Improving Quality and Safety on Ward Rounds

This an enjoyable, time consuming process that will undoubtedly improve the quality and safety of the care that clinical teams provide. Once you start you will never stop, because you will find that the professional conversations and performance on your rounds will always be moving to higher levels. In Toyota terms this is constant quality improvement.

Before you start

Is the Checklist a distraction?

The checklist must not become a distraction to providing high quality care. There will be times when you do not have enough staff to use the checklist – give the care without recording the data. I have prepared a summary document suitable for laminating so on a busy round you could refer to the checklist, without recording every item for every patient. Or you might use the Checklist on the first four patients only? This process teaches Doctors what has to be done. It will teach them to be systematic, in the same way they learned the processes for driving a car. It has a whiff of Airline Safety processes in it as well. The pilot can only take off once all systems are checked.

Will it make my Consultation less human?

The Checklist must not dictate the process of the Consultation. In the film "Wit" the Intern follows a Checklist clerking proforma – the interview is dry and with no humanity, and so falls flat. The Checklist is a final check before moving on, like the report given after a Pit Stop before Jenson Button powers off back onto the track.

Do I care about Quality and Safety?

If you think a good ward round is one that ends quickly or if you are convinced that nothing needs to be made better on your rounds, do not even start this process. If you think that it is important to get the diagnoses, treatments, reviews and documentation right first time, and are willing to commit time and effort to this, then start off. Do not ever stop. Once I thought that I had cracked good quality rounds on EAU and thought about stopping. Then I realised that there was a whole new intake of Juniors coming. I also recognised that performance improves when we are watched, and as soon as we stop watching, performance drops. I also found that if we wrote the drug charts well, then we had time available to talk about the drugs, interactions, safe doses etc – Toyota again – continuous quality improvement.

Make the Checklist Your Team's Own Property

I devised these checklists myself, alone, this was not the right way to do it.

This could have been done much better. It would have been good to have a brainstorming hour with my team of Juniors, Nurses and Pharmacists. Together we could have then said "These are the standards this team is going to work to. We are going to be the best team in the hospital."

Also I do not know your context, I do not know how your notes are laid out, what your drug chart is like, what your DVT prophylaxis guidelines are, how much you are computerised. Look at my Checklists and modify them for your context.

Also these charts are in constant development to try to make them easier to use. Keep a folder on your PC of "Old Versions" and don't be afraid to change them every day. The Ward Round Checklist is difficult to use. I tend to mark an open circle if something has been omitted e.g. "Took Nurse Report" and then tick through it when it has been done. The tasks that are not needed in all patients are a problem – if the patient has no cannula how is it best to mark the Checklist? Feedback new ideas, please!

Introduce the Idea and the Thinking

Again I am not good at this. I tend to have an idea in the shower at 7:30 and roll it out on the round at 9 o'clock. I am sure it would be good to spend an hour talking it through before you try any of these Checklists. You can cover thinking about team working. All Juniors claim to be excellent hard working team members who communicate well. An essential part to team work is to watch out for things that could go or have gone wrong and take action together to correct the situation. In a team this very simply means telling each other when we see something wrong and getting it fixed. This process allows team talking about poor performance and makes the team correct its deficiencies. It has the potential to change every conversation about every aspect of care. "Is the job being done well? No – then fix it!" – we are so habitually used to thinking "Is this doctor nice and are we getting on well" rather than "Are we getting the job done to the highest standards, and if not how can we fix it". I have already seen my Juniors now challenging me about decisions because they want to save the patient from a mistake – that is real team work!

Of course you will soon develop your own Checklists – why not have one for the weekly discharge meeting and get the F2 to check off the summaries against standard and report to the team – have a Dictaphone ready for all those short notes to the GPs when you find defects.

Or a Checklist for before you go to ask for an MRI Scan?

Or Fluid Balance Checklist etc etc.

But do not use more than 2 Checklists on one round! You might concentrate on Fluid Balance for a month, and then do one round a month rechecking.

Get some kit

A team strip? Maybe that would be a good idea! "Here comes the Jackson Team in their lemon yellow strip, and who is wearing the number 11 jersey today?"

You need a colour printer – yellow is the most visible colour to the human eye, so I have highlighted the "essential" items in yellow background. This seems to work well.

