admitted to the ward, sick patients, and those who can be discharged. While this inevitably does not offer the same standard of ward round care as during the week, this is felt to be the best practicable option to maintain safe ward round practice and timely discharge of patients. Commonly, fewer members of the multidisciplinary team will be present at weekends, and/or they will be less familiar with the patients. Again, clarity and consistency of staff is important, and all should be present at the board rounds. Conducting an excellent Friday handover can highlight patients who need review by each profession over the weekend and/or public holidays. Therefore, the Friday ward round should be consultant-led when daily consultant rounds are not possible, and are likely to require a longer scheduled time period, in order to devise weekend plans. Structured documentation for Friday rounds with weekend plans linked to handover lists is beneficial. These should be reviewed on the Friday afternoon and updated.

Certain clinical specialties will not be ward-based, or may have a role in contributing to the care of patients across a hospital. These rounds should also be multidisciplinary, and assessments should be conducted jointly with the ward-based team. If timing of visiting wards can be agreed, this will prove helpful with scheduling. Many of the principles around teamworking, patient involvement and the elements of review remain pertinent. Good examples are diabetes inpatient rounds, pain teams, rheumatology and nutrition.

D

Quality management, research and innovation

Quality management, research and innovation

Quality management requires three components: quality planning, quality assurance and control, and quality improvement. This approach should be applied to ward rounds.

Best practice: quality management, research and innovation

- It is essential to plan how ward rounds are delivered and supported.
- Quality measures should routinely be collected that relate to ward rounds, including staff and patient experience.
- Ward rounds should be included in ward accreditation schemes.
- Improvement programmes for ward rounds are required for units, as well as on a hospital-wide basis.
- Research and innovation should include new roles and maximising the benefits of new technology.

There are many elements of quality planning outlined in this report. These include:

- scheduling
- consistent staffing and shift patterns
- structured documentation availability and maintenance of technology
- rooms for confidential discussions.

Quality assurance and control requires agreed measures for ward rounds. Currently there is no agreed measurement set for this, but it should include elements around the key quality domains as defined by the Institute of Medicine: Safety, Timeliness, Effective, Efficient, Equitable and Person-centred. Key ward performance measures can be improved by effective ward rounds.

These include:

- hospital length of stay
- readmission rate
- prescribing errors
- antibiotic stewardship
- VTE prophylaxis rates
- incident reporting rates
- discharge times (within the day)
- patient experience measures
- staff experience measures.

Elements such as the reliability of start time, attendance on ward round, and duration of ward round could be used as process measures for efficiency.

Staff and patient experience will be major measures of effectiveness, as ward rounds and associated activities are the major function in which multidisciplinary staff work together. This should include effective teamworking and educational experience. Patient experience is key, and should include measures of effective communication and confidence, including the key patient questions outlined earlier. The use of real-time electronic patient experience measurement can give immediate feedback at the end of a session or ward round.

Many hospitals have ward accreditation or quality schemes, and the functioning and effectiveness of ward rounds should be included in these. Specific ward rounds accreditation schemes should be considered.

The implementation of all of the good practice features of ward rounds outlined in this report is rare. Ward rounds are therefore a very applicable area for quality improvement programmes and projects. These should take place in the context of a hospital-wide improvement programme, though individual projects should happen at an individual ward/team level, and the successful elements then spread across the hospital. We recommend that teams and hospitals self-assess against this guidance and develop quality improvement initiatives to address or improve areas identified.

There is considerable scope for research and innovation related to ward rounds. Areas for this would include:

- the roles of individual team members in ward rounds, maximising the use of new roles
- patient involvement
- use of technology – particularly voice or handwriting recognition, and remote involvement
- the role of artificial intelligence to identify key trends or risks
- mechanisms for increasing confidentiality.

Elements such as the reliability of start time, attendance on ward round, and duration of ward round could be used as process measures for efficiency.

Case studies

- Ward round accreditation, against agreed standards, has been incorporated into the wider ward accreditation programme at Warrington and Halton Teaching Hospitals.
- A patient 'How to hospital' diary is being tested in Ysbyty Gwynedd Hospital to build patient involvement in ward rounds.
- Noise levels on ward rounds are monitored using an app in Yeovil Hospital, encouraging lower noise levels for clearer thinking and decision making.

