

Making Ward Rounds Count

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Foreword

It is clear that delivering safe, high quality care to patients depends on developing and using reliable processes. In 2014, care in hospital is the result of many linked processes, usually delivered by several teams of clinicians, allied health professionals and others. The co-ordination of these multiple inputs/processes is a central function of the clinical ward round. The task may be considered as analogous to a team assembling a very difficult jig-saw puzzle 'against the clock'. It requires the development of an agreed plan of action (care), which records what is to be done - and by when. Such an approach can help deliver seamless, effective and efficient care in a compassionate manner. The post-take ward round, the focus of this GAIN audit, should be the foundation of such co-ordinated patient care.

Hospital treatment is now so complex that a systematic approach to all clinical rounds is non-negotiable. While variation may be needed for different specialties or patient groups, the underlying template for clinical rounds should be the same. There is no justification for compromising the safety of patients by having widely differing ward round practices depending on who is, or isn't, present.

This audit shows that, across HSC Trusts, a standardized approach is emerging which ensures core elements of care are discussed at the post-take round. In particular, the data on the use of VTE risk assessment, early warning scores, a written management plan and an estimated date of discharge are encouraging. While notes are signed and dated, recording the time the note was made is not reliable in many Trusts. This makes reviewing the patient journey, either for learning or judgment, more difficult.

The presence of nursing staff on ward rounds represents the best opportunity for exchange of information and discussion between the two groups central to the care of most hospital patients. This appears to be an area of weakness flagged by GAIN. We know that the timing and punctuality of ward rounds can make planning nursing presence on ward rounds more (or less) challenging. Another aspect is the resource implication versus the potential benefit gained by the presence of multiple disciplines on ward rounds.

Improvement is founded on the appropriate use of relevant data. GAIN is to be commended in supporting this work which provides a spur for learning and improvement. While this work focuses on a sample of post-take ward rounds, the learning should be applied to all ward rounds across secondary care and possibly further. The information assembled by this GAIN audit facilitates the spread of good practice and changing ways of working which compromise safety.

Our patients would expect us to use the opportunity well.

San for .

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Background

"Ward Rounds are the pit stops of clinical care, and require as much study and optimisation as a Formula One team would put into their pit stop routines." Dr Gordon Caldwell speaking at the Healthcare Conferences UK's effective Ward Rounds Conference in 2012.

Medical ward rounds are complex clinical activities, critical to providing high-quality, safe care for patients in a timely, relevant manner. They provide an opportunity for the multidisciplinary team to come together to review a patient's condition and develop a coordinated plan of care, while facilitating full engagement of the patient and/or carers in making shared decisions about care. Additionally, ward rounds offer great opportunities for effective communication, information sharing and joint learning through active participation of all members of the multidisciplinary team ¹.

The Federation of Royal Colleges of Physicians of the UK state "The physician's first responsibility must be to the patient and their safety. At the heart of a physician's practice is the consultation." ² Post take ward rounds are where a clinical diagnosis is obtained or revised, a clinical examination is undertaken, decisions about future investigations and treatment options are made, discharge plans are formulated and written and verbal communication is undertaken ³. However, ward rounds are not solely the responsibility of doctors. According to a recent joint publication between the Royal College of Physicians and the Royal College of Nursing, a nurse should be present at every bedside during ward rounds to help improve the quality of ward rounds ¹.

Thompson et al, state that the quality of patient care is reliant on the quality of information communicated between health care professionals. With new patterns of working (partial and full shift patterns) and ward based management systems, a patient's admission to hospital may involve several doctors and geographic moves⁴. With each move or different doctor there is a risk that some information may be lost regarding the patient. It is critical that each piece of information is appropriately documented. Often ward rounds are busy and pressurised times. In the study "Quality and safety at the point of care: how long should a ward round take?"⁵ it was found that the average time spent per patient was 12 minutes (10 minutes on routine ward rounds and 14 minutes on post-take rounds). During this short period of time with the patient there is a lot of information to record. Both the Royal College of Physicians (RCP) and the Nursing and Midwifery Council (NMC) agree that all information regarding the patient's condition, diagnosis and decisions about their care needs to be properly documented ¹. Each entry should signed, dated and timed and completed as close to the actual time as possible ^{6,7}. Fernando and Siriwardena found that junior doctors did not record the consultants' clinical findings and management plans during surgical ward rounds⁸. Recording the estimated date of discharge is also a useful tool in helping with planning, productivity and efficiency⁹, it can also help reduce costs on already stretched budgets. The National Audit Office estimated that a reduction in length of stay of between two and six days per patient could save NHS trusts £15.5m–£46.5m a year in total ¹⁰.