You need some clipboards – WH Smith sells some really good clipboards which open up to hold sheets of A4. They are blue and cost about £7. You can then store the Checklists inside, and have the current one on the outside.

Action Stations

I also now use an "Action Station" Ward Round Trolley for when we go out to see the patient. This is equipped with requests forms, TTOs, examination equipment etc. At the bedside we do nearly everything before we move off to the next patient, e.g. allocate one member to take an extra blood for D dimer, send the SPR off to ask for the CTPA, write the TTOs. It is tempting to move on to the next patient, but keep the team together – it is easy to find a task (write the blood form yourself) or maybe 1 minute's teaching "Give me 5 reasons why a menstrual history could be important in a 20 year old who has taken an overdose, and tell me the answers after the next patient."

Put the players in position

You can then introduce the idea that someone is going to be allocated the task of "Quality and Safety Checker". Now of course roles change from minute to minute so the role may change from patient to patient.

Your team will soon get the idea of roles and tasks. We now sit down at a long workbench for our pre-patient discussions. One person opens and read the notes to the Consultant, who can observe the quality and content of the notes. One person is looking up the "Bloods" and another has PACS open, someone else is pulling out a "CPR Status" form, whilst another anticipates that the patient will go home and is writing the TTOs, or that a CTPA will be needed and is filling in the X ray request. On good days a nurse brings in the nursing charts and the pharmacist the drug chart, to they can be doing their work and report at the same time.

Have a personal worksheet

I used to see one patient at a time, rather than all patients in one Bay. This was making for a huge amount of walking time. I now have a worklist of all patients on the round listed in bed order. I then make notes as I listen to the history of the points to look out for at the bedside. This way I can see up to 6 patients in one "Journey", and not miss items and save minutes of useless walking time.

Go, go, go

So now it is time to give it a go! Or is it? Why not show real leadership and try the job first? Step back, let your SPR lead the round, whilst you are the Checker. This is very enjoyable and I have found that the Juniors work harder and talk more about the patients when the Consultant stands back. Of course you may need to butt in – usually I find this is to give the SPR some more authority "Yes I agree with my SPR, you are ready to go home, and I will see you next Thursday with your calcium level, here is your blood form."

Using the Ward Round Checklist

I get the top section filled in to record the date, number of doctors on the round, start time etc. You will soon understand why some days feel pressurised and hard work. I have also now got evidence of how often we do not have nurses with us, as well as evidence for how long a ward round takes to do all the necessary tasks.

Patient Initials and Bed Number

The checker can easily lose track of which patient is which, if I listen to six cases before going to the bedside. Noting the initials and bed number makes it easy to track the patient without a breach of confidentiality.

Preparation

- Read and Filed Notes. Someone has to read the notes – do they make sense? Is there a précis of the case, or a comprehensive problems list? Have the current clerking sheets been filed in place or could they still get lost
- Checked New Results. Someone thought some tests were worth doing, have we looked at all the incoming results? Has the report on the ECG and CXR been noted in the notes?
- **Clinical Thinking - This is of course crucial to patient care. Is the diagnosis correct? Is the patient making the expected progress? Are we giving the correct treatments?** These are very difficult to measure, but there should be evidence that the team has thought this through. **I believe "diagnosis" is a team task. Every medical mind in the room should be thinking "What is the diagnosis? What fits? What does not fit? Have I seen this before?"** If the team does this, not just the Consultant, surely we are going to do better?
- Took Nurse Report - this may seem cloud cuckoo land in the current NHS, but there should be a senior nurse available who has an overview of the patient and can give a report. Rather than "We are too busy no nurse available" or "I have only come on duty, he seems OK" I would like "Your patient with the large haematemesis has had 3 units of blood, his pulse has settled from 120 to 70, his blood pressure is up to 140/70, he has passed 50 ml or urine an hour and is booked for endoscopy in an hour and needs to be consented"

Consultation

This is the bedside consultation. By now your team should be so fired up that one of them is looking at the drug chart, another at the fluids chart, someone looking for a cannula to be removed, and the nurse (if she is there) is anticipating that you will want the patient's pyjama top off to listen to the heart and the TV switched off and the cleaner asked to stop burnishing your shoes so that you can actually hear.

Of course you go up the patient, gel your hands, shake hands with the patient, get on his level and have a conversation with him. You ask questions and listen to the patient.