For details, please refer to the full case studies document that accompanies this report.

Clinical teams and hospitals should self-assess their ward rounds quality using the tool in Appendix 2.

Working party

Dr John Dean Co-chair. Clinical director for quality improvement and patient safety, Royal College of Physicians. Consultant physician and deputy medical director, East Lancashire Hospitals NHS Trust

Dr Nichola Ashby Co-chair. Associate professor. Head of learning and practice development, Royal College of Nursing

Dr Hussain Basheer Education fellow, Royal College of Physicians. Specialist registrar in respiratory medicine

Nina Barnett Consultant pharmacist, Northwick Park Hospital, Royal Pharmaceutical Society

Dr Lisa Waters Chief registrar, Warrington and Halton Hospitals NHS Foundation Trust

Jayne Black Joint head of policy, Royal College of Physicians

Dr Druin Burch Consultant geriatrician, Oxford Hospitals NHS Foundation Trust

Sarah Campbell Operations director, Quality Improvement and Patient Safety, Royal College of Physicians

Dr Sarah Clarke Clinical vice president, Royal College of Physicians. Consultant cardiologist, Royal Papworth Hospital

Dr Alex Crowe Deputy medical director, Warrington and Halton Hospitals NHS Foundation Trust

Linda Cuthbertson Head of PR and public affairs, Royal College of Physicians

Dr Alistair Gilmore Chair, New Consultant Committee, Royal College of Physicians. Consultant physician in acute medicine, Wirral University Hospitals NHS Trust

Deirdre McLelland Patient and member of Royal Collage of Physicians' Patient and Carer Network

Adele Mott Clinical fellow, Royal Pharmaceutical Society

Sarah Cahill Clinical fellow, Royal Pharmaceutical Society

Prof David Oliver Clinical vice president, Royal College of Physicians. Consultant geriatrician, Royal Berkshire Hospitals NHS Trust

Lynne Quinney Patient and carer. Representative of the Royal College of Physicians' Patient and Carer Network

Dr Andrew Rochford Consultant gastroenterologist, Barts Health NHS Trust, adviser Emergency Care Intensive Support Team (ECIST)

Helen Sharma Head of practice improvement, Chartered Society of Physiotherapy

Suman Shrestha Professional lead, acute, emergency and critical care, Royal College of Nursing

Kate Straughton President of Faculty of Physician Associates, Royal College of Physicians

Dr Nigel Trudgill Director, Medical Workforce Unit, Royal College of Physicians. Consultant gastroenterologist, Sandwell and West Birmingham NHS Trust

Beth Ward Head of professional development, Royal Pharmaceutical Society

The RCP's Patient and Carer Network workshop identified variable practice on successful two-way communication with patients, relatives and carers. Such variation can lead to frustration and confusion. Specific reported issues included:

- Patients are not always given information about whether there will be a ward round, the purpose of the round, who will be leading it, how long they will be seen and by whom, and whether there will be an opportunity to ask questions. Patients often feel they are talked over or down to, literally as well as psychologically. Patients are not always included in the conversation and are unsure if they can ask questions – or are reluctant to do so.
- Confidentiality is a major concern, as curtains or screens do not block sound and patients would like to have more confidential options to discuss their care. The concentration of the multidisciplinary team on the medical aspects of care sometimes left out the issues important to patients: quality/quantity of sleep, eating and drinking, general wellbeing etc. Using simple and clear language was felt to be extremely important, and something that is currently lacking.
- Following the ward round, patients are not usually given any written information on the next steps of their care to share with relatives and carers (if they are not present). Many ward rounds take place when visitors are not present so relatives and carers do not have any information and have to then approach the ward staff with questions when they arrive.