Medications are among the most frequently used treatment options used to improve patient health. The British National Formulary (BNF) states that medicines should be prescribed only when they are necessary, and in all cases the benefit of administering the medicine should be considered in relation to the risk involved ¹¹. Unsurprisingly drug errors are among the leading causes of avoidable harm to hospital inpatients ¹², as such the administration of drugs should be regarded as a high risk procedure. Coombes et al state that adverse events caused by medication have been

estimated to harm 1% to 2% of patients admitted to hospitals in the United States, United Kingdom and Australia ¹³. The drugs most frequently associated with Adverse Drug Reactions were diuretics, opioid analgesics, and anticoagulants ¹⁴. Potential causes for error can include doctors' poor handwriting, lack of attention to detail and failure to identify themselves as the accountable prescriber ¹⁵. Again the BNF advises that titles of drugs and preparations should be written *in full.* Unofficial abbreviations should not be used as they may be misinterpreted.

When a nurse or pharmacist identifies a potential error, it can be difficult to clarify with the prescriber as the consultant's name is not clear, or up to date. Other studies have identified other factors contributing to prescribing errors; these include a lack of training and the working environment in which junior doctors are exposed, as well as the perception of prescribing as routine and unimportant ¹⁶.

Not only do errors in drug administration lead to complications in treatments, increased financial cost of drugs but also according to the report, An Organisation with a Memory, serious errors in the use of prescribed medicines now account for 20% of all clinical negligence litigation ¹⁷.

During 2011/12, there were a total of 603,080 admissions to hospitals in Northern Ireland. Of these 603,080 patients admitted to hospital, 51.1% (308,051) were admitted to hospital for day case treatment while the remaining 48.9% (295,029) were admitted as an inpatient ¹⁸.

Aim

To audit and review current practice in relation to Post Take Ward Rounds and Prescribing Standards, identifying aspects of good practice and areas for improvement to ensure that patients receive high quality care.

Overall Purpose

To improve clinical teams performance in the care of acutely ill patients and reduce drug errors

Objectives

- 1. To improve team working on ward rounds
- 2. To improve the standard of care provided to patients and patient safety
- 3. To ensure drug charts meet minimum safe prescribing standards

Audit Methodology

Each HSCT was asked to identify all wards and consultants within Cardiology, Medical Assessment Unit, Emergency Department and Care of the Elderly (Table 1). Additionally to ensure consistency with the changeover of junior doctors in August, audit visits were split within each HSCT before and after August junior doctor appointments.

Limitations and exclusions of this audit

Limitations

- The auditor was only on the ward for a short period of time and could not observe if each ward had separate reporting systems for reporting the outcome of the doctor's consultation later in the day.
- A lower than expected number of patients were audited due to the low number of admissions. The audit had no way of knowing in advance the number of patients to be seen each morning.
- The audit was limited to weekday post-take ward rounds.
- The audit was limited to morning post-take ward rounds.

Exclusions

- Those patients who were under 18 years of age
- Those patients in maternity wards

Data Collection Methods

Two approaches were taken to capture the required information.

- Firstly an observation audit was undertaken to capture information regarding the standard of care provided to patients and patient safety.
- Secondly in order to ensure that drug charts met safe prescribing standards case note audits were conducted.

Two questionnaires were designed as data collection tools specifically to capture the required information (Appendices 1 & 2); one for case note reviews and one for observational audits. These questionnaires were tested within the acute setting by experienced research staff.

Consultants were aware that an audit was taking place during a specified period of time within each Trust, however, they did not know what date they would be having an auditor present. Data was collected between 27 June 2013 and 26 October 2013.

Patient Selection

Observational audit: Patients were selected as being on the post take ward round on the day the auditors visited each ward environment within each hospital.

Case Note review audit: The same patients who were assessed by the consultant on the post take ward round were also selected to have their medicine kardex reviewed following the ward round.

Data Management

Data was collected manually and then entered into Microsoft Excel 2010. To ensure consistency each auditor underwent training in the use of the data collection tools. Robustness of data entry was ensured using double blind entry techniques, a data entry quality control method. Additionally data cleansing occurred to identify and fix incomplete, incorrect, inaccurate and irrelevant data.

