Please find below the results of your literature search request.

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**Literature search results**

**Search completed for:**

**Search required by:** 20th September 2013

**Search completed on:** 20th September 2013

**Search completed by:** Richard Bridgen

**Impact of senior review of patients at ward rounds.**

**Resources searched**

NHS Evidence; TRIP Database; Cochrane Library; BNI; CINAHL; EMBASE; HMIC; MEDLINE; Google Scholar; Google Advanced Search

**Database search terms:** ward* adj2 round*; patient* adj2 round*; TEACHING ROUNDS; morning* adj2 round*; (doctor* OR consultant*) adj2 round*; (grand OR teaching OR attending) adj2 round*; morning adj2 report*; (family-centred OR “family centred” OR family-centered OR “family centered”) adj2 round*; (MDT OR multi-disciplinary OR multidisciplinary) adj2 round*; round* adj2 (medic* OR nurs* OR famil*); senior* adj2 review*; consultant*; CONSULTANTS; “specialist registrar*”; “staff grade*”; “speciality trainee*”; ST4; ST5; ST6; “associate specialist*”; review*; evaluat*; assess*; apprais*; examin*; analys*; attend*; “be present”; join*; senior*; review*; exp PATIENT ROUNDS

**Evidence search string(s):** (round OR rounds OR review OR reviews) (patient OR patients OR ward OR wards) (consultant OR consultants OR ST4 OR ST5 OR ST6 OR "speciality trainee*" OR "specialist trainees*" OR senior OR "associate specialist*")

**Google search string(s):** (round OR rounds OR review OR reviews) (patient OR patients OR ward OR wards OR care) (consultant OR consultants OR ST4 OR ST5 OR ST6 OR "speciality trainee*" OR "specialist trainees*" OR senior OR "associate specialist*")

**Summary**

There is a considerable amount of research looking into the best way of reviewing patient care during ward rounds or otherwise. Much of it concerns senior review by a consultant or senior physician during ward rounds. I have also included research looking at other models of reviewing patient care, including ward rounds comprising other health professionals. It
would have been too time consuming to have searched also for models used within different specialties or business units; however the search is broad enough to have found all relevant research, and if you are looking for the type of ward rounds used in various specialties, you will find them in the results – there weren’t very many.

Guidelines and Policy

**College of Emergency Medicine**


Regular review by a senior ED doctor is recommended and a consultant led ward round must take place twice in 24 hours

**London Health Programmes**

*Adult emergency services: Acute medicine and emergency general surgery Case for change* 2011

See 3.2.5 *Ward rounds for emergency admissions*

**NHS Improvement**

*Equality for all: delivering safe care, seven days a week* 2012

1. See ‘Golden hour' seven day ward rounds for general medical admissions on p. 30
2. Virtual ward rounds are completed daily – with communication across the MDT. p. 20
3. Emergency ward rounds carried out twice a day, seven days a week in medicine, along with the implementation of acute medicine, improved the flow of patients. Clinical decision making through consultant presence provides earlier diagnosis, management and discharge. The trust reports this as a possible contributor to reduced morbidity and mortality rates. p. 34
4. The philosophy of the ward is on rehabilitation, with joint working from nursing and therapists from the very beginning with therapy and nursing ward rounds. The assessments are done jointly and all the patient activities have a rehabilitation focus, with treatment being goal orientated rather than process orientated. p. 62

**Royal College of Anaesthetists**

*Guidelines for the Provision of Anaesthetic Services (GPAS)* 2013

For stand-alone neuroscience centres, local arrangements should be in place for specialist opinion and review of patients by other disciplines. Named consultants should be identified in 'core' specialties to facilitate such liaison.

**Royal College of Nursing**

*Ward rounds in medicine: principles for best practice* 2012

**Royal College of Obstetricians and Gynaecologists**

*Safer childbirth: minimum standards for the organisation and delivery of care in labour* 2007

1. The consultant obstetrician should be present on the labour ward and conduct procedures, labour ward rounds to include reviewing midwifery-led cases on referral and teaching, as appropriate. Outside the hours of consultant presence, we would expect as a minimum that there would be physical ward rounds at least twice daily during Saturdays, Sundays and bank holidays and once in the evenings.
2. The management of obstetric patients requiring high-dependency care should be a multidisciplinary one, involving the obstetric, anaesthetic and midwifery teams.
Whenever possible, all members of this team should review high-dependency patients together at all routine ward round visits. If this is not possible because of pressure of work, members of the team should make each other aware of the issues decided.

Royal College of Physicians
Future hospital: caring for medical patients 2013
1. The chief of medicine will ensure the development of, and adherence to, an agreed set of local clinical care operational performance standards operating throughout all medical specialties within the Division (eg 7-day working, planning for leaving hospital at first consultant review, collaboration with other teams, daily ward rounds in all care areas), underpinned by a professional culture linked to the NHS Constitution
2. Transition of care planning should therefore be incorporated into daily review processes and ward rounds.
Consultant input into acute medical admissions 2010

Royal College of Surgeons
Emergency Surgery: Standards for unscheduled care 2011
1. Acute General Surgery
   There is a twice-daily consultant-led ward round/review of all patients in the AMU, seven days a week, to support ongoing decision making and to review the management plans and results. These rounds include members of the nursing team to ensure proactive management and transfer of information.
2. Urology / Oral and Maxillofacial Surgery
   Daily ward rounds carried out by senior trainees (ST3 or above) or trust doctors with equivalent ability (ie MRCS with ATLSR provider status) and/or consultants, including weekends.
3. Oral and Maxillofacial Surgery
   Best practice: There are morning and evening ward rounds, daily, with one of these being consultant-led, including weekends.

The Higher Risk General Surgical Patient: towards improved care for a forgotten group 2011
1. MRCS will immediately leave less urgent tasks such as clinics and ward rounds and will delegate to an appropriately competent colleague if currently operating or attending another medium-high score case.
2. There should be a brief but structured review of risks towards the end of higher risk operations, conducted jointly between surgeon and anaesthetist. This end of surgery bundle should guide the location of postoperative care.
3. Senior review within 12hrs (Consultant or MRCS trainee should not be moved from ESU or nor should they be handed off to another team until review has occurred). If referred to another surgical team senior review within 12hrs.
4. Maintain minimum of 1 hrly observations following surgery until senior review.
5. Consultant review within 12hrs of emergency admission for all other patients.

The leadership and management of surgical teams 2007
The timetable of each grade of staff was redesigned; consultant surgeons had a fixed day on call, free of all elective activity, and then the following day undertook the post-take ward round to review all emergency patients, a commitment requiring several hours each day.

Evidence-based reviews
Aston Business School
The effectiveness of health care teams in the National Health Service 2011

Cochrane Database of Systematic Reviews
Interventions for preventing delirium in hospitalised patients 2009

Research evidence on effectiveness of interventions to prevent delirium is sparse. Based on a single study, a programme of proactive geriatric consultation may reduce delirium incidence and severity in patients undergoing surgery for hip fracture. Prophylactic low dose haloperidol may reduce severity and duration of delirium episodes and shorten length of hospital admission in hip surgery. Further studies of delirium prevention are needed.

Published research – Databases

1. Improving communication of the daily care plan in a teaching hospital intensive care unit.

Author(s) Karalapillai D, Baldwin I, Dunnachie G, Knott C, Eastwood G, Rogan J, Carnell E, Jones D
Citation: Critical Care & Resuscitation, June 2013, vol./is. 15/2(97-102), 1441-2772;1441-2772 (2013 Jun)
Publication Date: June 2013
Abstract: BACKGROUND: Patients admitted to intensive care units have complex care needs. Accordingly, communication and handover of the medical care plan is very important.OBJECTIVE: To assess changes in ICU nurses' understanding of the medical daily care plan after development and implementation of a pro forma to improve documentation and communication of the plan.DESIGN, SETTING AND PARTICIPANTS: The study was conducted between February and November 2012 in a mixed medical-surgical, 18-bed, closed ICU in a teaching hospital. Baseline and post-intervention surveys assessed ICU bedside nurses' self-reported understanding of elements of the daily care plan.INTERVENTION: After receiving input from bedside nurses and medical staff, we developed the daily care plan as a single-page pro forma for handwritten documentation of a clinical problems list, plan and interventions list, daily chest x-ray results, a modified FAST-HUG checklist, and discharge planning during the evening consultant ward round. The finalised pro forma was introduced on 25 July 2012.RESULTS: Introduction of the pro forma daily care plan was associated with marked and statistically significant improvements in nurses' self-reported understanding of a list of the patient's clinical problems, the management plan after the ward round, issues for discharge for the following day (all P < 0.001) and, to a lesser extent, the physiological targets and aims (P = 0.003) and interpretation of the daily chest x-ray (P < 0.001). In the post-intervention survey, only 4/118 free-text comments (3.4%) suggested that documentation of the plan was doctor-dependent, compared with 28/198 (14.1%) at baseline (P = 0.002).CONCLUSIONS: Introduction of a single-page, handwritten, structured daily care plan produced marked improvements in ICU nurses' self-reported understanding of elements of the medical plan, and may have reduced practice variation in medical plan documentation. The effects of this intervention on patient outcomes remain untested.
Source: Medline

2. Characteristics and outcomes of patients subject to intensive care nurse consultant review in a teaching hospital.

Author(s) McIntyre T, Taylor C, Reade M, Jones DA, Baldwin I
Citation: Critical Care & Resuscitation, June 2013, vol./is. 15/2(134-40), 1441-2772;1441-2772 (2013 Jun)
Publication Date: June 2013
Abstract: OBJECTIVE: To describe the evolution of our Intensive Care Nurse Consultant
ICNC) service, the characteristics and outcomes of the patients reviewed, and interventions performed. DESIGN, SETTING AND PARTICIPANTS: Retrospective observational study in a tertiary referral university-affiliated teaching hospital among all patients reviewed by the ICNC service between September 2007 and December 2009. MAIN OUTCOME MEASURES: Number and characteristics of patients reviewed, source of referral, interventions performed, inhospital mortality and hospital length of stay. RESULTS: Since August 2006, operating hours have increased and provision has been made for senior ICU nurses to undertake 6-month developmental allocations to the role. The name of the service was changed and a weekly report was commenced to capture patient referral source, and subsequent ICU medical referral. Additional changes included provision of an administration day, and use of an ICU discharge scoring tool. A total of 3118 (2278 post-ICU and 840 non-ICU) care episodes were provided by the ICNC service between September 2007 and December 2009. Median patient age was 64 years, inhospital mortality was about 9% and most reviews occurred in surgical patients and after ICU discharge. Most new ward referrals came from an ICU doctor or ward nurse, with few referrals from ward doctors. Communication with ward nurses was more common than with ward doctors. A common recommendation involved fluid and electrolyte management. In-hospital mortality was higher among patients entering the service after review by a medical emergency team or de-novo referral than in patients after ICU discharge. CONCLUSIONS: Most interventions are relatively simple, and the ICNC role may be augmented by limited rights to prescribe electrolyte replacement. The effect of the intervention on patient outcomes and the reproducibility of our findings in other hospitals remain to be determined.

Source: Medline

3. An evaluation of the activity of a 7-day, nurse-led specialist palliative care service in an acute district general hospital.