Thanks are also due for direct advice and input from:

Dr Vicky Reay PhD student and associate lecturer, Lancaster University

Dr Gordon Caldwell Consultant physician, NHS Highlands

Claire Merriman Head of professional practice skills, Department of Nursing, Oxford Brookes University

James Maguire Clinical adviser, NHSX. Geriatric medicine registrar

Linda Patterson Lead nurse / national improvement adviser, Modernising Patient Pathways Programme (Scottish Government)

Appendix 1: surveys of professions

Ward rounds: summary of surveys

In order to inform the working group, the professional bodies conducted surveys of physicians, nurses, physiotherapists and pharmacists in May and June 2019.[1–4] The main numerical findings of the surveys are reported here.

2,022 physicians, 2,000 nurses, 509 pharmacists and 185 physiotherapists took part in the surveys, providing quantitative answers and free text comments about their current practice, challenges and good practice. These responses have been used to inform the recommendations within the body of the report. Differences in cohorts for the surveys and perceptions of participation are likely to account for the differences between the professions.

Which professionals participate in ward rounds?

Nursing input to ward rounds:

9.3 % of consultants on acute medical units and 17.7 % on wards reported that the nurse looking after the patient was present on the ward round, with only 5.5 % stating that this happened all of the time. However, nurses across different units stated that they participated in ward rounds 61 % of the time. Many also stated that they were so busy with patient care that it was impossible for them to join the ward round – despite wishing to do so.

11.7 % of consultants on acute medical units (and 9.5 % on other wards) reported the presence of an advanced nurse practitioner on ward rounds.

Pharmacist input to ward rounds:

4.7 % of consultant physicians report a pharmacist is present on acute medical unit ward rounds and 5.7 % on other wards. Nurses across different units reported that this occurred 17 % of the time, however 69 % of pharmacists responding stated that they participated in ward rounds. 55 % reported being present throughout the round, 45 % attending 3–5 per week, 8 % attended five days a week, 9 % at weekends; with 45 % present for the whole round.

Physiotherapist input:

The sample of physiotherapists was dominated by those working in key clinical areas, eg neurology, critical care, respiratory and rehabilitation. 42 % regularly attended ward rounds, 74 % once or twice a week and only 5 % on five days a week. 40 % of physiotherapists reported always receiving important information from the ward round, and some commented on not being invited to participate.

Overall staffing levels, planning, and lack of mutual respect were the main barriers to multidisciplinary working on ward rounds.

Nurses were sometimes perceived by medical staff to be too busy with nursing tasks for increasingly complex patients, however nurses expressed frustration at not being always involved in wards rounds.

How many patients are seen on ward rounds?

Physicians across specialties reported that 55.5 % see between 10 and 20 patients on a ward round, with 19.5 % seeing less than 10 patients, 22.5 % seeing 20–30 patients and 2.5 % more than 30.

31 % of consultants had their ward rounds confined to one ward, with 55 % seeing patients on between two and four wards. 78 % reported seeing patients on 'outlying' wards, with 60 % reporting that this happens all year round. 60 % reported that there was more than one consultant ward round on their ward. 25 % led a ward round five days per week, 37.2 % on two days a week, 31.8 % on three or four days a week. Nurses report that 17.2 % of ward rounds take longer than three hours. Only 11 % always start on time; 40 % sometimes, rarely or never start on time. 61 % of the nurses responding said this disrupts other ward care. Variable start times were also seen as an impediment by other professions.

Board rounds, huddles and priorities

42 % of consultant physicians report attending or leading board rounds of huddles, with 21.9 % of these occurring both before and after the ward round, 48.2 % only before the ward round, and 17.5 % only after the ward round. 69.5 % report debriefing at the end of the ward round.

95.6 % of consultants reported seeing the sickest patients, and 76.1 % reported prioritising patients who might be discharged that day. However 33 % of nurses reported that their was no particular order to the ward round.

30 % of physiotherapists reported attending some form of multidisciplinary team board round or huddle 3–5 times a week.

Teaching

85 % of consultants saw teaching as an active part of their ward rounds. While this predominantly referred to teaching medical staff, it also included the teaching of the wider team, if those team members were present. Pharmacists almost all emphasise the importance of multidisciplinary learning on ward rounds, and both participate in teaching and receiving learning. 72 % of physiotherapists state the importance of teaching and education on ward rounds.