Results

In total there were 35 ward round audits carried out, accounting for 232 individual observations across the 5 Health and Social Care Trusts. Table 1 below shows the type of ward where the audits were carried out within each HSCT. Where the table indicates a 0, this indicates that there were no patients to be observed when the auditor visited. The Emergency Department also took into account Ambulatory Units where patients were waiting to be transferred to a ward.

| | Ca | ardiology | Care | e of Elderly | ſ | Medical | Emergency Department | | |
|--------|-------|-------------|-------|--------------|-------|-------------|-------------------------|-------------|--|
| | No. | No. of | No. | No. of | No. | No. of | No. | No. of | |
| | of | observation | of | observation | of | observation | of | observation | |
| | audit | S | audit | S | audit | S | audit | S | |
| | S | | S | | S | | S | | |
| BHSCT | 2 | 7 | 3 | 11 | 3 | 22 | 0 | 0 | |
| NHSCT | 2 | 7 | 3 | 22 | 4 | 36 | 1 | 1 | |
| SEHSCT | 1 | 4 | 1 | 1 | 3 | 21 | 2 | 18 | |
| SHSCT | 1 | 7 | 0 | 0 | 2 | 33 | 1 | 5 | |
| WHSCT | 2 | 11 | 2 | 5 | 2 | 21 | 0 | 0 | |
| Total | 8 | 36 | 9 | 39 | 14 | 133 | 4 | 24 | |

Table 1: Audits carried out by ward type in each HSCT

It is important that the correct people are present at the commencement of and during the ward round. The figures below show who was present at the commencement of the ward round.



Figure 1: Details of Consultants present at commencement of ward round

Figure 1 shows that the Consultant was present at the commencement of 100% of the ward rounds across all 5 HSCTs.



Figure 2: Details of Nurses present at the commencement of ward round

Figure 2 shows the NHSCT had a nurse present at 100% (10) of the audits carried out within the Trust, the WHSCT had a nurse present at 83% (5 out of 6), the SEHSCT had a nurse present at 71% (5 out of 7), the BHSCT had a nurse present at 63% (5 out of 8) and SHSCT had a nurse at 50% (2 out of 4). The overall percentage was 77% of nurses present at the commencement of the ward round.



Figure 3: Details of other doctors present at the commencement of the ward round

Figure 3 shows that there were other grades of doctors present at the commencement of the ward rounds in 34 out of 35 audits. The most common grade of doctor on the ward round was Foundation Year 2 (F2). The only occasion where a consultant did a ward round without another grade of doctor was in the BHSCT. The information regarding doctors' grades was taken from their Identification Badges.



Figure 4: Details of completion of admission proforma

Figure 4 above shows that 4 out of the 5 HSC Trusts used and completed an admission proforma for all the patients in the audit which represents 96% completion. The only Trust not to have completed an admission proforma in all cases was the WHSCT where they completed 73% (27 out of 37) of admission proformas.





Each Trust completed a VTE risk assessment tool. In some Trusts this was part of the medicine kardex, while in others it was part of the admission proforma. As shown in Figure 5, the only HSCT to have 100% completion of the VTE risk assessment tool was the SHSCT. The WHSCT (36 out of 37) and NHSCT (64 out of 66) both completed 97%, while SEHSCT (42 out of 44) and BHSCT (38 out of 40) both completed 95%. The overall completion of VTE risk assessment tools was 97%.



Figure 6: Details of completion of Pressure Damage risk assessment tool

Each Trust completed a Pressure Damage risk assessment tool. During the audit it was found that the Pressure Damage Risk assessment tool was completed by the nursing staff and was held in the nursing notes. The overall completion rate of the Pressure Damage risk assessment tool was 85%. Figure 6 shows that WHSCT completed 92% (34 out of 37), SHSCT completed 87% (39 out of 49), SEHSCT 86% (38 out of 42), NHSCT 85% (56 out of 66) and BHSCT 75% (30 out of 40).



Figure 7: Details of diagnostic tests checked

In 4 out of 5 of the HSCTs 100% of patients had their diagnostic tests checked by the ward round team before going to the patient's bedside. Figure 7 shows that in 5% of patients in NHSCT (3 out of 66) the ward round team did not check the patients diagnostic tests before going to the patient's bedside.



Figure 8: Details of patient's identity checked

In 100% of cases the patient's identity was checked and confirmed before the consultation began. This was done by confirming with the patient their name, of if the patient was not able to respond by checking their wrist band or with the patient's nurse.



Figure 9: Details of patients who had an identification wristband

Overall 93% of patients had an identification wristband in place at the time the audit took place. WHSCT had 97% of patients with a wrist band (36 out of 37), NHSCT had 95% (63 out of 66), SEHSCT had 93% (41 out of 44), SHSCT had 91% (41out of 45) and BHSCT had 88% (35 out of 40). The scope of the audit did not allow for the reason of the patient not having an identification wristband to be explored.