Author(s) Hall S, Davies A

Citation: International Journal of Palliative Nursing, March 2013, vol./is. 19/3(148-50), 1357-6321;1357-6321 (2013 Mar)

Publication Date: March 2013

Abstract: INTRODUCTION: This report describes the activity of a new 7-day-per-week, nurse-led palliative care service in an acute district general hospital in the UK. METHODS: The service is based in a hospital with an integral cancer centre. On the weekends, one clinical nurse specialist (CNS) is present within the hospital, with a consultant providing telephone support. The data for this report was obtained by reviewing the team's clinical database and the patients' individual clinical assessments. RESULTS: During the first year, the CNSs undertook 651 face-to-face weekend consultations. Overall, 25% of the total consultations and 18% of new patient consultations were undertaken on the weekends. The primary reasons for reviewing patients on the weekends were pain (46%), other symptoms (27.5%), and patient on the Liverpool Care Pathway (17%). Overall, 23% of new patients died over the weekend or in the early hours of the Monday morning. CONCLUSIONS: This service evaluation provides evidence of the value of having a 7-day-per-week palliative care service in an acute district general hospital.

Source: Medline

Available in fulltext from International Journal of Palliative Nursing at EBSCOhost

4. Resident full-time specialists in the ICU: a survivable model?.

Author(s) Parry-Jones J, Garland A

Citation: Current Opinion in Critical Care, December 2012, vol./is. 18/6(677-82), 1070-5295:1531-7072 (2012 Dec)

Publication Date: December 2012

Abstract: PURPOSE OF REVIEW: Intensivists have a professional and personal interest in trying to answer whether immediate review of patients by a consultant intensivist improves outcomes. Although some advocate in-hospital around-the-clock consultant intensivist presence, does the available evidence suggest all ICUs should be staffed in
such a manner and is such a service sustainable given the shortage of intensivists, potential loss of staff from burnout and cost?

RECENT FINDINGS: We present in narrative form the background and recent literature for a consultant resident service in terms of the ethical tenets of nonmaleficence, beneficence, autonomy and justice. Nonmaleficence - what is the evidence it is bad for patients not to provide a resident service? Beneficence - what is the evidence a resident intensivist service is good for patients? Autonomy - is it in intensivists' own interests to provide a 24-h service? And justice - is it a justifiable use of healthcare resources?

SUMMARY: A unified staffing solution within a country's different ICUs, let alone between countries, is unlikely. The current evidence does not universally support or justify 24 h/7 days consultant intensivist presence. International differences in staffing models and ICU structures make direct comparisons difficult and in some circumstances the balance may favour 24 h/7 days consultant intensivists.

Source: Medline

Available in fulltext from Current Opinion in Critical Care at the ULHT Library and Knowledge Services’ eJournal collection

5. Emergency Nurse as Hospital Clinical Team Coordinator – Shining a light into the night.

Author(s) Williams, Ged, Hughes, Vickii, Timms, Jo, Raftery, Chris

Citation: Australasian Emergency Nursing Journal, 01 November 2012, vol./is. 15/4(245-251), 15746267

Publication Date: 01 November 2012

Abstract: Summary: Background: The Clinical Team Coordinator (CTC) is a senior experienced nurse from the Emergency Department (ED) that provides an after-hours clinical supervision and liaison service for the entire hospital. The role guides and supports nursing and junior medical staff regarding clinical and hospital procedures, protocols and individual patient problems and assists with clinical issues on the wards such as patient assessment and management. Method: Following a qualitative evaluation of the CTC role in 2009, the scope of activity and impact on clinical services after hours was established through shift data collation and analysis during the calendar year 2011. Results: In 2011, the CTC was directly involved with 18,165 occasions of care across the evening and night shift periods, with only one third of these calls requiring Resident Medical Officer (RMO) attention. The CTC role reviews patients, provides support and advice, facilitates impromptu education and learning, as well as assists nursing and medical staff with difficult and complex clinical tasks. Conclusion: Senior clinical nursing support from the CTC has been well received from nursing and medical staff and the role is now a permanently established in the hospital.

Source: CINAHL

7. Is the post-take ward round standardised?.

Author(s) Mansell A, Uttley J, Player P, Nolan O, Jackson S

Citation: The clinical teacher, October 2012, vol./is. 9/5(334-7), 1743-4971;1743-498X (2012 Oct)

Publication Date: October 2012

Abstract: BACKGROUND: The importance of the post-take ward round to both patient safety and medical education cannot be overemphasised. Despite this, significant variation exists between consultants and senior doctors in the conduct and content of ward rounds. This discrepancy prompted the idea of using a checklist to audit whether essential components were being consistently addressed during post-take ward rounds. This would allow an exploration of whether introducing a checklist would benefit both patient safety and medical education.METHODS: The post-take ward round was audited by a small group of medical students over a few months using a checklist. This checklist contained 17 evidence-based items that had been identified as important for patient safety. A number of different consultants were included in the audit.RESULTS: Results of the audit analysis confirmed that there was significant variability between consultants in both the approach
and the content of the post-take ward round. Although some areas were completed most of the time, there were other areas in which inconsistent approaches were demonstrated. DISCUSSION: As such variability was demonstrated between consultants in their conduct of the ward rounds, it was concluded that the introduction of this checklist would provide a standardised approach that junior doctors could learn from. Therefore, the introduction of this checklist into clinical practice was identified as a worthwhile teaching resource for juniors in order to enhance patient safety and foundation doctor learning.

Source: Medline

8. Republished: Daily consultant gastroenterologist ward rounds: reduced length of stay and improved inpatient mortality.


Citation: Postgraduate Medical Journal, October 2012, vol./is. 88/1044(583-7), 0032-5473;1469-0756 (2012 Oct)

Publication Date: October 2012

Abstract: BACKGROUND: For gastroenterology, The Royal College of Physicians reiterates the common practice of two to three consultant ward rounds per week. The Royal Bolton Hospital NHS Foundation Trust operated a 26-bed gastroenterology ward, covered by two consultants at any one time. A traditional system of two ward rounds per consultant per week operated, but as is commonplace, discharges peaked on ward round days. OBJECTIVE: To determine whether daily consultant ward rounds would improve patient care, shorten length of stay and reduce inpatient mortality. METHODS: A new way of working was implemented in December 2009 with a single consultant taking responsibility for all ward inpatients. Freed from all other direct clinical care commitments for their 2 weeks of ward cover, they conducted ward rounds each morning. A multidisciplinary team (MDT) meeting followed immediately. The afternoon was allocated to gastroenterology referrals and reviewing patients on the medical admissions unit. RESULTS: The changes had an immediate and dramatic effect on average length of stay, which was reduced from 11.5 to 8.9 days. The number of patients treated over 12 months increased by 37% from 739 to 1010. Moreover, the number of deaths decreased from 88 to 62, a reduction in percentage mortality from 11.2% to 6%. However, these major quality outcomes involved a reduction in consultant-delivered outpatient and endoscopy activity. CONCLUSION: This new method of working has both advantages and disadvantages. However, it has had a major impact on inpatient care and provides a compelling case for consultant gastroenterology expansion in the UK.

Source: Medline

Available in fulltext from Postgraduate medical journal at Highwire Press

9. The influence of physician seniority on disparities of admit/discharge decision making for ED patients.

Author(s) Wu, Kuan-Han, Chen, I-Chuan, Li, Chao-Jui, Li, Wen-Cheng, Lee, Wen-Huei

Citation: American Journal of Emergency Medicine, 01 October 2012, vol./is. 30/8(1555-1560), 07356757

Publication Date: 01 October 2012

Abstract: Objectives: Differences in disposition between emergency physicians (EPs) have been studied in select patient populations but not in general emergency department (ED) patients. After determining whether a difference existed in admit/discharge decision making of EPs for general ED patients, we focus our study in examining the influence of EP seniority on the decision to discharge ED patients. Methods: In a 1-year retrospective study, we included a convenience sample of all 18 953 adult nontraumatic ED patients. We reviewed the admit/discharge dispositions at each shift made by 16 EPs. EPs were categorized by seniority to determine whether seniority influenced disposition. Three groups had 5, 4, and 7 EPs each, with >10 years, 5 to 9
years, and <5 years of working experience, respectively. Results: Patient demographics, triage level, and number of patients per shift did not differ statistically between EPs and each group. The number of discharged patients per shift differed statistically between EPs (P < .001) and each group. The most senior EPs had the lowest discharge rates compared with EPs in intermediate and junior groups. They had lower discharge rates for patients at triage levels 1, 2, and 3 as well as for all patients. However, no difference in unscheduled ED revisit rates was found. Conclusions: EPs vary in their admit/discharge decision making for general ED patients. More importantly, the most senior EPs were found to have the lowest discharge rates compared with their junior colleagues.

Source: CINAHL

Author(s) Martinez ML, Vande Griend JP, Linnebur SA
Citation: Consultant Pharmacist, October 2012, vol./is. 27/10(729-36), 0888-5109;0888-5109 (2012 Oct)
Publication Date: October 2012
Abstract: A 91-year-old woman living independently in the community presented along with her son for a medication therapy management (MTM) appointment with the clinical pharmacist at the University of Colorado Hospital Seniors Clinic. The purpose of the visit was to review the patient's medications, perform medication reconciliation, and identify ways to increase proper medication management. As requested for the MTM appointment, the patient and her son brought in several large bags of her over-the-counter (OTC) and prescription medications from her home, including those that she was not currently taking. The clinical pharmacist reviewed the medications and found multiple instances of duplicate therapies, nonadherence, discrepancies in her medication regimen, cost concerns, and other drug-therapy problems. In addition, the pharmacist's evaluation showed that the patient had been hoarding more than 100 medications, which increased her risk for drug-related problems. Most of the OTC and some prescription medications were voluntarily removed from the patient's possession to reduce the likelihood of potential overuse of medications. The pharmacist educated the patient and her son regarding her updated medication list and how to properly manage her medications. Finally, the patient's son volunteered to help his mother with medication management or hire someone to assist her. This case demonstrates the usefulness of requesting all medications—including OTC and prescription, active and inactive medications—be brought to the MTM appointment. The case also supports the need for family support for older adults struggling with managing polypharmacy.
Source: Medline

11. OSBORNE PARK HOSPITAL STROKE REHABILITATION UNIT: Major changes achieved through teamwork and continuous improvement
Author(s) Morgan P., Cream A., West D.
Citation: International Journal of Stroke, September 2012, vol./is. 7/(56), 1747-4930 (September 2012)
Publication Date: September 2012
Abstract: Background: Osborne Park Hospital is a secondary hospital in the North Metropolitan Area Health Service providing rehabilitation and aged care, surgical services and Women's and Newborn services to the surrounding area. The 10 bedded Stroke Rehabilitation Unit (SRU) is contained within a 30 bedded ward. Aim: To improve rehabilitation services available to the stroke survivor by maximising service within existing financial and physical resources. Methods: Improvements are initiated through Multidisciplinary Seniors meetings. They are formalised, evaluated and reviewed regularly as Quality Improvement Projects. Value adding has focussed on the following areas (i) education to staff, (ii) patient outcomes, (iii) satisfaction levels in the stroke survivor and their family/carer, (iv) optimising the physical environment. Examples:- continual staff training to night and day staff on rehabilitation wards and external agencies in the management of stroke; the CNS undertook the Certificate in Continence nursing; review of
patient fatigue levels in relation to intensity of therapy; follow up with patients and families post discharge; carer support group; utilisation of un-used foyer space for patient education and recreation. Results: The use of Multidisciplinary Seniors meetings and commitment to continuous improvement has resulted in the SRU adding value to patient outcomes and increasing satisfaction levels for patients/carers and staff. Initiatives arising in the SRU are made available to the wider hospital and external agencies providing management to stroke patients following discharge. Conclusion: Major improvements in patient care and outcome may be achieved by maximising the use of existing resources and can be replicated in other units.