'The junior staffing rotas are so fragmented that attendance on sequential ward rounds is poor and their learning opportunities reduced.'

Interruptions

Interruptions are frequent throughout the ward round and this affects the accessing of data, communication and delivery of care.

The overwhelming majority of nurses (91 %) reported being interrupted at least three times an hour, with over a fifth (21 %) interrupted ten times an hour. Over three quarters (76 %) of physicians were typically interrupted at least once by colleagues on the same ward while conducting a ward round, and 83 % of pharmacists reported interruptions.

Structured record

59.6% of physicians reported that a multidisciplinary record was in place. 33.6% of consultants use a form of check list, as do 34% of pharmacists. Only 1.7% provide a written summary for patients. 88.3% review drug charts on each round.

Most nurses and physicians agreed that there was sufficient access to electronic patient records (EPRs) during ward rounds. Only 14% of nurses and 10% of physicians said this was not the case. However, 57% of physicians and 29% of nurses said this was not exclusive for ward round participants.

Many respondents made free text comments about problems with the functionality of EPRs, indicating that ward rounds were slowed down by faulty and non-functional electronic observation devices.

Relatives, carers and confidentiality

Most nurses (76%) and nearly all doctors (98%) agreed that relatives were very rarely given a written summary of the ward round. 18% of nurses said that relatives and carers were sometimes given a written summary. 1.7% of physicians reported giving a written summary to patients.

88% of nurses said that carers and relatives were provided with information on how to contact a member of staff if they had any questions regarding their care.

91% of nurses said there was an area where confidential discussions with relatives could happen away from the patient's bed, although half of these areas are not specifically dedicated to this purpose. Similarly, 87% of physicians said there was an area for confidential discussions with relatives and carers, but 57% said that this area was not specifically dedicated to this. 13.2 % stated there was no discussion area away from the bed for confidential discussions.

References

1 The Royal College of Physicians (Medical Workforce Unit). Focus on physicians: ward round survey. London: RCP, 2019.

2 A Ward Round Snapshot Survey was undertaken by the Royal College of Nursing

3 Focus on Pharmacists: Ward Rounds was undertaken by the Royal Pharmaceutical Society

4 Focus on Physiotherapists: Ward Rounds was undertaken by the Chartered Society of Physiotherapists.

Appendix 2: Self-assessment template

Rate your current performance of ward rounds below, using a 0–4 scoring system.