Figure 10: Details of PEWS/MEWS/NEWS charts checked

Figure 10 shows that in 100% of cases across all 5 HSCTs that the patient's PEWS/MEWS/NEWS charts were checked during the consultation.



Figure 11: Details of Vital Signs checked

The overall percentage of vital signs checked at the consultation was 98%. Figure 11 shows that 3 out of the 5 HSCTs had checked all of their patients vital signs. In WHSCT 8% (3 out of 37) and in NHSCT 3% (2 out of 66) did not have their vital signs checked.



In 4 out of 5 HSCTs all the patients had their medicine kardexes checked at their consultation. Figure 12 above shows that 3% of patients in the NHSCT did not have their medicine kardex checked at their consultation (2 out of 66).

The audit looked to see if a member of the nursing team from each ward accompanied the medical team as they completed the post take ward round. If a nurse was not present the audit then looked to see if the medical team reported back to nursing staff following the consultation or ward round.



Figure 13: Details of nurses present at the bedside during the consultation

Overall the percentage of nurses who were in attendance at the patient's bedside during the consultation with medical staff was 74%. Figure 13 above shows that NHSCT had a nurse present in 97% of consultations (64 out of 66), WHSCT had 76% (28 out of 37), BHSCT had 68% (27 out of 40), SHSCT had 67% (30 out of 45) and SEHSCT had 52% (23 out of 44).

Figure 12: Details of medicine kardex checked

Figure 14: Details of cases reported back to nursing staff if no nurse present at bedside during the consultation



Of the 60 patients where a nurse was not present at their consultation a total of 78% of these had the details reported back to nursing staff on the ward during the time the auditor was present on the ward. In 3 out of the 5 HSCTs all 100% were reported back, while in SHSCT it was 67% (10 out of 15) and in SEHSCT it was 62% (13 out of 21). It should be noted that it is possible that details were reported back to the nursing staff later in the day after the auditor had completed the particular visit.



Figure 15: Details of diagnosis recorded in the patient's notes

Figure 15 shows that both SHSCT and SEHSCT had 100% of the patient's diagnosis recorded in their notes during the consultation. BHSCT had 98% recorded (39 out of 40), NHSCT had 91% (60 out of 66) and WHSCT had 86% (32 out of 37). The overall percentage was 95%.



Figure 16: Details of Estimated Date of Discharge recorded in the patient's notes

The overall percentage of estimated date of discharge (EDD) recorded in the patient's notes was 92%. Figure 16 above shows that SHSCT had 98% of EDD's recorded (44 out of 45). BHSCT also had 98% recorded (39 out of 40), SEHSCT had 93% (41 out of 44), WHSCT had 89% (33 out of 37) and NHSCT had 85% recorded (56 out of 66). The 1 N/A for SHSCT was a patient in palliative care.

Figure 17: Details of management plans that have been agreed and recorded in the patient's notes



Figure 17 shows that all 5 HSCTs agreed and recorded the patient's management plan in their notes.

Figure 18: Details of tasks that have been delegated if action is required following the consultation



Figure 18 shows that if a task was required to be completed following the consultation, this was delegated to a member of staff. All 5 HSCTs had 100% completion in this.



Figure 19: Details of patient's notes signed by a Doctor on the ward round

Four out of the 5 HSCTs had a 100% completion rate of having the patient's notes signed by one of the Doctors on the ward round, the overall percentage was just under 100%. The WHSCT had 97% of the patient's notes signed by a doctor (36 out of 37).



Figure 20: Details of notes dated and timed

The overall percentage of notes which were dated and timed was 82% with the remaining 18% being dated only. BHSCT were the only Trust to have 100% of their notes dated and timed. Table 2 shows the percentage of all the Trusts.

| Trust | % Dated and Timed | % Dated only |
|--------|-------------------|--------------|
| BHSCT | 100% | 0% |
| SEHSCT | 91% | 9% |
| SHSCT | 82% | 18% |
| WHSCT | 81% | 19% |
| NHSCT | 65% | 35% |

Table 2: Comparison of notes dated and timed versus dated only

In addition to the processes of the Post Take Ward Round, the audit also looked at the way the patient's medicine kardex was completed.



Figure 21: Details of patient's name recorded on the medicine kardex

Figure 21 above shows that all 5 HSCTs had 100% of the patients' name recorded on their medicine kardex.





As shown in Figure 22, all 5 HSCTs had 100% of the patients' date of birth recorded on their medicine kardex.



Figure 23: Details of patient's hospital number recorded on the medicine kardex

Overall a total of 99% of patients had their hospital numbers recorded on the medicine kardex. Figure 23 above shows that 4 out of 5 HSCTs had 100% of the patient's hospital number recorded. The WHSCT had 97% recorded (36 out of 37).