Source: EMBASE

12. The use of a consultant-led ward round checklist to improve paediatric prescribing: an interrupted time series study.

Author(s) Lepee C, Klaber RE, Benn J, Fletcher PJ, Cortoons PJ, Jacklin A, Franklin BD

Citation: European Journal of Pediatrics, August 2012, vol./is. 171/8(1239-45), 0340-6199;1432-1076 (2012 Aug)

Publication Date: August 2012

Abstract: A Check and Correct checklist has previously been developed to increase feedback on prescribing quality and enhance physicians’ focus on patients’ drug charts during ward rounds. Our objective was to assess the impact of introducing such a prescribing checklist on the quality and safety of inpatient prescribing in two paediatric wards in a London teaching hospital. Between 15 March 2011 and 15 May 2011 (pre-intervention) and between 23 May 2011 and 23 July 2011 (post-intervention), we recorded rates of both technical prescription writing errors and clinical prescribing errors twice a week. During the pre-intervention period, the overall technical error rate was 10.8 % (95 % confidence interval 10.3 %–11.2 %); the clinical error rate was 4.7 % (3.4 %–6.6 %). The most common errors were absence of prescriber’s contact details and dose omissions. After the implementation of Check and Correct, error rates were 7.3 % (6.9 %–7.8 %) and 5.5 % (3.9 %–7.9 %), respectively. Segmented regression analysis revealed a significant decrease of -5.0 % in the technical error rate (-7.1 to -2.9 %; -37.7 % relative decrease; R (2)=0.604) following the intervention, independent of changes in overall medical records’ documentation quality. Regarding clinical errors, no significant impact of the intervention could be detected. CONCLUSION: Implementing a Check and Correct checklist led to an improvement in the quality of prescription writing. Although a change in culture may be needed to maximise its potential, we would recommend its more widespread use and evaluation.

Source: Medline


Author(s) Catangui, Elmer Javier, Slark, Julia

Citation: British Journal of Nursing, 12 July 2012, vol./is. 21/13(801-805), 09660461

Publication Date: 12 July 2012

Abstract: Stroke is a devastating condition. The Royal College of Physicians (2008) highlights that integrated stroke care can improve patient care. Nurses are an integral part of the multidisciplinary team, providing 24/7 stroke care from planning and implementing care to the evaluation of the patient’s condition. To improve the way nurses manage stroke patients in an acute setting, a nurse-led ward round was initiated to look at essential nursing care. The Imperial College Healthcare Trust stroke senior nursing team, consisting of a clinical nurse specialist, a ward manager, and a charge nurse, have organised a weekly stroke nurse-led ward round. The team takes rounds to each stroke patient in the ward to examine and evaluate the essentials of nursing care (e.g. oral care, skin integrity, continence, bowel and bladder management), and current stroke outcome measures. During the rounds, the team address nursing issues, make appropriate nursing goals, and discuss their plans with the nurses and other members of the team. A nurse-led ward round has addressed nursing issues in a timely proactive fashion. The initiative has been successful in improving clinical communication between nurses and patient involvement in
their care planning. It has also empowered nurses to make decisions within their professional arena, and its contribution has had an impact on patient care and safety through early detection and prevention of stroke complications.

**Source:** CINAHL

Available in *print* at Pilgrim Hospital Staff Library

Available in *fulltext* from British Journal of Nursing at EBSCOhost

Available in *print* at Grantham Hospital Staff Library

Available in *print* at Lincoln County Hospital Professional Library


**Author(s)** O’Keeffe, Fran, Cronin, Sinead, Gilligan, Peadar, O’Kelly, Patrick, Gleeson, Aidan, Houlihan, Patricia, Kelada, Sherif

**Citation:** Emergency Medicine Journal, 01 July 2012, vol./is. 29/7(550-553), 14720205

**Publication Date:** 01 July 2012

**Abstract:** Objectives This study was undertaken to assess the usefulness of senior emergency medicine specialists' review of all 'did not wait' (DNW) patients' triage notes and the recall of at-risk patients. Methods A prospective study of all DNW patients was performed from 1 January to 31 December 2008. Following a daily review of charts of those who failed to wait to be seen, those patients considered to be at risk of adverse outcome were contacted by the liaison team and advised to return. Data were gathered on all DNW patients on the Oracle database and interrogated using the Diver solution. Results 2872 (6.3%) of 45959 patients did not wait to be seen. 107 (3.7%) were recalled on the basis of senior emergency medicine doctor review of the patients’ triage notes. Variables found to be associated with increased likelihood of being recalled included triage category (p<0.001), male sex (p<0.004) and certain clinical presentations. The presenting complaints associated with being recalled were chest pain (p<0.001) and alcohol/drug overdose (p=0.001). 9.4% of DNW patients required admission following recall. Conclusion The systematic senior doctor review of triage notes led to 3.7% of patients who failed to wait being recalled. 9.4% of those recalled required acute admission. The daily review of DNW patients' triage notes and the recalling of at-risk patients is a valuable addition to our risk management strategy.

**Source:** CINAHL

Available in *fulltext* from Emergency Medicine Journal at Highwire Press

15. Nurse-led ward rounds: a valuable contribution to acute stroke care.

**Author(s)** Catangui EJ, Slark J

**Citation:** British Journal of Nursing, July 2012, vol./is. 21/13(801-5), 0966-0461;0966-0461 (2012 Jul 12-25)

**Publication Date:** July 2012

**Abstract:** Stroke is a devastating condition. The Royal College of Physicians (2008) highlights that integrated stroke care can improve patient care. Nurses are an integral part of the multidisciplinary team, providing 24/7 stroke care from planning and implementing care to the evaluation of the patient's condition. To improve the way nurses manage stroke patients in an acute setting, a nurse-led ward round was initiated to look at essential nursing care. The Imperial College Healthcare Trust stroke senior nursing team, consisting of a clinical nurse specialist, a ward manager, and a charge nurse, have organised a weekly stroke nurse-led ward round. The team takes rounds to each stroke patient in the ward to examine and evaluate the essentials of nursing care (e.g. oral care, skin integrity, continence, bowel and bladder management), and current stroke outcome measures. During the rounds, the team address nursing issues, make appropriate nursing goals, and discuss their plans with the nurses and other members of the team. A nurse-led ward round has addressed nursing issues in a timely proactive fashion. The initiative has been successful in improving clinical communication between nurses and patient involvement in
their care planning. It has also empowered nurses to make decisions within their professional arena, and its contribution has had an impact on patient care and safety through early detection and prevention of stroke complications.

**Source:** Medline
Available in print at Pilgrim Hospital Staff Library
Available in fulltext from British Journal of Nursing at EBSCOhost
Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library

### 16. Trust transforms ward culture after adopting Care campaign.

**Author(s):** Snow, Tamsin

**Citation:** Nursing Standard, 06 June 2012, vol./is. 26/40(7-7), 00296570

**Publication Date:** 06 June 2012

**Abstract:** An NHS trust has revised its inpatient questionnaire and asked senior nurses to prioritise communication, toileting, pain management and help with eating and drinking during ward rounds after adopting Nursing Standard’s Care campaign.

**Source:** CINAHL
Available in print at Pilgrim Hospital Staff Library
Available in fulltext from Nursing Standard at EBSCOhost

### 17. Nurse management rounds: Influence on quality of work at the bone marrow transplantation unit

**Author(s):** Froymovich L., Katzman N., Furer M.

**Citation:** Bone Marrow Transplantation, April 2012, vol./is. 47/(S469), 0268-3369 (April 2012)

**Publication Date:** April 2012

**Abstract:** Objectives: Clinical rounds are an established method of physician education and practice, providing opportunity to discuss clinical cases and receive peer supervision. We have adopted this tool to the nursing field aiming to increase the efficacy of care rendered to patients hospitalized at the Bone Marrow Transplantation (BMT) Unit. Methods: Over the last 4 years we have used the checklist identifying vital parameters to be followed in BMT inpatients. It was developed by our senior physicians and adopted by nurses. During clinical rounds of the head unit nurse (3/week), introduced to our practice, a junior nurse accompanied by colleagues presents each patient according to the checklist, including the following issues: Patient diagnosis Primary treatment: type of chemotherapy, etc. Current and anticipated problems in body systems: Hemodynamic status: vital signs, weight, current fluid balance. Infections: type of isolation, current treatment. Complications in gastro-intestinal tract: mucositis, diarrhea, alimentation. Respiratory status: need for oxygen support, type of mechanical ventilation. Cardiac status: congestion, arrhythmia. Renal status: urine output, type of dialysis, if any. Line care. Wound care. Emotional state. Results: Clinical rounds of the head nurse focused on current problems aiming to prevent pitfalls in nursing care. They created learning environment for nurses working with BMT patients and gave opportunity to exchange ideas and formulate the plan of nursing care. The information acquired at the rounds was incorporated with other medical data on each patient which could have an impact on decision making regarding further therapy. This approach increased cooperation between nurses, physicians and other caregivers. It allowed the nurses to apply measures taken by colleagues to their own practice and participate in dynamic processes. The rounds encouraged patients to express themselves, ask more questions and be involved in treatment, which eventually increased patient satisfaction with care. Conclusions: Nurse clinical rounds introduced to the BMT Unit improved the quality of patient care, providing optimal head nurse control on “doing”, immediate evaluation of nursing care and continuous nurse coaching and advancing patient involvement and communication with the team. Further investigation of options to implement nursing rounds
as a standard-of-care for BMT patients is required to enable the caregivers to render comprehensive patient-focused care.

Source: EMBASE
Available in fulltext from Bone Marrow Transplantation at EBSCOhost

18. The impact of twice-daily consultant ward rounds on the length of stay in two general medical wards--effect on training?.