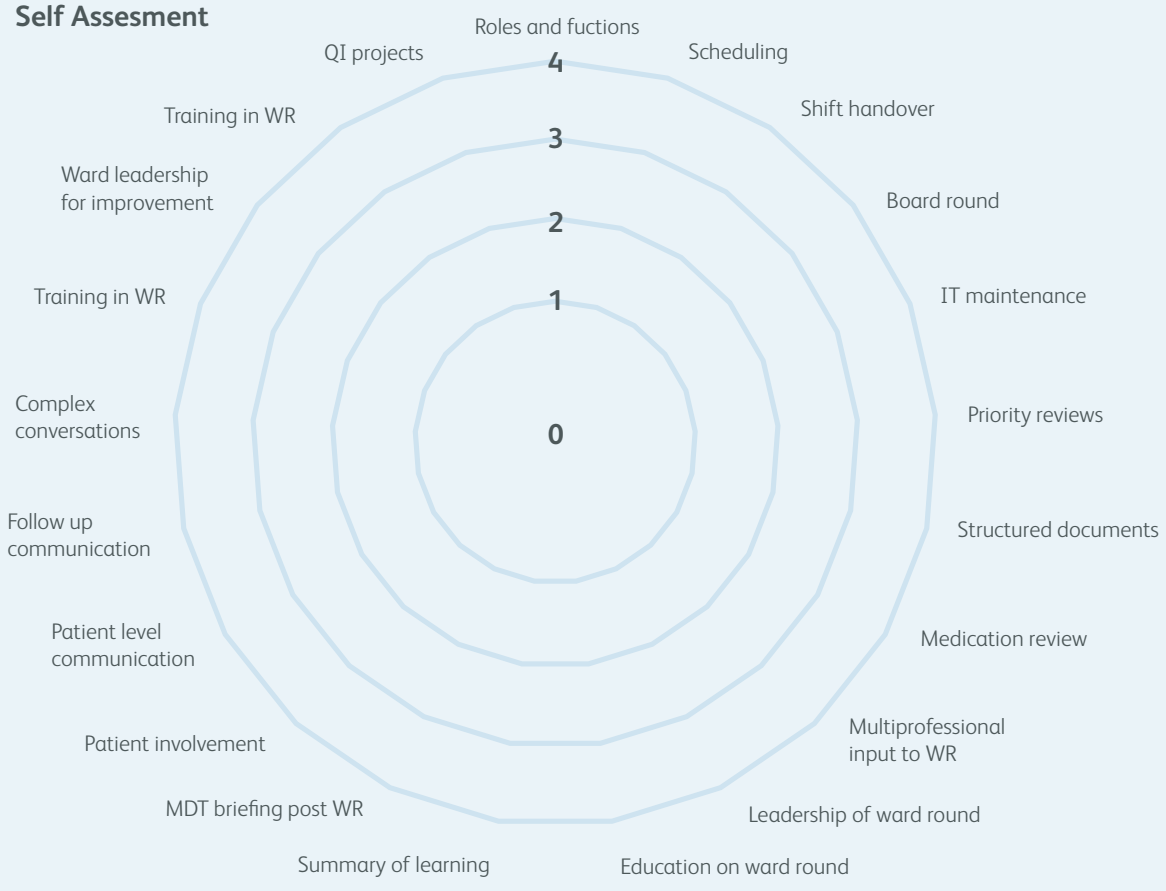
0 – not in place, **1** – in development, **2** – in place but incomplete, **3** – in place but not consistently followed, **4** – in place and reliably followed

Plot scores on radar chart to identify priorities for improvement.

Preparation	Assessment	Score
Ward team members roles and functions agreed, documented and understood		
Ward rounds and other activities are scheduled to prevent conflicts		
Shift handover is structured to feed information into ward round		
Pre ward round board round is scheduled, structured, attended by all MDT staff and well led		
IT equipment is maintained and adequately available for ward rounds		
Ward round process	**Assessment**	**Score**
Patients are reviewed in priority order on ward rounds		
Structured documentation including safety checklists are used		
Medication and monitoring charts are reviewed		
The staff who directly care for the patient input to the ward round		
The ward round leader creates an environment for active participation and involvement in care planning		
Interprofessional education occurs during the ward round		
Learning points are summarised and planned at the end of the ward round		
Debriefing and multidisciplinary agreement and handover of plans occurs after the ward round		

Patient-centred	Assessment	Score
Patients, families and carers are actively involved in ward round decisions		
Communication with patients during the ward round is at eye level		
Follow up communication with the patient on progress of plans is agreed		
Complex conversations and assessments with patients and families are planned outside the ward round		
QI	**Assessment**	**Score**
Staff are trained in how to conduct ward rounds and use relevant hardware and software		
Ward leadership team has regular meetings to review quality		
Quality improvement projects are in place for ward rounds.		

Self Assesment



References

1 Royal College of Physicians. *Focus on Physicians: 2018–19 census of consultant physicians and higher specialty trainees in the UK*. London: RCP, 2019. www.rcplondon.ac.uk/projects/outputs/focus-physicians-2018-19-census-uk-consultants-and-higher-specialty-trainees

2 The Royal College of Nursing. *Safe and effective staffing: nursing against all odds*. London: RCN, 2017.

3 Royal College of Physicians. *Guidance on safe medical staffing*. Report of a working party. London: RCP, 2018

4 NHS Improvement. *Good practice guide: Focus on improving patient flow*. London: NHS, 2017. https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/

5 Royal College of Physicians. *National Early Warning Score (NEWS) 2. Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017. www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

6 The Scottish Government. *The Daily Dynamic Discharge Approach*. Edinburgh: Scottish government, 2016. www.gov.scot/Resource/0050/00503010.pdf

7 Royal College of Physicians. *Talking about dying: How to begin honest conversations about what lies ahead*. London: RCP, 2018.