Figure 24: Details of patient's ward name recorded on the medicine kardex

Figure 24 shows that only a total of 40% of patients had the name of the ward recorded on their medicine kardex. WHSCT had 59% recorded (22 out of 37), SHSCT had 58% recorded (26 out of 45), SEHSCT had 41% recorded (18 out of 44), BHSCT had 35% recorded (14 out of 40) and NHSCT had 20% recorded (13 out of 66).



Figure 25: Details of patient's weight recorded on the medicine kardex

Overall a total of only 15% of patients had their weight recorded on their medicine kardex. Figure 25 shows that SHSCT had 40% of the patients weight recorded on their medicine kardex (18 out of 45), SEHSCT had 18% recorded (8 out of 44), WHSCT had 14% recorded (5 out of 37), NHSCT had 5% recorded (3 out of 66) and BHSCT had no weights recorded on the medicine kardex. It should be noted that patient's weight is also recorded in the nursing notes, although this was not audited in this audit.



Figure 26: Details of drug idiosyncrasies (allergy) box completed

Overall 99% of patients had their drug idiosyncrasies box completed on the medicine kardex. Figure 26 above shows that 4 out of 5 HSCTs had 100% of the patients' hospital number recorded. The SHSCT had 97% recorded (44 out of 45).

Figure 27: Details of items recorded on the medicine kardex that are readily legible, clear and unambiguous



A total of 226 patients out of the 232 audited had drugs prescribed on their medicine kardex. Of these 225 were deemed by the auditors to be legible, clear and unambiguous, which equates to 99% of records. Figure 27 shows that 4 out of 5 HSCTs had 100% of the entries which were legible, clear and unambiguous. NHSCT had 1 entry of which was deemed as unclear (1 out of 64). The N/A entries (BHSCT – 1, NHSCT – 2 and SEHSCT – 3) relate to patients who did not have any entries made in their medicine kardex.

Table 3: BNF recommendations for recording drug units

The unnecessary use of decimal points should be avoided, e.g. 3 mg, not 3.0 mg.

Quantities of 1 gram or more should be written as 1 g etc.

Quantities less than 1 gram should be written in milligrams, e.g. 500 mg, not 0.5 g.

Quantities less than 1 mg should be written in micrograms, e.g. 100 micrograms, not 0.1 mg.

When decimals are unavoidable a zero should be written in front of the decimal point where there is no other figure, e.g. 0.5 mL, not .5 mL.

Use of the decimal point is acceptable to express a range, e.g. 0.5 to 1 g.

'Micrograms' and 'nanograms' should not be abbreviated. Similarly 'units' should not be abbreviated.

Table 3 above shows how the BNF recommends that drug units should be recorded on all prescriptions and notes.

Figure 28: Details of drugs prescribed on the medicine kardex whose units are recorded in the recommended BNF format



Of the 226 patients who had drugs prescribed all were written on the medicine kardex in the format recommended by the BNF.





Of the 226 patients who were prescribed medication, only 197 were prescribed PRN drugs. From Figure 29 above it can be seen that all of these prescriptions had a dose and a maximum dose or frequency recorded on the medicine kardex.

Discussion

The audit showed that all the post-take ward rounds were initiated by the consultants and not carried out by junior doctors. There was also at least one junior doctor on 34 out of the 35 ward rounds audited; these ranged in grades from Foundation Year 1 doctors to Registrars.

Nurses were also present at the start of the post-take ward round in 77% of the audits. The NHSCT had nurses present at 100% of the post-take ward rounds.

Of the ward rounds audited, it was found that 4 out of the 5 HSCTs had used an admission proforma for 100% of their patients.

Completion rate of the VTE Risk assessment were very good, with the overall completion rate of 97%. SHSCT completed 100% of the VTE Risk assessments. WHSCT and NHSCT both completed 97%, SEHSCT and BHSCT both completed 95%.

Details of the Pressure Damage Risk assessment were held in the nursing notes of each patient. The audit showed that overall this risk assessment was completed in 85% of cases. While this represents a reasonably high completion rate it is expected that this should be completed for all patients especially when consideration is given to the high cost involved in treating pressure ulcers and also the delay in discharging patients.

It was shown in the audit that the majority of doctors on the ward round had checked for diagnostic tests before going to the patient's bedside. This is essential in providing a full and accurate picture of the patient's condition and assisting in decision making. The only HSCT not to have done this in all the consultations was the NHSCT where 5% of patients' diagnostic tests were not checked.