You may then do a focussed examination, or it you are a really good Educational Supervisor get the F1 to listen to the heart for a miniCEX, whilst you discuss with the SPR the echo result from last year that she has just dug up from the notes – you know you only listen to the heart to buy some thinking time!

Charts

- Vital Signs, TPR, Mews Score – anything used in your Trust, someone has to look and give a verbal report – do not write all that down in the notes – why duplicate it?
- Drugs Chart – you can use a separate "Check and Correct" for the drugs chart – I do this on post take rounds to ensure that my team sends patients on to other teams with 100% correct(ed) charts. On a routine round we always look at every chart. Because we use "Check and Correct" on post take rounds, we are far better at checking the chart on the ward. We have recently followed our Geriatricians' habit of writing a reason for discontinuing a drug on the drug chart.
- Fluid Prescription and Fluid Balance – this is a heart sink area. Our prescribing and monitoring of fluid balance is so very poor. Overall we try to do far too many fluid charts and end up doing them badly. Far better to do the important ones well, and tell the nurses which ones to stop doing. However we can only tell a nurse to stop doing a useless chart if the nurse is there! There are also many variations – in some cases we only want to know input, in others only output, in others only the daily weight – a few need the works.
- Weight – all medical patients need to be weighed once in case they need weight related drugs. When we have asked for daily weights we must look at them.
- Glucose – for patients with diabetes – how often do we want the glucose checked? Why that often? Is it being recorded so that I can make sense of the chart? Can it be stopped? Where is that nurse to tell her she does not need to spend 20 minutes a day doing blood glucose levels?
- Peak Flow – for asthmatics, not for COPD
- Other – any other charts – why?

Reduce Risk of Hospital Acquired Infection and Deep Vein Thrombosis

- Cannula – does the patient have a cannula in? Can it be removed now – don't wait for the nurse who is not with you – have one of the team remove it now.
- Any Watery Diarrhoea? Could this be C diff, has specimen been sent, should patient be isolated, has the Senna and Lactulose been crossed off?
- Urinary Catheter – is there a urinary catheter in place? Why? Could a sheath have been used instead? Can the catheter come out now?
- Lines and Drains – any other lines in place or drains (chest drain, surgical drain) – can it come out, how much has drained etc
- DVT Prophylaxis – has a decision been made? Is the patient as mobile as he will be at home, can the Dalteparin be stopped?

Food and Drink

Simply asking if the patient is eating and drinking is enough to remind the medical team that nutrition and hydration are important.

Discharge Planning

- EDD in notes – there should be a cleat Estimated Date of Discharge in the notes, or a time for review ("Stroke" – review EDD in 7 days), or statement that the patient no longer needs daily review by a doctor and is a delayed discharge from hospital.
- Discharge Team – does the patient have complex medical and social needs that need to be met for a safe discharge – get the team in action now! Why don't we have a progress board at the end of the bed "Referred to Physio, tick, seen by Physio, tick, Physio report ready, tick" etc
- Write TTOs now? The TTOs can always be started now – the patient will likely have the same name, GP and admission date by the time he goes home – fill that in and there will be less to do at 5:30 pm on Friday with Pharmacy about to close

Ceiling of Care

You will probably want to change this section. This is my thinking. I assess the patient on a post take round and think "If this patient suddenly deteriorated would I think that the patient would do better in the long run if he was sent to ITU or HDU?" If the answer is "Yes" then the patient is "For full CPR". If the answer is no to ITU or HDU care then I make the patient "For full ward level care, but not for CPR" – reason "Futility". So many of my patients have very frail health, even if they were in town shopping the day before, that they do not survive CPR, or if they do go to ITU or HDU to die.

Of course some patients are for "full nursing care only" and some are for "Liverpool Care Pathway".

I do dislike "not for CPR" – why could we not write "For a natural death without dramatic medical intervention" – the question that I have to ask would then be "If you deteriorated and looked like you were dying would you like a natural death without dramatic medical intervention and with all your symptoms well treated?" – "Yes please Doc I'll have a death like that."

CPR status

In my thinking all acute medical admissions are at risk of abrupt deterioration and there should be clear decision before a crisis of "For" or "Not for CPR". The form should be actively filed in the correct place and the nurse, (where is she?), needs to know.