Author(s) Eccersley L, Tan L
Citation: Clinical Medicine, April 2012, vol./is. 12/2(186-7), 1470-2118;1470-2118 (2012 Apr)
Publication Date: April 2012
Source: Medline

19. Modular acute system for general surgery: hand over the operation, not the patient.

Author(s) Poole GH, Glyn T, Srinivasa S, Hill AG
Citation: ANZ Journal of Surgery, March 2012, vol./is. 82/3(156-60), 1445-1433;1445-2197 (2012 Mar)
Publication Date: March 2012
Abstract: INTRODUCTION: Various models have been proposed to effectively provide acute surgical care in Australasia. Recently, General Surgeons Australia (GSA) has published a 12-point plan with guiding principles on this matter. This study describes a model of providing acute general surgical care in a high-volume institution, evaluates clinical outcomes and critically appraises the system against the GSA 12-point plan.METHODS: The acute care system is qualitatively described with quantitative measures of workload. The outcomes of acute laparoscopic cholecystectomy were used as a proxy of system performance. The system was critically appraised against the GSA 12-point plan.RESULTS: Teams are on call once per week with each surgeon on call once per fortnight. The three key elements of acute management - collecting patients, post-acute ward round and operating - are treated as modules. The patient remains under the care of the admitting consultant but is often operated on by another team. From June 2009 to 2010, there were 7429 acute general surgical admissions (mean: 20.4 patients per day) with 2999 acute operations (mean: 8.4 operations per day). The other activities of the department were not compromised. In that time, 388 acute laparoscopic cholecystectomies were performed with a conversion rate of 1.3% and no major bile duct injury. The system is compatible with the GSA 12-point plan.CONCLUSION: This study describes an efficient and safe system for providing acute general surgical care in a high-volume setting with satisfactory clinical outcomes. It is compatible with the GSA 12-point plan. 2012 The Authors. ANZ Journal of Surgery 2012 Royal Australasian College of Surgeons.
Source: Medline
Available in fulltext from ANZ Journal of Surgery at EBSCOhost

20. Increasing the frequency of consultant ward rounds reduces hospital bed use.

Author(s) Rayner HC
Citation: BMJ, 2012, vol./is. 344/(e1037), 0959-535X;1756-1833 (2012)
Publication Date: 2012
Source: Medline
Available in print at Pilgrim Hospital Staff Library
Available in fulltext from BMJ at Highwire Press
Available in print at Louth County Hospital Medical Library
21. Including pharmacists on consultant-led ward rounds.

**Author(s)** Quantrill S, Webbe D

**Citation:** Clinical Medicine, December 2011, vol./is. 11/6(627-8; author reply 628), 1470-2118;1470-2118 (2011 Dec)

**Publication Date:** December 2011

**Source:** Medline

22. The impact of twice-daily consultant ward rounds on the length of stay in two general medical wards.

**Author(s)** Ahmad A, Purewal TS, Sharma D, Weston PJ

**Citation:** Clinical Medicine, December 2011, vol./is. 11/6(524-8), 1470-2118;1470-2118 (2011 Dec)

**Publication Date:** December 2011

**Abstract:** Excess average length of stay (ALoS) not only results in an increased cost to hospitals but also increases the risk of hospital-acquired infection and thromboembolism. Various factors suggested to affect ALoS have yet to demonstrate a significant impact in clinical practice. Increased consultant input has been identified as an important factor influencing ALoS. As a result, a radical and innovative consultant job plan, replacing twice-weekly with twice-daily ward rounds (WRs) on a university teaching hospital's two medical wards has been designed. The number of discharges (NoDs) significantly increased (p < 0.01), ALoS reduced (p < 0.01), whereas, readmission rate and mortality remained unchanged (p = NS) over 12 months following twice-daily WRs compared to two other wards with twice-weekly WRs. This innovative model resulted in almost doubling the NoDs and halving the ALoS. This study suggests that ALoS can be reduced and sustained with a cultural and behavioural shift in consultant working patterns, without affecting readmission rate or inpatient mortality.

**Source:** Medline

23. Team situation awareness and the anticipation of patient progress during ICU rounds.

**Author(s)** Reader TW, Flin R, Mearns K, Cuthbertson BH

**Citation:** BMJ Quality & Safety, December 2011, vol./is. 20/12(1035-42), 2044-5415;2044-5423 (2011 Dec)

**Publication Date:** December 2011

**Abstract:** BACKGROUND: The ability of medical teams to develop and maintain team situation awareness (team SA) is crucial for patient safety. Limited research has investigated team SA within clinical environments. This study reports the development of a method for investigating team SA during the intensive care unit (ICU) round and describes the results.METHODS: In one ICU, a sample of doctors and nurses (n = 44, who combined to form 37 different teams) were observed during 34 morning ward rounds. Following the clinical review of each patient (n = 105), team members individually recorded their anticipations for expected patient developments over 48 h. Patient-outcome data were collected to determine the accuracy of anticipations. Anticipations were compared among ICU team members, and the degree of consensus was used as a proxy measure of team SA. Self-report and observational data measured team-member involvement and communication during patient reviews.RESULTS: For over half of 105 patients, ICU team members formed conflicting anticipations as to whether patients would deteriorate within 48 h. Patient-outcome data were collected to determine the accuracy of anticipations. Anticipations were compared among ICU team members, and the degree of consensus was used as a proxy measure of team SA. Self-report and observational data measured team-member involvement and communication during patient reviews. Exploratory analysis found that team processes did not predict team SA. However, the involvement of junior and senior trainee doctors in the patient decision-making process predicted the extent to which those
team members formed team SA with senior doctors. CONCLUSIONS: A new method for measuring team SA during the ICU round was successfully employed. A number of areas for future research were identified, including refinement of the situation awareness and teamwork measures.

Source: Medline
Available in fulltext from BMJ Quality and Safety at Highwire Press

24. The influence of computerized decision support on prescribing during ward-rounds: are the decision-makers targeted?.

Author(s) Baysari MT, Westbrook JI, Richardson KL, Day RO
Citation: Journal of the American Medical Informatics Association, November 2011, vol./is. 18/6(754-9), 1067-5027;1527-974X (2011 Nov-Dec)
Publication Date: November 2011
Abstract: OBJECTIVE: To assess whether a low level of decision support within a hospital computerized provider order entry system has an observable influence on the medication ordering process on ward-rounds and to assess prescribers' views of the decision support features. METHODS: 14 specialty teams (46 doctors) were shadowed by the investigator while on their ward-rounds and 16 prescribers from these teams were interviewed. RESULTS: Senior doctors were highly influential in prescribing decisions during ward-rounds but rarely used the computerized provider order entry system. Junior doctors entered the majority of medication orders into the system, nearly always ignored computerized alerts and never raised their occurrence with other doctors on ward-rounds. Interviews with doctors revealed that some decision support features were valued but most were not perceived to be useful. DISCUSSION AND CONCLUSION: The computerized alerts failed to target the doctors who were making the prescribing decisions on ward-rounds. Senior doctors were the decision makers, yet the junior doctors who used the system received the alerts. As a result, the alert information was generally ignored and not incorporated into the decision-making processes on ward-rounds. The greatest value of decision support in this setting may be in non-ward-round situations where senior doctors are less influential. Identifying how prescribing systems are used during different clinical activities can guide the design of decision support that effectively supports users in different situations. If confirmed, the findings reported here present a specific focus and user group for designers of medication decision support.

Source: Medline
Available in fulltext from Journal of the American Medical Informatics Association : JAMIA at National Library of Medicine


Author(s) Dhillon P, Murphy RK, Ali H, Burukan Z, Corrigan MA, Sheikh A, Hill AD
Citation: Irish Medical Journal, November 2011, vol./is. 104/10(303-5), 0332-3102;0332-3102 (2011 Nov-Dec)
Publication Date: November 2011
Abstract: Checklists have been shown to improve patient outcomes. Checklist use is seen in the pre-operative to post-operative phases of the patient pathway. An adhesive checklist was developed for ward rounds due to the positive impact it could have on improving patient safety. Over an eight day period data were collected from five consultant-led teams that were randomly selected from the surgical department and divided into sticker groups and control groups. Across the board percentage adherence to the Good Surgical Practice Guidelines (GSPG) was markedly higher in the sticker study group, 1186 (91%) in comparison with the control group 718 (55%). There was significant improvement of documentation across all areas measured. An adhesive checklist for ward round note taking is a simple and cost-effective way to improve documentation, communication, hand-over, and patient safety. Successfully implemented in a tertiary level centre in Dublin,
Ireland it is easily transferable to other surgical departments globally.

Source: Medline


Author(s) Richmond C, Merrick E, Green T, Dinh M, Iedema R

Citation: Emergency Medicine Australasia, October 2011, vol./is. 23/5(600-5), 1742-6723;1742-6723 (2011 Oct)

Publication Date: October 2011

Abstract: OBJECTIVE: Clinical handover is a critical point in medical care in the ED, which can contribute to adverse effects for patient care and staff workloads. Over a 4 and a half months in a tertiary referral hospital ED, a centralized whiteboard handover was performed followed by a multidisciplinary review of each patient. This round was referred to as the 'Cow Round'. METHODOLOGY: This observational study used a standardized feedback survey of clinicians leading each Cow Round. The survey asked participants in the round to report issues found, which were not handed over during the centralized whiteboard handover. Data were analysed for the number of issues identified, the type of issue identified, and to determine if there was a relationship between the number of issues reported and patients in the department. RESULTS: 204 surveys met inclusion criteria. Clinical issues not handed over at the standard whiteboard round were found in 64% of Cow Rounds. Of the 2411 patients reviewed on Cow Rounds, 14.1% had at least one clinical issue not handed over during the whiteboard round. A mean of 2.2 issues per round (95% CI 1.9-2.5) were found. Pearson correlation found a relationship between the number of issues identified and the total number of patients in the department (r= 0.246 P= 0.005). CONCLUSION: Review of patients led by a senior member of medical staff, at the patient bedside enables the timely identification and management of issues not communicated during the whiteboard handover process. This review is important when more patients are receiving treatment in the department. 2011 The Authors. EMA 2011 Australasian College for Emergency Medicine and Australasian Society for Emergency Medicine.

Source: Medline

27. Improving the efficiency of the emergency general surgical service.

Author(s) Western CE, Faux JW, Feldman M

Citation: European Journal of Emergency Medicine, October 2011, vol./is. 18/5(261-4), 0969-9546;1473-5695 (2011 Oct)

Publication Date: October 2011

Abstract: OBJECTIVE: To improve the quality and efficiency of our emergency surgical service. METHODS: Until 2007, the surgical on-call in our unit was run on a 'consultant of the day' model with triage in a 10-bed surgical receiving unit (SRU) before admission to the wards. The reduction in junior doctors' hours meant little continuity and delays in care. In July 2007, the SRU was expanded and a daily on-ward ultrasound session was established. The consultant rota was changed to a split-week model with twice-daily SRU ward rounds, allowing unstable patients regular senior assessment. RESULTS: As a result of the change, our acute length of stay reduced from 4.4 to 3.8 days and our actual versus expected length of stay was the best figure country-wide. CONCLUSION: Early consultant review and swift ultrasound assessment reduce admissions and patient stay. We have combined these factors in our emergency service and have delivered significant cost savings and improved care. 2011 Wolters Kluwer Health Lippincott Williams & Wilkins.