During the audit, the consultants checked the identity of each patient before the consultation began. However, it was recorded that a total of 7% of patients did not have an identification wristband in place. While this may seem a small percentage, it should be noted that not all patients may have the ability to communicate with the medical or nursing staff and the patients may not always be known to the staff on the ward round. It is here that potential mistakes could be made in treatment or prescribing medication. It must be noted that the audit did not look into the reason for the patient not having an identification in place.

Again it was encouraging to note that all the patients' early warning scoring tools were checked. This is vital that this is used to aid recognition of deteriorating patients and can help to inform doctors' decision making.

Overall the doctors on the post-take ward rounds check the vital signs of 97% of the patients. A total of 3 out of 5 HSCTs checked 100% of the patients' vital signs. This is an essential tool to inform the doctor of the progress of a patient.

Four out of the 5 HSCTs had all their patients' medicine kardexes checked at their consultation. A total of 3% of patients in NHSCT did not have their medicine kardex checked at their consultation.

Both the Royal College of Physicians and the Royal College of Nursing state a nurse should be present at every bedside during ward rounds to help improve the quality of ward rounds¹. In the audit it was shown that a nurse was present at 172 out of 232 patients' bedside during the patient's consultation. This represents 74%. With a nurse present at the bedside during the consultation, it helps to provide up to date information on the patient and how they have been doing since their admission. It is also a useful opportunity for information to be passed from the consultant to their nursing colleagues about changes required to the patient's care.

Of the 60 patients where it was identified that a nurse was not present during the consultation, a total of 47 patients had the information discussed during the consultation and passed to a nurse following the consultation. This equates to 78%. Of the remaining 22% the audit found no evidence of a report being made to nursing staff during the time the auditor was present.

The audit showed that during the time the auditor was on the ward, for 95% of patients there was a diagnosis, either actual or working, recorded in the patient's notes. Only the SHSCT and SEHSCT had a diagnosis recorded for all their patients.

A key component to planning is the estimated date of discharge for each patient. While it is recognised that this is an estimate and not fixed, it is an extremely useful in determining the hospital resources. It is also recognised as good practice and helps the patient to feel a little more in control during their stay in hospital. The audit showed that the EDD was recorded in 92% of patients' notes.

Along with planning for discharge, management plans for the patient while in hospital are essential. The audit found that a management plan had been agreed by all those present at the consultation and the details recorded in the patient's notes for each patient in the audit.

Likewise, the audit found that the actions required to be carried out following the agreement of the management plan or consultation had been delegated to the appropriate staff in 100% of cases.

Only one set of patient notes was not signed by a doctor during the ward round.

A total of 82% of patients' notes were dated and timed, while the remaining 18% were dated. BHSCT had 100% of their patients' notes dated and timed. Both the Royal College of Physicians and the Nursing and Midwifery Council¹ agree that all records should be dated and timed.

Regarding the patient's medicine kardex, in all cases the patient's name and date of birth were recorded, and all but one had the patient's hospital number recorded.

40% of patients had the name of the ward recorded on the medicine kardex. It is acknowledged that sometimes patients move around in the hospital setting, particularly following a post take ward round. However if the details are on the medicine kardex then they should be completed.

One patient did not have their drug idiosyncrasies recorded on their medicine kardex. While the completion rate is very good, we should be achieving 100% in such an important aspect of patient safety.

Some medications require the patient's weight to calculate the dosage, and while the weight may be recorded in the nursing notes, in an emergency situation there may not always be time to consult these. Recording of the patient's weight on the medicine kardex was poor. Only 15% of patients had their weight recorded.

Although a subjective observation, the audit showed that in one patient's kardex the medication recorded on the patient's medicine kardex was illegible and unclear. Patients should if the wish be able to read what they are being prescribed and be able to ask questions regarding their medication.

All the patients in the audit who were prescribed medication, whether regular or PRN medicines, were written in the recommended BNF format. All PRN drugs had the dose recorded and were appropriate the maximum dose recorded.

Conclusions

According to the Institute of Medicine, patient safety is "indistinguishable from the delivery of quality health care ¹⁹. As stated at the start of this report medical ward rounds are complex clinical activities, critical to providing high-quality, safe care for patients in a timely, relevant manner.

The audit found care to be delivered to a high standard:

- The medical staff were very thorough in their consultations and in agreeing a management plan for each patient.
- Details of tests and all other information regarding the patient were checked before going to the patient's bedside.

Some areas of improvement were identified in the audit:

- Not all patients had an identification wristband
- There was not always a nurse present at the patient's bedside during the consultation.
- All patients should have a diagnosis or working diagnosis recorded in the notes following the consultation. The audit found that just over 94% had this recorded.
- Only 91% of patients had their estimated date of discharge recorded in their notes, this is essential when it comes to planning for a patient going home or about the availability of beds within the hospital.

