Training students and doctors for ward rounds

Dr Natalie Powell
Surrey and Sussex Healthcare NHS Trust
Hon Senior Lecturer Brighton and Sussex Medical School
@npowellnatalie  @sashnhs
Ward rounds

• Fundamental part of hospital life
• Ward round have influence on patient management and patient experience
• Many rounds are junior led
• Ward round etiquette is not part of Foundation curriculum

#teamAMU @sashnhs
Why do we need to look at ward rounds?

- **National**
  - Considerable variability in organisation and efficiency,
  - quality and patient experience

- **Local**
  - Feedback from SI’s
  - Standardisation of ward rounds in medicine
Background work:

- Junior doctor survey issued in SASH
  - \( n = 72 \) (35% FY1)

- Only 15% had any previous training

- 49% rated themselves as confident to lead a round
- 63% reviewed VTE risk and adherence
- 38% reviewed allergy status routines
- 28% reviewed resuscitation status, 48% ceiling of care
Patient survey

• Patient experience survey – 100 medical in-patients

• 79% said doctors introduced themselves

• Did not introduce whole team

• 58% were not given discharge plan information

• 39% felt they did not know their current treatment plan

“New members of the team should be introduced (and) where consultants rotate this should be explained”

“Simple name/rank chest labels”

“not too sure of what is happening but did not want to ask”
### Ward safety checklist

#### Ward Round Safety Check
- □ Hands decontaminated
- □ Key team members introduce themselves to patient/carer

#### Drug Chart Check
- □ Name & number correct
- □ Allergies on BOTH pages
- □ Missed doses reviewed
- □ Dose units written in full: 'micrograms' or 'units'
- □ Drug levels if applicable
- □ Dose adjustments for organ dysfunction if applicable
- □ Antibiotic route, indication and duration
- □ DVT risk assessment and prophylaxis is prescribed
- □ Prescribers’ names printed

#### Time Out
- □ Working diagnosis & differential
- □ Investigations and radiology reviewed
- □ MEWS chart/Fluid balance/other (eg drains)
- □ IV cannulae/urinary catheter reviewed
- □ Resuscitation/Escalation status reviewed
- □ Nutrition/fluid intake addressed
- □ Bowels/stoma
- □ Additional risks: eg falls/pressure areas
- □ Clear management plan
- □ Additional assessments: OT / PT /Sec 2 (circle)
- □ Key nursing staff informed of plan
- □ Documentation: name & bleep, date &time, filed

#### EDD/Discharge plan:
- EDD......................
- Sec 2 / Sec 5 (please circle)
- Is Patient Medically Fit? Y/N

#### Sign:
- Print name:
- Date

Adapted from BSUH checklist 2012
• Mandating checklist use alone will not work
• Widespread adoption of checklists elsewhere lacking

• Encouraging their use requires culture change

• And education....
Training in ward rounds

- Foundation curriculum
- Learning from seniors - the good, the bad and the ugly

- Simulation established as superior training method (2)
- Widely used in anaesthesitics, ICU and Emergency medicine
- Simulated ward environment validates as for assessing ward based process of surgical care (3)
Ward round simulation

- 3 hour training session
- Simulated ward patients and scenarios
- Learners have opportunity to lead and participate and observe
- Debrief
- Focus on safety and quality
- Low technology
- Low cost
- Faculty-min 4 for 20 students
- Groups 5-6 max
- Simulation suite not needed

### Scenario 3

<table>
<thead>
<tr>
<th>Scenario Background</th>
<th>Scenario Algorithm</th>
<th>Scenario Scene</th>
<th>Learning Objectives</th>
</tr>
</thead>
</table>
| You are the FY1 on the Acute Medical Unit. Your consultant has reviewed the new patients but has asked you to see the patients who were admitted yesterday. | Conduct a ward review of the patient | The patient is a 27 year old lady who presented to the medical take yesterday (30/07/13) with back pain. She was seen by the on call medical consultant during a busy intra-take ward round. You now see her on the acute medical unit the following morning. You are provided with the medical clerking, intra take notes and basic investigations. | Clinical:  
Identify haemodynamic instability  
Review antibiotics  
VTE prescription  
Non-Clinical:  
Clear introduction of team  
Empathetic approach  
Non intimidating (layperson terms, involve patient) |