Source: Medline

28. The first 13 months of nurse-led ward rounds for patients post PCI in a tertiary centre.

Author(s) Pottle, A
Abstract: Review of nurse-led ward rounds in the cardiology unit at Harefield Hospital, West London for patients following percutaneous coronary intervention (PCI). The format and purpose of the ward round conducted by the nurse consultant and specialist pharmacist and its role in speeding up discharge, patient education, continuity of care and non-medical prescribing are discussed. ([BNI unique abstract]) 10 references

Source: BNI
Available in print from British Journal of Cardiac Nursing

29. Including pharmacists on consultant-led ward rounds: a prospective non-randomised controlled trial.

Author(s) Miller G, Franklin BD, Jacklin A

Abstract: This study aimed to compare interventions made by pharmacists attending consultant-led ward rounds in addition to providing a ward pharmacy service, with those made by pharmacists providing a ward pharmacy service alone. A prospective non-randomised controlled study on five inpatient medical wards was carried out at two teaching hospitals. A mean of 1.73 physician-accepted interventions were made per patient for the study group, compared to 0.89 for the control (Mann Whitney U, p < 0.001) with no difference between groups in the nature or clinical importance of the interventions. One physician-accepted intervention was made every eight minutes during the consultant-led ward rounds, compared to one every 63 minutes during a ward pharmacist visit. Pharmacists attending consultant-led ward rounds in addition to undertaking a ward pharmacist visit make significantly more interventions per patient than those made by pharmacists undertaking a ward pharmacist visit alone, rectifying prescribing errors and optimising treatment.

Source: Medline

30. Patient and carer unmet needs: a survey of the British association of head and neck oncology nurses.

Author(s) Rogers SN, Clifford N, Lowe D

Abstract: The aim of this survey was to ask members of the British Association of Head and Neck Oncology Nurses (BAHNON) about the identification of patients and carers unmet needs in the routine out-patient review clinic and the support services available during consultation. A national postal survey was sent out to the 210 current members of BAHNON in November 2009. Reminders were sent to non-responders in February 2010. The response rate was 61% (129/210). The vast majority (80%) were Clinical Nurse Specialists (CNS). The questionnaire data support the strong belief in attempts to identify unmet needs with over three-quarters feeling strongly about themselves being personally involved in attempting to identify unmet needs. Most of the responders used counselling and communication methods to elicit unmet concerns rather than specific tools such as questionnaires. The vast majority clearly felt that identifying unmet needs in clinic improves patients’ perception of outcome post-treatment. Support services ‘readily’ available at the time of consultation were as follows: H&N CNS (99%), Speech and Language (86%), Oncologist (84%), Dietician/Nutritionist (84%), Dentist (44%), Oral Rehabilitation consultant (27%), Dental Hygienist (26%), Physiotherapist (21%), Chaplain (20%), Emotional Support therapist (15%), Psychologist (15%), Occupational therapist (13%), Social worker (8%),
Although responders felt it very important to identify unmet needs in follow-up clinics, there is reliance on one to one discussion with the patient and carer. Hence in a busy clinic, needs might be easily missed and further research is required into ways to facilitate their identification.

Source: Medline

31. Initiative to change ward culture results in better patient care.

Author(s): Desai T, Caldwell G, Herring R

Citation: Nursing Management (Harrow), July 2011, vol./is. 18/4(32-5), 1354-5760;1354-5760 (2011 Jul)

Publication Date: July 2011

Abstract: One of the main features of ward rounds is the professional conversation that occurs between doctors and nurses. Such conversation needs to be perfected to avoid iatrogenic harm and increase efficiency. This article looks at data collected from 146 consultant-led medical ward rounds at a hospital trust using the Caldwell considerative checklist process (Herring et al 2011) to identify the frequency and quality of such conversations. A total of 1,921 patients' reviews were undertaken. A nurse was present during preparatory discussions on 604 occasions (31 percent) and during bedside review on 1,134 occasions (59 percent). These data demonstrate an urgent need to change ward cultures to improve the professional conversations between doctors, nurses and patients. By increasing nurse presence as a result of this research patient care and safety has improved at ward level, increasing satisfaction for everyone involved.

Source: Medline

Available in fulltext from Nursing Management - UK at EBSCOhost

32. Mini-rounds, An interprofessional panacea to the inefficiencies of an internal medicine clinical teaching unit

Author(s): Goldstein C., Ghuman K., Ann Colbourne S.

Citation: Journal of General Internal Medicine, May 2011, vol./is. 26/(S570), 0884-8734 (May 2011)

Publication Date: May 2011

Abstract: STATEMENT OF PROBLEM OR QUESTION: In developing an Integrated Plan of Care for patients admitted to our Internal Medicine teaching units, we found a lack of routine interprofessional communication leading to patient treatment delays. DESCRIPTION OF PROGRAM/INTERVENTION: An interprofessional Change Team comprised of front-line staff on the General Internal Medicine Clinical Teaching Units at the University of Alberta Hospital, a tertiary care center, was created to streamline the care processes for admitted patients. Ad hoc and infrequent regular communication among physicians, nurses and allied health professionals was a barrier to delivering effective care on our wards. The current state consisted of once weekly interprofessional 30 minute rounds per ward (3 wards, 18-20 beds each) to discuss individual patient care needs and discharge planning. We developed daily rapid communication touch points, Minirounds, focused on the Integrated Plan of Care. To determine the duration, timing and necessary participants for the rounds we ran PDSA (Plan, Do, Study, Act) cycles and used these to hone the intervention. Feedback regarding staff satisfaction and usefulness of the intervention was provided by each participant and recorded. OBJECTIVES OF PROGRAM/INTERVENTION: To facilitate patient throughput via brief daily rounds and enhance team communication among physicians, nurses and allied health professionals. Decrease time spent by care team members searching through charts, or paging a consultant to clarify a consult request/review findings. Improve patient and family satisfaction by providing more coordinated care. FINDINGS TO DATE: Findings from the Mini-Rounds PDSA cycles: Key players required: Charge Nurse, Senior Medical Resident (or Attending Physician), Physical Therapist, Occupational Therapist, Social Worker, and
the Care Coordinator. Optimal characteristics: brief and focused, one minute per patient, goal of 15-30 minutes, early in the morning prior to initiating the work day, and led by the Charge Nurse or Senior Resident. Care prioritization: Allied Health care workers consistently reported that the rounds enabled them to prioritize and organize their daily assessments. Empowerment: Charge Nurses felt more empowered to provide the patient and/or family members with up to date care plans, providing communication when physician team members were unavailable. Role Awareness: An educational opportunity to provide residents practical, hands-on instruction regarding scope of practice, allied health care professionals. KEY LESSONS LEARNED: To care for our elderly patient population with multiple co-morbidities and societal needs, daily interprofessional care rounds provide an opportunity for a 360-degree assessment and review of the integrated plan of care. Initial PDSA cycles trialed at the bedside to involve patient/family members. Due to time constraints and scheduling logistics the rounds were moved to the nurses' station with input on patient/family concerns provided by care team members. Ideally Mini-rounds will allow for a cohesive care plan that represents patient preferences and can be relayed back to the patient via multiple care team members rather than physicians alone. Current PDSA cycles will determine the most relevant issues to be covered during Mini-rounds to create a checklist or script to ensure efficiency and reproducibility. Geographic contiguity of patients and the alignment of the allied health professionals with the physician team will optimize the functionality of Mini-rounds.

Source: EMBASE
Available in fulltext from Journal of General Internal Medicine at National Library of Medicine
Available in fulltext from JGIM: Journal of General Internal Medicine at EBSCOhost

33. Mirrabook EUM model of care
Author(s) Garg V.
Citation: Australian and New Zealand Journal of Psychiatry, May 2011, vol./is. 45/(A61), 0004-8674 (May 2011)
Publication Date: May 2011
Abstract: Background: The standard approach to managing inpatient routines commences from handover, patient review by consultant and registrar, family meeting and discharge towards the later part of the day. This is carried out by a multidisciplinary team (MDT). Each member of the MDT has a certain set of responsibilities. I noted that the standard method of care was ineffective with issues including effective time management and resource management leading to delays in patient care requiring crucial decisions. In light of the many irregularities, I introduced the EUM model of care that stands for evaluation, understanding and management. The benefits have been quite startling. Objective: To introduce the EUM model and explore its intricacies and potential advantages when compared with the standard model of inpatient care. We share our experiences and the changes noticed after introducing this model of care. Results: The EUM is a better model of care in comparison with the standard one. All patients are reviewed, discussed and MDT plans are made by the afternoon. More than 90% of the daily workload is completed by the midday leaving more time for psychotherapy, family therapy and other activities. Discharge decisions are made by the team and coordinated by the end of the day. To achieve these outcomes in busy inpatient acute psychiatric units is our achievement. Conclusion: The EUM model of care is an effective method of care for inpatient units from our experience.
Source: EMBASE
Available in fulltext from Australian and New Zealand Journal of Psychiatry at EBSCOhost
Available in fulltext from Australian and New Zealand Journal of Psychiatry at EBSCOhost

34. Outcome of nurse based review using a computer - Guided consultation in COPD
Author(s) Angus R.M., Trusdale A., Davies L., McKnight E., Hodgson C., Thompson E., Pearson M.G.
Citation: American Journal of Respiratory and Critical Care Medicine, May 2011, vol./is.
**Abstract:** Background: Guided reviews support clinicians in providing chronic disease management. We have developed a computer-guided consultation with algorithms based on UK NICE guidelines that can facilitate COPD review and prompt clinical decision-making. Patients and methods: 983 COPD patients (mean age 70 (11) yrs, 47% male) were identified from 5 GP practice systems using the "Points" system mirect type review. 92 patients (mean age 70 (10) yrs, 47% male) were randomly selected and attended for nurse review. Only 29% had COPD severity previously recorded. A computer guided consultation was undertaken with the laptop screen placed between the practice nurse and patient. Changes and recommendations for interventions were recorded. Nurse opinion of the system was canvassed using 4 point Likert Scales. Results: of the 92 reviewed, 86 performed spirometry [inadequate in 2]. 18.6% had normal spirometry and were removed from the COPD register. 17.4% were GOLD STAGE 1, 37% had moderate COPD, 19.7 % severe and 4.6% very severe COPD. The consultations prompted a significant number of interventions which included: smoking cessation recommended for 17 (18%) but declined by all, referral for oxygen assessment 2 (2%) and a recommendation of pulmonary rehabilitation for 24 (26%) of whom 19 declined. Altered prescribing included addition of short-acting beta agonist 7% long-acting bronchodilator (LAB or LAM) 5%, adding or increasing long-acting beta agonist/inhaled corticosteroid (LABA/ICS) 17 (18%) patients, change of device 21 (23%) patients. Reductions in therapy were prompted in 14% patients: LAB or LAM 5, LABA/ICS 6, and ICS 2. A recommendation for a change of management was suggested in 78 (84%) of the 92 patients. For the nurse evaluation of the system 4 questions were used: Q1. Use of the software will help standardise patient care? 6/7 agree: 1/7 tend to agree. Q2. The flow ensures no aspect of assessment is omitted? 5/7 agree: 2/7 tend to agree. Q3. Using the software will aid accurate diagnosis? 4/7 agree: 3/7 tend to agree. Q4. I would need the following training to use the software: 7/7 ticked the lowest option 1-2 days Discussion: A COPD computer-guided consultation review by non-COPD trained practice nurses is feasible and results in a number of actions that support the implementation of guideline based management.