As recommended by both the RCP and NMC all notes should be dated and timed. The audit showed 81% compliance.

Regarding the completion of the patient's medicine kardex, although this was completed to a high standard, there were concerns regarding completion of the ward name and the patient's weight. Some medications require the dosage to be calculated according to the patient's weight; therefore it is essential that this is recorded for all patients.

Recommendations for post take ward round

- A member of the wards nursing staff should be present at the commencement and throughout the post take ward round
- > All patients should have their pressure damage risk assessment tool completed at admission
- > All patients should have an identification wristband fitted on admission
- H&C number should be used as a unique identifier on the patients wrist band, this can link with Electronic Care Record
- All patient diagnosis should be recorded in the patients notes before the conclusion of the post take ward round
- All patients estimate date of discharge should be recorded in their notes before the conclusion of the post take ward round
- > All patients should have their notes dated and timed
- > All patients should have the name of the ward recorded on their medicine kardex
- > All patients should have their weight recorded on their medicine kardex

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| Glossary | |
|---------------------------------|---|
| BHSCT | Belfast Health and Social Care Trust |
| BNF | British National Formulary: provides prescribers, pharmacists and other healthcare professionals with up-to-date information about the use of medicines |
| Drug Idiosyncrasies | An adverse drug reaction |
| Medicine Kardex | Document where a patients medication is recorded |
| NHSCT | Northern Health and Social Care Trust |
| NMC | Nursing and Midwifery Council |
| PEWS / MEWS / NEWS charts | Early warning scoring tools used to aid recognition of deteriorating patients, and are based on physiological parameters, which are taken when recording patient observations. Trusts are moving to replace PEWS / MEWS with NEWS |
| Pressure Damage Risk Assessment | An assessment to identify the risk of developing a pressure ulcer |
| PRN | The Latin initials for the medical term meaning "As Needed" |
| PTWR | Post Take Ward Round – first ward round following a patients admission to hospital. This should be within 24 hours of a patient being admitted to hospital. |
| RCN | Royal Colleague of Nursing |
| RCP | Royal Colleague of Physicians |
| RQIA | The Regulation and Quality Improvement Authority is Northern Ireland's independent health and social care regulator |
| SEHSCT | South Eastern Health and Social Care Trust |
| SHSCT | Southern Health and Social Care Trust |
| VTE Risk Assessment | An assessment to identify the risk of developing venous thromboembolism (blood clots) |
| WHSCT | Western Health and Social Care Trust |







Considerative Checklist for Complete Patient Review

| Date | //2013 | Pers form | son cor า | n completing | | | | Hospita | al | | | | | | | |
|---|--|--|--------------|--------------|----------|---------|---------|------------|-------------|----------|------------------|-------|-------|---------|-------|--------|
| Ward | Name | | | | Ward | Туре | | | | | | | | | | |
| Name | of Dr leading | | | | Gra | ade of | Dr lead | ling | | | | | | | | |
| ward r | ound | | | | wa | rd rour | nd | 0 | | | | | | | | |
| Ward | round number | Start Tim | | | rt Time | e | | | | | Finish | Time | ; | | | |
| Were | key people pre | sent a | at the st | art of th | ne war | d roun | d | | | | | | | | | |
| Consu | ultant | Nurs | е | | Othe | r Docto | or | | Otł | her (Spe | ecify) | | | | | |
| | | | | | Yes/I | No | | | | | | | | | | |
| Yes/N | 0 | Yes/ | / NO | | Spec | ify | | | | | | | | | | |
| Aspe | ct of Care | | | | | | | | | | | | | | | |
| | Audit Nun | nber | | | | | | | | | | | | | | |
| | Date of Admis | sion | | | | | | | | | | | | | | |
| | Time of Admis | sion | | | | | | | | | | | | | | |
| Prepa | aratory Discuss | ions | | | P | repara | ation E | Befo | re | Going | to the | Bed | side | • | | |
| Is adr | nission proform | na in | | | | | | | | | | | | | | |
| | | use | | | | | | | | | | | | | | |
| Check | k Bloods ECG (| CXR | | | | | | | | | | | | | | |
| | Nurse Pre | sent | | | | | | | | | | | | | | |
| VT | E Risk Assessn | nent | | | | | | | | | | | | | | |
| Pres | sure Damage I | Risk | | | | | | | | | | | | | | |
| Assessment | | nent | | | | | | | | | | | | | | |
| | Canadita | 4 | ~ | | II mala | | | | | 1- / D- | de la la | | | lt. | - 1 | |
| | <u>Consulta</u> | ation | C | heck a | ll rele | evant | bedsic | de ch | har | ts / Beo | dside | Patie | ent C | onsulta | ation | |
| Has | Consulta Patient a wristb | ation and | C | heck a | | evant l | bedsic | de ch | har | ts / Bee | dside | Patie | ent C | onsulta | ation | |
| Has | <u>Consulta</u> Patient a wristb Is the patient | ation and s ID | C | heck a | II rele | evant | bedsic | de ch | har | ts / Beo | dside | Patie | ent C | onsulta | ation | |
| Has | Consulta Patient a wristb Is the patient chec WS / MEWS C | ation and s ID ked hart | C | heck a | | | bedsic | de ch | har | ts / Bee | dside | Patie | ent C | onsulta | ation | |
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| Has PE | Consulta Patient a wristb Is the patient chec WS / MEWS C Vital S Medicine Ka | ation band s ID cked hart igns rdex | C | heck a | | evant | bedsic | le ch | har | ts / Bee | dside | | ent C | onsult | | |
| Has PE | Consulta Patient a wristb Is the patient chec WS / MEWS C Vital S Medicine Kar | ation band s ID cked hart igns rdex | C | heck a | | evant | bedsic | ing s | Sta | ts / Beo | rticipa | | and | Report | | k |
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The purpose of this process is to bring the drug charts up to minimum safe standards