Planning

- Agree Future Tests - For years I have let my Juniors decide what tests to do. We then drown in results. Of course 5% of "normal" blood tests results are "abnormal" – the more tests we do the more we have to do to find out if the test was really abnormal! The same applies to radiology tests – you wanted a carotid ultrasound and now you have found a 10 mm lesion in the thyroid. Or in our Trust the Juniors do the Sunday "bloods" and always complain of too many tests to do. So why not agree the tests that can be done. I can see why the Boomtown Rats didn't like Mondays – we have a tradition of "Monday Bloods" – "Why did you do the Hb, ESR, CRP, U+E, LFTs, glucose?" "Because it is Monday.
- Referral or Senior Help Needed – do we need to get a Specialist Opinion or transfer care to another team. If the Consultant is not on the round, do we need the Consultant's advice, OK or decisions?

Documentation

- Today's note written – did someone write in the notes – did they write sense? So often after all the work done above the note says "Seen by Dr Caldwell, pulse 90, bp 120/70, sats 96% (on what O2?), plan "Continue" Useless!
- Night Plan Needed – is the patient unstable, should a plan for the night be written, does the Hospital at Night Team need to know the details
- Weekend Plan – if it is Friday a weekend plan must be written – diagnosis, anticipated progress, ceiling of care and CPR and why tests have been requested. If patient needs review a note must be written and given to the weekend team

Sum up to

- Patient – one or two sentences "So you have pneumonia, you were critically ill, you are getting better, two more days antibiotics into the vein then you will be ready for home. You will have an X ray in 4 weeks and I will write to you with the result and call you back to my clinic if needed."
- Report Back to Nurse – of course your nurse was with you all the time and understood all that you said, so you don't need to go down to the other end of the ward where she is giving out lunches, and find a quiet place to report back to her on the progress of her patient!

Checklist Report Back Time

Before leaving the bedside the Consultant or Team Leader must say out loud something like this "We are just going to check that we have covered everything, Mark, have we covered it all?" – if Mark always says "Yes" he is probably not a good checker. We have been very poor on CPR decisions, DVT propylaxis, eating and drinking, taking reports from and giving reports to nurses. If something has been missed do not move on until someone in the team has corrected it. Keep the team there until it is done.

Good Job Well Done Debrief Time

Again I am poor at this. At the end the team deserves it post match break – a cup of coffee and a re-run of the round. When you look at the Checklist you can see how much, and how complex a job you have done and how well you did it! Aren't we a great team? How well and safely our patients were treated! Also you can think "Next time what would be better" and "If we fiddled with the Checklist it might be better like this".

Also I have found that this gives students and Juniors a real insight into what the job is that they are doing. The routine also starts to become automatic, the team looks out now and anticipates the work.

Prescribing Standards – Check and Correct

This process can be used to ensure that your team's drug charts are the best in the hospital. It also ensures that the Pharmacist on your team can concentrate on important issues like drug interactions, allergies, side effects, patient's compliance and understanding. It is a great way to teach a student or Foundation Doctor the importance of clear legible and accountable prescribing.

I use this on post take rounds when the chart is fresh, and ensure that the team brings the chart up to standard. If the Pharmacist is checking she should not do the correcting – it is the Doctors' responsibility to produce a chart which is safe for nurses to use. It is not the Pharmacist's job to make the corrections for a doctor's deficient work!

We have bifold prescription chart with once only medications on the front, a two page regular prescriptions area on the inside and as required drugs on the back. You may have to adjust the Check and Correct for your own charts. If you have electronic prescribing, you will probably have stopped reading this already! However around the world most hospitals still have some sort of paper chart.

Patient initials and bed number

This simply helps the checker to keep track of which patient is which and to ensure that all charts have been checked.