**Source:** EMBASE

**35. Multidisciplinary team rounding leads to increased patient satisfaction**

**Author(s)** Schumacher E., Liston B.

**Citation:** Journal of Hospital Medicine, April 2011, vol./is. 6/4 SUPPL. 2(S131), 1553-5592 (April 2011)

**Publication Date:** April 2011

**Abstract:** Background: Joint Commission on Accreditation of Healthcare Organizations sentinel event reporting demonstrates that 70% of preventable medical errors are due to communication errors. The national patient safety goals for 2006 include improving "the effectiveness of communication among care providers" to reduce those errors. Within internal medicine, a growing body of literature suggests teamwork and collaboration have real effects on patient care. In the intensive care unit, multiple studies demonstrated improved patient outcomes associated with enhanced interprofessional collaboration. Similarly, in the general medicine inpatient setting, wards with structured care teams including allied health professionals and a clinical nurse consultant had decreased inhospital mortality, and the patients exhibited decreased functional decline. Nonetheless, interprofessional teamwork remains limited, and multiple barriers exist including lack of perceived time for adequate discussion, lack of knowledge regarding other professional roles, and differing communication styles. Purpose: To improve patient care through enhanced interprofessional teamwork and communication by instituting a multidisciplinary rounding system on a large hospitalist nonteaching service at an academic center. Description: In an effort to improve patient satisfaction and communication among health care providers, a physician-nurse rounding initiative was established. Our hospitalist group worked in collaboration with the nurse manager and charge nurse to develop a bedside rounding system. A communication plan was developed enabling the hospitalist to contact the nurse manager or charge nurse who had initiated the rounding scheme. Through more strategic nursing assignments based on the hospitalist attending, an effective and efficient rounding system was developed. A short debriefing was performed prior to each patient
encounter to summarize the overnight events, answer questions/concerns, and address family/social issues. Formal rounding was done bedside with the plan of care reviewed with both the nurse and patient. Future additions to this program include providing a written summary of the care plan to each patient upon rounding completion. Conclusions: Multidisciplinary rounding is feasible and was well received on a busy hospitalist service in an academic center. Physicians and nurses alike were quick to adopt the system and had positive responses. Hospitalist subjective reports suggest decreased interruption during the day from nursing pages, which will likely result in improved work efficiency. Data from the first month of implementation demonstrate an increase in overall patient satisfaction and physician communication scores and patient knowledge of plan of care on Press Ganey surveys. Further study will be done to assess effects on additional measures such as length of stay and readmission rates. Widespread implementation of this policy should be strongly considered.

Source: EMBASE

36. Ward rounds: missed learning opportunities in diagnostic changes?.

Author(s) Bhangu A, Hartshorne G

Citation: The clinical teacher, March 2011, vol./is. 8/1(17-21), 1743-4971;1743-498X (2011 Mar)

Publication Date: March 2011

Abstract: BACKGROUND: The introduction of the European Working Time Directive has resulted in the on-call general surgery junior doctor regularly missing consultant-led post-take ward rounds (PTWRs). This study aimed to determine the frequency with which the admission diagnosis was changed on the PTWR, and thus whether an educational opportunity for trainees is missed.METHODS: Prospective observational study of consecutive admissions to a general surgery department over a 4-week period was conducted. Patients with exacerbations of known conditions were excluded.RESULTS: Fifty-two included patients were admitted by seven general surgery juniors, and 27 per cent (14/52) of diagnoses were changed on the PTWR. There were two 'major' diagnostic changes: peritonitis and ischaemic bowel. Patients whose diagnoses were changed by the consultant were no more likely to be older (p = 0.575) or have differing white cell counts (p = 0.471), C-reactive proteins (CRPs; p = 0.643) or amylase levels (p = 0.666) than those whose initial diagnosis was agreed with. Thirty-five per cent of patients (18/52) had further investigations ordered at the PTWR. These included nine ultrasound scans, four computed tomography scans, three abdominal or chest X-rays, two flexible sigmoidoscopies and one barium enema. In one case, a serum amylase was ordered.CONCLUSIONS: The rate of incorrect diagnoses by on-call surgical juniors is high, and educational feedback to these doctors is important. The PTWR represents a strong educational opportunity that is missed if admitting junior doctors are not present. These results should be taken into account for any specialty that uses junior doctors to admit patients who are then reviewed by a consultant on a PTWR. Blackwell Publishing Ltd 2011.

Source: Medline

37. Beyond grand rounds: a comprehensive and sequential intervention to improve identification of delirium.

Author(s) Ramaswamy R, Dix EF, Drew JE, Diamond JJ, Inouye SK, Roehl BJ

Citation: Gerontologist, February 2011, vol./is. 51/1(122-31), 0016-9013;1758-5341 (2011 Feb)

Publication Date: February 2011

Abstract: PURPOSE OF THE STUDY: Delirium is a widespread concern for hospitalized seniors, yet is often unrecognized. A comprehensive and sequential intervention (CSI) aiming to effect change in clinician behavior by improving knowledge about delirium was tested.DESIGN AND METHODS: A 2-day CSI program that consisted of progressive 4-part didactic series, including evidence-based reviews of delirium recognition, prevention, and management, interspersed with interactive small group sessions and practical case conferences was conceptualized in consultation with a leading expert on delirium. Pretest
and posttest instruments were designed to test the attendees on their knowledge and confidence around delirium identification. RESULTS: An average of 71 people attended each didactic session. Among all responses, 50 pretests and posttests were matched based on numeric coding (6 MD/DOs, 34 RNs, and 10 others). Mean pretest and posttest scores were 7.9 and 10.8 points, respectively (maximum: 17), showing a positive change in knowledge scores after the intervention (2.9 points, p < .001). Improvement in knowledge scores was higher in the cohort attending 2 or more lectures (3.8 points, p < .001) compared with those attending only 1 lecture (1.3 points, p < .12). Confidence in identifying patients with delirium increased by 28% (p < .001), and self-assessed capacity to correctly administer the Confusion Assessment Method increased by 36% (p < .001). IMPLICATIONS: A novel CSI increased clinician knowledge about delirium identification and management and improved confidence and self-assessed capacity to identify delirium in the hospitalized elderly patients. This strategy, which incorporates multiple reinforcing modes of education, may ultimately be more effective in influencing clinician behavior when compared with traditional grand rounds.

Source: Medline

38. Creating efficiencies in the acute care pathway: the rapid assessment, treatment and discharge approach.

Author(s) Bowers, Alexis, Aldouri, Elham
Citation: Mental Health Review Journal, 2011, vol./is. 16/2(50-55), 1361-9322
Publication Date: 2011
Abstract: PURPOSE: Despite contemporary mental health services shifting to a community-based model of care, acute inpatient care is still necessary for many patients experiencing an acute psychological crisis. As inpatient services cost the National Health Service nearly 600 million a year, initiatives to reduce time spent in hospital, whilst maintaining safety and quality, are being actively promoted on a national level. Mental health patients in Hertfordshire spend on average two weeks in hospital during their acute crisis. The aim of this study is to reduce bed occupancy rates by implementing a novel approach to inpatient management. DESIGN/METHODOLOGY/APPROACH: A pragmatic controlled clinical trial design was used to address the aim of this study. FINDINGS: The results demonstrate that, compared to a functionalized inpatient ward (one with a designated inpatient consultant psychiatrist conducting a weekly ward round), it is possible to reduce bed occupancy rates without increasing demand on other wards. Furthermore, 28-day readmission rates and total admissions over seven days were reduced. RESEARCH LIMITATIONS/IMPLICATIONATIONS: Limitations relating to the study design and potential generalisability to similar services are discussed. Further studies to triangulate the data are suggested. PRACTICAL IMPLICATIONS: This novel approach to inpatient management provides exciting data that suggest patients can be moved along the acute pathway more efficiently. Recommendations for further studies are made in light of the findings. ORIGINALITY/VALUE: This paper will appeal to acute care clinicians, service managers, and commissioners of mental health services. It provides an evidence base for making efficiencies within the acute service whilst maintaining quality of care for patients. [Abstract]
Source: HMIC

39. Impact of a weekly multidisciplinary tumor board conference on the management of women with gynecologic malignancies.

Author(s) Greer HO, Frederick PJ, Falls NM, Tapley EB, Samples KL, Kimball KJ, Kendrick JE, Conner MG, Novak L, Straughn JM Jr
Citation: International Journal of Gynecological Cancer, November 2010, vol./is. 20/8(1321-5), 1048-891X;1525-1438 (2010 Nov)
Publication Date: November 2010
Abstract: BACKGROUND: The objective of this study was to evaluate the impact of a weekly tumor board conference on the management of patients with gynecologic malignancies. METHODS: The medical records of consecutive patients referred to a
multidisciplinary gynecologic oncology tumor board were reviewed. Patient demographics were abstracted from medical records and tumor board minutes. An evaluation was made whether the pathological or radiological findings were changed by the tumor board consultants. If a discrepancy existed, it was determined whether the change impacted clinical management.

RESULTS: From January 2004 to December 2006, 741 patients presented at the tumor board were evaluable. Seventy-one percent of the patients were presented for pathology review and 29% for radiology review. The most common diagnoses were ovarian cancer (29%), endometrial cancer (26%), and cervical cancer (12%). Of the 526 pathology reviews, 27% had a change in diagnosis; this discrepancy altered clinical management 74% of the time (20% of all reviews). Of the 215 radiology presentations, 89% were reviewed to confirm recurrent or persistent disease; malignant disease was confirmed 74% of the time. Review of imaging studies resulted in a new diagnosis or upstaging 10% of the time.

CONCLUSIONS: A multidisciplinary tumor board allows a wide range of gynecologic diagnoses and clinical scenarios to be discussed. Careful review of pathology results in a change in the clinical management of 20% of patients presented at the tumor board. The majority of radiology reviews are presented to confirm persistent or recurrent cancer before recommending further therapy.

Source: Medline

40. Post-operative telephone review is cost-effective and acceptable to patients.

Author(s) Gray RT, Sut MK, Badger SA, Harvey CF

Citation: Ulster Medical Journal, May 2010, vol./is. 79/2(76-9), 0041-6193;0041-6193 (2010 May)

Publication Date: May 2010

Abstract: INTRODUCTION: Patients undergoing selective minor emergency and elective procedures are followed up by a nurse-led structured telephone review six weeks post-operatively in our hospital. Our study objectives were to review patients' satisfaction, assess cost-effectiveness and compare our practice with other surgical units in Northern Ireland (NI).

PATIENTS AND METHODS: Completed telephone follow-up forms were reviewed retrospectively for a three-year period and cost savings calculated. Fifty patients were contacted prospectively by telephone using a questionnaire to assess satisfaction of this follow-up. A postal questionnaire was sent to 68 general and vascular surgeons in NI, assessing individual preferences for patient follow-up.

RESULTS: A total of 1378 patients received a telephone review from September 2005 to September 2008. One thousand one hundred and seventy-seven (85.4%) were successfully contacted, while 201 (14.6%) did not respond despite multiple attempts. One hundred and forty-seven respondents (10.7%) required further outpatient follow-up, thereby saving 1231 outpatient reviews, equivalent to 41,509 per annum. Thirty-nine (78%) patients expected post-operative follow-up, with 29 (58%) expecting this in the outpatient department. However, all patients were satisfied with the nurse-led telephone review. Fifty-three (78%) consultants responded. Those who always, or occasionally, review patients post-operatively varies according to the operation performed, ranging from 2.2% appendicectomy patients to 40.0% for varicose vein surgery.