<table>
<thead>
<tr>
<th>Scenario States / Equipment</th>
<th>Instructor’s Notes</th>
<th>General Notes</th>
</tr>
</thead>
</table>
| Variable Flow of consultation Interaction between team members | **Possible outcomes:** Team leader covers all key elements of patient interaction:  
Review of patient clerking  
Review of ECG  
Review of radiology  
Review of last entry and generation of problem list  
Assigns responsibilities to other team members  
**Patient review:**  
Hand washing  
Confidentiality, privacy and dignity consideration  
Introductions including team members  
Clanification of the correct patient  
Review of admission so far  
Social background  
Safety elements (DVT/TEDS, drug chart, allergies abx)  
Review frequency of observations  
Summarise to patient and check understanding  
Review patient concerns | **Debrief:**  
Clarity understanding with the team  
Check documentation reflects consultation  
Feedback to nursing staff/MDT members |
Initial project

- 72 final year medical students and 30 FY1 doctors trained
- Useful session - 100%
- Quality of session - 93% very good/excellent
- All wanted further training

<table>
<thead>
<tr>
<th>Learner</th>
<th>Confidence rating</th>
<th>leading (mean)</th>
<th>Confidence rating</th>
<th>documenting (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre training</td>
<td>Post training</td>
<td>Pre training</td>
<td>Post training</td>
</tr>
<tr>
<td>Medical students</td>
<td>2.08</td>
<td>3.33 * p&lt;0.001</td>
<td>3.30</td>
<td>3.72 p=0.08</td>
</tr>
<tr>
<td>FY1 doctors</td>
<td>2.13</td>
<td>3.35 * p&lt;0.01</td>
<td>3.32</td>
<td>3.66 p=0.056</td>
</tr>
<tr>
<td>Pooled data</td>
<td>2.10</td>
<td>3.34 * p&lt;0.001</td>
<td>3.30</td>
<td>3.70 *p&lt;0.001</td>
</tr>
</tbody>
</table>
• BSMS education conference/SAM/Medical leaders conference
• TELI bid
• QWRP formation
QWRP project plan

• Simulation sessions at two sites
• Baseline survey at control sites

• Re-survey at 3 months at all four

[Diagram showing two branches: QWRP (SASH, WSH(Chichester)) and Control (BSUH, WSH(worthing))]
QWRP 2014

• Sessions run for 60 FY1’s
• 3 scenarios
• Actors
• 15 minutes for review
• 10 mins debrief at end of each scenario
• SASH- pharmacists
• WSH- nurses
Scenarios

1. 42 yrs asthma
   - No guidance given

2. 27 yrs back and loin pain
   - Aim to incorporate checklist for structure

3. 84 yrs chest pain
   - Importance of MDT approach
Results:

- 34% had previous training (1 previously at SASH!)
- 90% felt useful
- 93% rated good/excellent
- 83% would like further sessions
- 93% felt training should be in undergraduate curriculum
- 100% felt the checklist gave them more confidence on the round
- “Really useful for start of FY1”
- “Demonstration by faculty would be useful”
Control sites: Worthing

- 56% had previous training (2 had simulation)
- Lack of confidence in leading
- More confidence in documenting
**QWRP sites**
Confidence leading

Significant improvement
Paired t test
P<0.001
Significant improvement
Paired t test
P<0.001
Paired t test
Significance level
p=0.003
AHP feedback - Pharmacists

- 6 pharmacists (SASH)
- None had any previous training
- Much more confident to play active role

- 100% rated excellent
AHP feedback-Nurses

- 12 band 5/6 Nurses (Chichester)
- 1/3 had previous “training”
- All felt valuable in reinforcing their role
- 100% rated excellent
Limitations

• Not all learners had opportunity to lead
• Training for AHPs may need to be slightly different
• Improving confidence does not mean improved competence
• Demonstrating improved clinical outcomes difficult
Conclusions

• Gap in training around ward round skills
• Simulation ward round training is well received and improves confidence
• Reinforces the role of AHPs and nurses in ward rounds
Next steps

- BSMS ‘prepare to practice’ week
- Wider MDT participation
- More Trusts joining the project
- Undergraduate vs postgraduate training
- Foundation competency?

- “Surely being able to perform a safe and structured ward review is just as important as being able to site a cannula??”
Acknowledgements

- Dr Chris Bruce, ST3 KSS Deanery
- Dr Des Holden - Executive sponsor
- Michael Wilson CEO and executive team for ongoing support
- Dr Martin Parry - STFS Associate Director
- Dr Wes Scott-Smith BSMS
- Dr Neal Gent - WSH
- Dr Gordon Caldwell - WSH
- Dr Graham Dewhurst - WSH, Head of the School of Medicine, KSS Deanery
References