| Date | /2013 | Person completi | ng form | | | | | Hospital | | | | | |
|---|---|---|---------|--|--|--|--|----------|--|--|--|--|--|
| | | Audit Number | | | | | | | | | | | |
| Safe Prescribing Standard | | Ward | | | | | | | | | | | |
| 1) Pati | ent details | Patient Name | | | | | | | | | | | |
| compl | ete and legible | Patients DOB | | | | | | | | | | | |
| (Label | preferred) | Patients Hospital Number | | | | | | | | | | | |
| | | Patients Ward | | | | | | | | | | | |
| 2) Is th | ne patients weigh | t recorded? | | | | | | | | | | | |
| 3) Dru compl | g idiosyncrasies eted? | (allergy) box | | | | | | | | | | | |
| 4) Are all items readily legible, clear, and unambiguous – <u>could the patient</u> easily read and check the drug names? | | | | | | | | | | | | | |
| 5) If any drugs are prescribed, are the units written in the recommended BNF format (see below from BNF) | | | | | | | | | | | | | |
| 6) PRN approj maxim parace | l drugs all have c priate a maximun num frequency e. etamol? | lose and where n dose or g. morphine, | | | | | | | | | | | |

The unnecessary use of decimal points should be avoided, e.g. 3 mg, not 3.0 mg.

Quantities of 1 gram or more should be written as 1 g etc.

Quantities less than 1 gram should be written in milligrams, e.g. 500 mg, not 0.5 g.

Use of the decimal point is acceptable to express a range, e.g. 0.5 to 1 g.

Quantities less than 1 mg should be written in micrograms, e.g. 100 micrograms, not 0.1 mg.

When decimals are unavoidable a zero should be written in front of the decimal point where there is no other figure, e.g. 0.5 mL, not .5 mL.

^{&#}x27;Micrograms' and 'nanograms' should not be abbreviated. Similarly 'units' should not be abbreviated.

Steering Team

Membership of the Making ward rounds count Steering Team

| Name | Designation | Trust |
|-----------------------|--|--------------------|
| Chairperson | 1 | |
| Dr Marina Lupari | Assistant Director Nursing – Research & Development | Northern HSC Trust |
| Members | | |
| Jonathan Wright | Project Facilitator | NHSCT |
| Richard Bigger | Auditor | NHSCT |
| Ruth McDonald | Head of Governance | NHSCT |
| Dr Gerard Rafferty | Medical Consultant | NHSCT |
| Dr Neil Black | Medical Consultant | WHSCT |
| Dr Seamus Dolan | Medical Consultant | WHSCT |
| Dr Charlie McAllister | Medical Consultant | SHSCT |
| Dr Kate Ritchie | Medical Consultant | SHSCT |
| Dr Roland McKane | Medical Consultant | SEHSCT |
| Dr Darren McLaughlin | Medical Consultant | SEHSCT |
| Dr Niall Leonard | Medical Consultant | SEHSCT |
| Eimear McCusker | Head of Pharmacy and | BHSCT |
| | Medicines Management | |
| Anne Quinn | Effectiveness and Evaluation | SEHSCT |
| | Manager | |
| Fintain McErlean | Multi-professional Audit Manager | BHSCT |

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