CONCLUSION: Current practice in NI varies, but a significant proportion of patients are not routinely reviewed. This study confirmed that patients expect post-operative follow-up. A nurse-led telephone review service is acceptable to patients, cost-effective and reduces the number of unnecessary outpatient reviews.

Source: Medline

Available in fulltext from Ulster Medical Journal, The at National Library of Medicine

Available in fulltext from Ulster Medical Journal at EBSCOhost

41. Ward rounds: the next focus for quality improvement?.

Author(s) Bradfield OM

Citation: Australian Health Review, May 2010, vol./is. 34/2(193-6), 0156-5788;0156-5788 (2010 May)

Publication Date: May 2010
Abstract: The Garling Report, published in November 2008, was a public inquiry into the provision and governance of Acute Care Services in New South Wales Public Hospitals. Garling's 139 recommendations, aimed at modernising clinical care and equipment, include better supervision of junior staff, multidisciplinary teamwork, structured clinical handover and improved culture within health services. Garling also made specific recommendations about ward rounds, arguing that they should be daily, supervised and multidisciplinary. Given the importance of ward rounds in planning and evaluating treatment, implementation of these recommendations will require further evidence, engagement of senior clinicians and cultural change. This article discusses some of the barriers to Garling's recommendations.

Source: Medline

42. Impact of senior clinical review on patient disposition from the emergency department.

Author(s) White AL, Armstrong PA, Thakore S

Citation: Emergency Medicine Journal, April 2010, vol./is. 27/4(262-5, 296), 1472-0205;1472-0213 (2010 Apr)

Publication Date: April 2010

Abstract: INTRODUCTION: The delivery of high quality emergency medicine ideally involves input from senior doctors 24 h a day. This study aims to assess the influence of 'real-time' senior clinician supervision on patient disposition from a UK emergency department. METHODS: The study was set in a UK teaching hospital with 24 h senior cover. Patients were initially seen by a junior doctor who completed a plan for the patient before seeking senior advice. Primary outcome measures were a change in patient outcome of discharge, admit, telephone specialty for opinion or outpatient follow-up. RESULTS: 556 patients underwent senior review during the study period. Review reduced inpatient admissions by 11.9% (95% CI 7.2% to 18.2%) and specifically reduced admissions to the acute medical assessment unit by 21.2% (95% CI 13.5% to 30.8%). Inappropriate discharge was prevented in 9.4% (95% CI 6.2% to 13.7%) and appropriate use of outpatient facilities resulted in a rise of 34.6% in appointments. CONCLUSIONS: Senior doctor input in patient care in the ED adds accuracy to disposition decisions, impacting on patient safety and improving departmental flow.

Source: Medline
Available in fulltext from Emergency Medicine Journal at Highwire Press
Available in fulltext from Emergency Medicine Journal : EMJ at National Library of Medicine

43. A new model for neurology care in the emergency department

Author(s) Ahmed R.M., Green T., Halmagyi G.M., Lewis S.J.G.

Citation: Medical Journal of Australia, January 2010, vol./is. 192/1(30-32), 0025-729X;1326-5377 (04 Jan 2010)

Publication Date: January 2010

Abstract: Objective: To assess the feasibility of using a rapid access neurology clinic to assess and manage patients considered safe to discharge home from the emergency department (ED), yet requiring specialist neurology review. Design, setting and participants: The ED Rapid Access Neurology (ED RAN) clinic was trialled at Royal Prince Alfred Hospital, a major tertiary teaching hospital in Sydney, over a 12-month period (23 March 2008 - 22 March 2009). The service uses a new clinic and referral system to offer suitable patients specialist neurology outpatient review within 5 working days of their discharge from the ED. Main outcome measures: Quality of patient care, patient satisfaction, estimated service impact on the hospital system. Results: During the 12-month trial period, 311 patients were referred to the ED RAN clinic. Of these referrals, 222 patients (71%) attended the clinic, where a number of serious neurological diagnoses were made, and eight patients required admission after specialist review. All patients attending the clinic found the visit helpful. Consultant ED physicians believed that the clinic prevented 83 unnecessary
admissions and 188 out-of-hours neurology registrar consultations, and saved an estimated 809 hours of ED bed time. Conclusions: The ED RAN clinic provides a viable model for improving the quality of patient care, with high levels of patient satisfaction. This model of care may allow significant cost savings and help to relieve the major access block in Australian EDs.

Source: EMBASE

44. Acute medical care. The right person, in the right setting--first time: how does practice match the report recommendations?.

Author(s) Ward D, Potter J, Ingham J, Percival F, Bell D

Citation: Clinical Medicine, December 2009, vol./is. 9/6(553-6), 1470-2118;1470-2118 (2009 Dec)

Publication Date: December 2009

Abstract: An acute medicine Royal College of Physicians report makes key recommendations. This study reviews organisational issues and consultant working patterns against these recommendations. Thirty-nine trusts in England and Wales were asked to participate in an online survey, which 27 completed. Twenty-six sites had an acute medical unit (AMU) and all had a lead consultant. Two trusts had no written operational policy. Of the 26 AMUs, 22 had at least level 1 facilities and 21 used an early warning score at point of entry to care. Ten reported a minimum of twice daily ward rounds seven days a week. Consultant of the day was the most common pattern of work. Ten trusts cancelled other clinical duties for consultants responsible for acute take. The pilot shows evidence of good practice in leadership and operational policies. Further work to standardise and improve acute care is needed including a more consistent twice daily consultant review.

Source: Medline

45. Patient-centred care: Nice but not necessary?

Author(s) Luxford K., Delbanco T., Gelb Safran D.

Citation: Asia-Pacific Journal of Clinical Oncology, November 2009, vol./is. 5/(A153-A154), 1743-7555 (November 2009)

Publication Date: November 2009

Abstract: Objective: To investigate organizational characteristics for improving patient-reported service quality in US health care institutions renowned for focusing on patient care experience. Case studies to highlight transformation of care delivery in cancer services. Design: A qualitative study, involving interviews with senior staff and patient representatives and review of patient survey reports. The main themes covered in the interviews were organizational characteristics, data collection and feedback mechanisms, responsiveness, patient engagement, motivation and sustainability. Eight health care organizations across the United States with a recognized reputation for focusing on improving patient care experience. A total of 40 staff including chief executives, quality directors, chief medical officers, administration directors and patient committee representatives. Results: Organizational characteristics viewed by respondents as critical for improving patient care experience were strong committed leadership, regular collection and feedback of patient care experience data, provision of resources and staff capacity building, performance review and remuneration incentives, a culture strongly supportive of improvement and a considerable focus on staff satisfaction. Patient care experience data was collected using a wide variety of tools and reported with high specificity. A subset of three striking sites displayed common governance elements, used patient feedback to drive quality improvement, remodeled their workforce to support service quality and exhibited high levels of patient engagement within the organization. Patient engagement in cancer service care realignment will be featured. Improvement in a suite of performance benchmarks will be discussed. Conclusion: A comprehensive organization-wide approach is required to drive improvements in patient assessment of care quality, including extensive collection and use of patient feedback, responsiveness to the 'customers' of the service, service-level engagement of patients, workforce remodeling and accountability and
46. Improving communication among nurses, patients, and physicians.

**Author(s)** Chapman, K  
**Citation:** American Journal of Nursing, Nov 2009, vol. 109, no. 11, p. 21-25, 0002-936X (November 2009)  
**Publication Date:** November 2009  
**Abstract:** Major care initiatives introduced at a hospital in the USA participating in the Transforming Care at the Bedside programme. Changes to shift report practices, implementation of nurse/consultant patient rounds and the introduction of a 'safety huddle' at the beginning of a shift change to allow critical information to be shared among staff are described.  
**Source:** EMBASE  
**Available in fulltext from American Journal of Nursing at the ULHT Library and Knowledge Services' eJournal collection**

47. Pilot study to compare the effectiveness of assessment by a consultant cancer nurse compared to consultant oncologist for patients receiving chemotherapy in terms of toxicities experienced

**Author(s)** Roe H.  
**Citation:** European Journal of Cancer, Supplement, September 2009, vol./is. 7/2-3(239), 1359-6349 (September 2009)  
**Publication Date:** September 2009  
**Abstract:** As a consultant cancer nurse the author provides a nurse led service including review of patients receiving chemotherapy and needed to assess her practice in terms of effectiveness, rather than just from the patient perspective, as most other evidence looks at patient satisfaction and does not discuss patient safety. Also consultant nurses are an example of the development of nursing roles and the blurring of professional boundaries in the Health Service in the United Kingdom, as well as there often being comparisons made between consultant nurses and consultants. The study utilised a qualitative design using a triangulation of interviews and transcripts. The patient group were adjuvant breast cancer patients who are received chemotherapy in the outpatient setting. The patients were selected so half were reviewed by the consultant oncologist and half by the consultant cancer nurse. Analysis involved cross over analysis by both the consultant oncologist and the consultant cancer nurse who reviewed initial information provided by the patient prior to their consultation, the transcripts of the consultation and medical notes to determine if their management was appropriate and effective. Results of the study demonstrated that the consultant cancer nurse review was as effective as that provided by the consultant oncologist in terms of detecting side effects, offering management strategies and monitoring outcomes of previous interventions. The conclusion of the study was that patient care was not compromised by them being reviewed by the consultant cancer nurse.  
**Source:** EMBASE

48. The value of the post-take ward round: are new working patterns compromising junior doctor education?.

**Author(s)** Chaponda M, Borra M, Beeching NJ, Almond DS, Williams PS, Hammond MA, Price VA, Tarry L, Taegtmeyer M  
**Citation:** Clinical Medicine, August 2009, vol./is. 9/4(323-6), 1470-2118;1470-2118 (2009 Aug)  
**Publication Date:** August 2009  
**Abstract:** This prospective observational study assessed the impact of the changes in
junior doctors' working hours and waiting-time initiatives on teaching and learning opportunities for junior doctors in acute medicine. An audit cycle of post-take ward rounds including all medical admissions to an urban teaching hospital was conducted. During two seven-day periods in July 2006 and 2008, 317 and 354 patients were admitted respectively. In the two-year interval a number of changes were implemented resulting in a significant increase in patients reviewed by a consultant within 24 hours of admission. Target waiting times were being met but there were many missed learning opportunities for junior staff. Senior doctors continue to perform the majority of post-take reviews in the absence of the doctors who had admitted the patient. Similar patterns are likely to be found in other hospitals attempting to balance training with government targets for waiting times and junior doctors' working hours.

Source: Medline

49. Does early review by a respiratory physician lead to a shorter length of stay for patients with non-severe community-acquired pneumonia?.