Audit Domains

- Patient name, correct Consultant, Ward, Hospital Number on the front page – if the Consultant is wrong the nurse can spend valuable minutes trying to contact the correct doctors to clarify and questions about the chart.
- Patient name, Ward and Hospital Number of page 2 – this is the page that the nurse has open most often as she dispenses medication. The nurse must check name and number against the patient's wristband to ensure that the correct patient gets the medication. Leaving this blank makes the nurse's job far more difficult and time consuming.
- Weight on Kg – several important drugs depend on the patient's weight. Even a self reported weight is better than a blank!
- Drug idiosyncracies (allergy) box completed – patients can die if given a drug to which they are allergic. The box should be highlighted when the patient has dangerous allergies. The history should be carefully documented in the notes as well, and on any e-health record.
- Prescription entries all in black – easy to read, easy to photocopy
- All items prescribed as approved generic names? Most drugs should be prescribed using generic names e.g. aspirin. Insulin is an obvious exception and the correct brand name must be used. Some combination drugs can only be prescribed by brand name. Bio-availability issues with e.g. lithium, diltiazem means that the brand names have to be used. The full details are in the BNF.

- Regular drugs all have a date, dose and frequency? This is obvious.
- PRN drugs all have a date, dose and maximum frequency? Again this is obvious, but maximum frequency is often missed off "PRN" drugs
- All items are readily legible, clear and unambiguous. No one should have to squint and guess the name of any drug.
- For all antibiotics an indication and duration are written. The Pharmacist needs to check that the antibiotic matches Hospital Policies to reduce the emergence of resistant organisms. Prolonged courses increase the risk of Clostridium difficile diarrhoea, which carries an important mortality in the elderly.
- If insulin or heparin like agents are prescribed the word "units" written in full – a hastily written "U" can look like a zero resulting in a 10 fold increase in dose. Ten times too much insulin can result in severe hypoglycaemia.
- If there is an anticoagulant pink card, is warfarin also written on the main drug chart? Interactions with warfarin as so important that is must be clear that warfarin is being dispensed and the is being INR checked.
- All items signed by the prescriber. Obvious!
- All prescribers clearly identifiable by name, not just initials. A nurse or pharmacist must know who wrote a prescription in case she needs to ask about the medication. Is it safe to omit the drug is there is no supply? What if the patient refuses the drug? What if the dose seems wrong? Of course this is a back up to "Is the correct Consultant name on the front of the chart". I want anyone who adds to or alters the chart to do this – I do! Buy a rubber stamp is the easy solution!
- Have prescribers added bleep or GMC number of some other contact number? I now add a sticker to my home ward charts with the bleep numbers of my Juniors and my Radiopager number.

Check and Correct Report Back

Before leaving the bedside the Pharmacy Chart checker must be asked to give a report back e.g. "All correct on this chart, except no maximum frequency on the paracetamol, and the abbreviation "U" was used not units, no patient weight and the patient is on a therapeutic dose of Dalteparin, we need to weigh the patient now.

Of course if one chart is perfect the Consultant has to have a bottle of Pink Champagne on Ice ready for the end of the day. My Pink Champagne is aging undisturbed, because as yet I have not found a way for patients to get weighed routinely on admission.

So What, Incidents and Audit

Using this you will know that your team has worked hard and well. This will likely improve the precision of diagnosis, the correct treatment and reduce the time a patient has to be in hospital.

This has definitely increased my incident reporting. I have learned to look at the patients' care more comprehensively and to see when care has gone wrong. We also now discuss much more openly about deficiencies and errors. I recognise now how much inferior a ward round is, when we cannot find the nurses. This will have an impact on the Trust's planning for nurse numbers and how nursing time is used.

I have also seen my Juniors grow in confidence in challenging poor standards with me and with each other. This can only benefit patients.

You will also find out how much time it takes to do the job well – a lot!

Of course you need to know if this really benefits patients and the Trust. In an ideal world it would be easy to find out that your patients stayed in for a shorter period of time, were readmitted less often, made fewer complaints and sent you more bottles of Whisky at Christmas than other Consultants' patients. In reality these data are hard to find. Also I strongly suspect that other Consultants' patients benefit from your work! Your Juniors go and work for the other Consultant and take the good practice with them.

So you are left with audits – make sure the Audit Department audits your prescribing and your notes keeping. If they will not do it, then get your team to do quick audits. My student audited 10 of my patients' prescription charts after the end of my round and 10 each from two other Consultants who had just finished their rounds. Our charts were far superior!

Final Words

This is all so simple and logical I am ashamed that it has taken me 16 years as a Consultant to come up with it all.

At the end of it all it is so very straightforward

- Make it plain what you want
- Measure whether you are getting it
- If you are, say thank you, well done
- If you are not, say thank you, and correct it now, before we move on

Dr Gordon Caldwell
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