8 Royal College of Physicians. *Improving teams in healthcare*. London: RCP, 2017. www.rcplondon.ac.uk/projects/improving-teams-healthcare

9 Basheer H, Allwood B, Lindsell CM, Freeth D, Vaux E. *Never too busy to learn: how the modern team can learn together in the busy workplace*. London: RCP/HEE, 2018. www.rcplondon.ac.uk/projects/outputs/never-too-busy-learn

10 Stein J, Payne C, Methvin A *et al*. Reorganizing a hospital ward as an accountable care unit. *J Hosp Med* 2015;10(1):36–40.

11 NHS Improvement. *Guide to reducing long hospital stays*. London: NHS Improvement, 2018. https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays/

12 The Health Literacy Place. *Encouraging patient questions*. Edinburgh: Scottish government. www.healthliteracyplace.org.uk/tools-and-techniques/encouraging-patient-questions

13 Rosenberg K. The Joint Commission Addresses Health Care Worker Fatigue. *The American Journal of Nursing* 2014;114(7):17.

14 Vohs KD, Baumeister RF, Schmeichel BJ *et al*. Making choices impairs subsequent self-control: a limited-resource account of decision making, self-regulation, and active initiative. *J Pers Soc Psychol* 2008;94(5):883–98.

References

15 NHS Improvement. *SAFER patient flow bundle.* London: NHS Improvement, 2017. https://improvement.nhs.uk/resources/safer-patient-flow-bundle-implement/

16 https://improvement.nhs.uk/resources/safer-patient-flow-bundle-board-rounds/

17 Royal Pharmaceutical Society. *Making the most of your medicines.* www.rpharms.com/resources/pharmacy-guides/medicines-optimisation-hub

18 Rudall N, McKenzie C, Landa J *et al* PROTECTED-UK – Clinical pharmacist interventions in the UK critical care unit: exploration of relationship between intervention,service characteristics and experience level. *Int J Pharm Pract* 2017;25(4):311–9.

19 National Institute for Health and Care Excellence. Chapter 28 Structured ward rounds. *Emergency and acute medical care in over 16s: service delivery and organisation.* NICE guideline 94. London: NICE, 2018. www.nice.org.uk/guidance/ng94/evidence/28.structured-ward-rounds-pdf-172397464641

20 NHS Scotland. *PolyPharmacy Guidance – Medicines review*. https://managingmeds.scot.nhs.uk/for-healthcare-professionals/7-steps/

21 Royal College of Physicians. *Shared decision making: information and resources.* London: RCP, 2015. www.rcplondon.ac.uk/projects/outputs/shared-decision-making-information-and-resources

22 The Health Literacy Place. http://www.healthliteracyplace.org.uk/tools-and-techniques/techniques

23 NHS Improvement. SBAR communication tool – situation, background, assessment, recommendation. London: NHS Improvement. https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf

24 Pearce PF, Ferguson LA, George GS, Langford CA. The essential SOAP note in an EHR age. *Nurse Pract* 2016;41(2):29–36.

25 Royal College of Physicians. *Acute care toolkit 5. Teaching on the acute medical unit*. London: RCP, 2012.

26 http://wardround.net/network-2/

27 Sawhney S, Fluck N *et al*. Acute kidney injury—how does automated detection perform? *Nephrol Dial Transplant* 2015;30(11):1853–61.

28 Walker K, Ben-Meir M *et al*. Impact of scribes on emergency medicine doctors' productivity and patient throughput: multicentre randomised trial. *BMJ* 2019 Jan 30;364:l121.

29 Coiera E, Ash J and Berg M. The Unintended Consequences of Health Information Technology Revisited. *Yearb Med Inform* 2016;(1):163–9. www.ncbi.nlm.nih.gov/pmc/articles/PMC5171576/

30 ECRI Institute. *Health IT safe practices: toolkit for the safe use of copy and paste*. February 2016. www.ecri.org/Resources/HIT/CP_Toolkit/Toolkit_CopyPaste_final.pdf

11 St Andrews Place
Regent's Park
London NW1 4LE

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