Author(s) Bewick T, Cooper VJ, Lim WS

Citation: Thorax, August 2009, vol./is. 64/8(709-12), 0040-6376;1468-3296 (2009 Aug)

Publication Date: August 2009

Abstract: BACKGROUND: The aim of this study was to evaluate whether patients with non-severe community-acquired pneumonia (CAP) have a shorter length of stay (LOS) when initially seen by a respiratory physician compared with a non-respiratory physician. METHODS: At Nottingham City Hospital, following nurse triage, acute medical patients who are not severely ill are admitted to the consultant-led emergency short stay unit (ESSU). Records of patients seen on ESSU between January 2004 and December 2007 with a clinical discharge code relating to CAP were retrospectively examined. Patients with a diagnosis of cellulitis over the same time period were used as controls. Patients were grouped depending on whether they were seen on their first post-take ward round by a respiratory consultant physician (group A), non-respiratory consultant physician (group B) or on a Saturday or Sunday (group C). RESULTS: Following exclusions, 426 patients with CAP and 935 patients with cellulitis were analysed. The median LOS for patients with CAP in group A was 1.74 days (n = 123, interquartile range (IQR) 0.97-4.09) compared with 3.03 days for patients in group B (n = 174, IQR 1.12-6.23; p<0.01). There was a larger percentage of discharges within 24 h of consultant review in group A (43.1%) compared with group B (31.9%), although this was not statistically significant (p = 0.18). There was no statistically significant difference between groups A and B with cellulitis in LOS or percentage discharged within 24 h of first consultant review. CONCLUSION: Patients with non-severe CAP have a shorter hospital LOS when initially seen by a respiratory compared with a non-respiratory physician.

Source: Medline

Available in fulltext from Thorax at Highwire Press
Available in fulltext from Thorax at Highwire Press
Available in fulltext from Thorax at National Library of Medicine

50. Assessing the feasibility of a one-stop approach to diagnosis for urological patients.

Author(s) Coull N, Rottenberg G, Rankin S, Pardos-Martinez M, Coker B, Jenkins E, O'Brien T

Citation: Annals of the Royal College of Surgeons of England, May 2009, vol./is. 91/4(305-9), 0035-8843;1478-7083 (2009 May)

Publication Date: May 2009

Abstract: INTRODUCTION: Conventional publicly funded out-patient services in many specialties are characterised by delays, fragmented diagnostic processes, and overloaded clinics. This is bad for patients as it is clinically dangerous; bad for managers who spend hours managing the failure; bad for doctors who respond by overloading clinics; and bad for
purchasers who have to fund the multiple out-patient visits needed. Sound clinical and financial reasons exist for introducing more efficient diagnostic processes.

PATIENTS AND METHODS: A total of 330 consecutive patients referred to the urology department of Guy's and St Thomas' NHS Foundation Trust were invited to attend one of nine one-stop clinics staffed by consultant urologists with specialist registrars, nurses, and clerical staff. Pre-clinic blood and urine tests were ordered based on the referral letter. Clinics had facilities to perform cystoscopy, ultrasound, and urinary flow studies. Correspondence was generated in real time, and a copy given to the patient.

RESULTS: Overall, 257 patients attended the clinics. Twenty-three patients cancelled appointments and 50 patients did not attend. Pre-clinic tests were requested in 133 patients and were completed by 86% of the patients who attended. Of patients, 42% were diagnosed and discharged; 28% were listed for surgery, extracorporeal shock wave lithotripsy (ESWL), or referred to another specialty. About 30% of patients needed further out-patient review; in approximately two-thirds to complete a diagnosis and one-third to review the results of therapy initiated. An estimated 350 appointments and 550 patient visits to hospital were saved.

CONCLUSIONS: A one-stop method of consultation is efficient across a range of urological presenting complaints, and dramatically reduces the need for follow-up consultations. It has potential to: (i) reduce delays to being seen in out-patients; (ii) lead to more cost-effective care; and (iii) increase safety and patient satisfaction. It should become the standard of care in urology, and is probably applicable in many other disciplines.

Source: Medline
Available in fulltext from Annals of The Royal College of Surgeons of England at National Library of Medicine


Author(s) Yee PL, Edwards ML, Dixon J, Gleason NS

Citation: Nursing Administration Quarterly, 01 January 2009, vol./is. 33/1(48-53), 03639568

Publication Date: 01 January 2009

Abstract: Many healthcare organizations have implemented patient safety initiatives aimed at creating a safer healthcare environment. At North Carolina Children's Hospital at University of North Carolina Hospitals, patient safety rounds were established in the fall of 2005. Rounds are held weekly and involve all members of the healthcare team. Senior leadership actively participates and helps staff seek out solutions for the identified issues. Within the first year of operation, 191 issues were identified, of which 58% were resolved. Rounds continue to occur and have expanded over to the Women's services. Other initiatives such as Just Culture and Six Sigma have been established and help further cultivate a climate that strives toward optimizing patient safety.

Source: CINAHL

52. Dealing with difficult doctors.

Author(s) Castledine, G

Citation: British Journal of Nursing, Nov 2008, vol. 17, no. 20, p. 1305., 0966-0461 (November 13, 2008)

Publication Date: November 2008

Abstract: Castledine Column. The importance of patient dignity and respect when consultants conduct ward rounds. [(BNI unique abstract)] 1 references

Source: BNI
Available in print at Pilgrim Hospital Staff Library
Available in fulltext from British Journal of Nursing at EBSCOhost
Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
53. Emergency department board rounds: are they worthwhile?

Author(s) Chitnis J, Cumberbatch GLA, Thomas PW

Citation: Emergency Medicine Journal, 01 July 2008, vol./is. 25/7(437-438), 14720205

Publication Date: 01 July 2008

Abstract: OBJECTIVE: To determine whether daily board rounds in the emergency department (ED) alter patient management and whether they provide educational opportunities. Method: A prospective observational study of board rounds conducted in a small to medium-sized ED in the United Kingdom. Data were collected on changes made and educational events that took place. RESULTS: Data were collected on 120 board rounds (984 patients). 5.8% of patients had a clinical change made. 12% of board rounds led to a significant change in at least one of investigation, treatment or disposition. 2% of board rounds led to a change in diagnosis. In 30% of board rounds teaching events took place. CONCLUSION: Regular conduct of board rounds in a medium-sized UK ED is worthwhile and provides an additional teaching opportunity for juniors. Performing board rounds in the emergency department (ED) provides a useful means of combining timely senior review with an opportunity for snapshot focussed teaching events. In our ED it was felt that we made a number of changes to the management of patients during board rounds and this also worked as an additional teaching tool for juniors. Very little literature exists studying the effectiveness of such rounds. We therefore decided to study how effective these board rounds were, both in terms of clinical management and as an educational tool. The objectives of the study were: (1) to determine whether daily board rounds in the ED alter patient diagnosis, investigation, treatment or disposition; (2) to determine whether they simultaneously provide an educational opportunity; (3) to discover whether such rounds significantly delayed doctors seeing unseen patients.

Source: CINAHL

Available in print at Grantham Hospital Staff Library

Available in fulltext from Emergency Medicine Journal at Highwire Press

Available in fulltext from Emergency Medicine Journal: EMJ at National Library of Medicine

54. Anatomy of the ward round.

Author(s) O’Hare JA

Citation: European Journal of Internal Medicine, July 2008, vol./is. 19/5(309-13), 0953-6205;1879-0828 (2008 Jul)

Publication Date: July 2008

Abstract: The ward round has been a central activity of hospital life for hundreds of years. It is hardly mentioned in textbooks. The ward round is a parade through the hospital of professionals where most decision making concerning patient care is made. However the traditional format may be intimidating for patients and inadequate for communication. The round provides an opportunity for the multi-disciplinary team to listen to the patient’s narrative and jointly interpret his concerns. From this unfolds diagnosis, management plans, prognosis formation and the opportunity to explore social, psychological, rehabilitation and placement issues. Physical examination of the patient at the bedside still remains important. It has been a tradition to discuss the patient at the bedside but sensitive matters especially of uncertainty may better be discussed elsewhere. The senior doctor as round leader must seek the input of nursing whose observations may be under-appreciated due to traditional professional hierarchy. Reductions in the working hours of junior doctors and shortened length of stay have reduced continuity of patient care. This increases the importance of senior staff in ensuring continuity of care and the need for the joint round as the focus of optimal decision making. The traditional round incorporates teaching but patient's right to privacy and their preferences must be respected. The quality and form of the clinical note is underreported but the electronic record is slow to being accepted. The traditional multi-disciplinary round is disappearing in some centres. This may be regrettable. The anatomy and optimal functioning of the ward round deserves scientific
55. A study to evaluate nurse-led on-treatment review for patients undergoing radiotherapy for head and neck cancer.

**Author(s)** Wells M, Donnan PT, Sharp L, Ackland C, Fletcher J, Dewar JA

**Citation:** Journal of Clinical Nursing, June 2008, vol./is. 17/11(1428-39), 0962-1067;1365-2702 (2008 Jun)

**Publication Date:** June 2008

**Abstract:** AIMS AND OBJECTIVES: To evaluate a nurse-led clinic for patients undergoing radiotherapy to the head and neck. BACKGROUND: The side effects of radiotherapy to the head and neck are superimposed on already significant physical and psychological morbidity. Medical review clinics tend to focus on treatment complications and there is evidence that specialist nurses can provide more holistic care for patients. However, doubts have been raised about the appropriateness of nurse-led review in this highly symptomatic and complex group. DESIGN: This evaluation compared medical on-treatment review (Phase 1) with a nurse-led clinic (Phase 2) for patients having radiotherapy to the head and neck, using an historical control group. METHODS: Twenty patients were reviewed by their consultant and 23 by a nurse specialist, using a clinic protocol. A mixed-method approach to data collection was taken. Patients completed weekly quality of life questionnaires and were asked about their experiences of support and care. General practitioners completed a questionnaire about the communication received from the clinic. Checklists assessed the content of clinic consultations. RESULTS: Patients valued the relationship developed with the nurse specialist, had longer, more frequent consultations and were more often referred to the multidisciplinary team. The nurse specialist managed 83% of consultations without referral to the consultant. Few significant differences in quality of life were found between the groups. There were indications that oral and nutritional problems were managed more effectively in the nurse-led clinic, although emotional functioning was higher in the medical group. GPs were positive about the timing and content of information received. CONCLUSIONS: On-treatment review for patients with head and neck cancer can be effectively managed by a nurse specialist. Relevance to Practice. Radiotherapy nurse specialists make an important contribution to the supportive care of patients with head and neck cancer. More investment is required to maximize their contribution.

**Source:** Medline

Available in fulltext from Journal of Clinical Nursing at EBSCOhost

Available in fulltext from Journal of Clinical Nursing at the ULHT Library and Knowledge Services' eJournal collection

56. Integrated hospital emergency care improves efficiency.

**Author(s)** Boyle AA, Robinson SM, Whitwell D, Myers S, Bennett TJH, Hall N, Haydock S, Fritz Z, Atkinson P

**Citation:** Emergency Medicine Journal, 01 February 2008, vol./is. 25/2(78-82), 14720205

**Publication Date:** 01 February 2008

**Abstract:** BACKGROUND: There is uncertainty about the most efficient model of emergency care. An attempt has been made to improve the process of emergency care in one hospital by developing an integrated model. METHODS: The medical admissions unit was relocated into the existing emergency department and came under the 4-hour target. Medical case records were redesigned to provide a common assessment document for all patients presenting as an emergency. Medical, surgical and paediatric short-stay wards were opened next to the emergency department. A clinical decision unit replaced the more traditional observation unit. The process of patient assessment was streamlined so that a patient requiring admission was fully clerked by the first attending doctor to a level suitable for registrar or consultant review. Patients were allocated directly to specialty on arrival. The effectiveness of this approach was measured with routine data over the same 3-month periods in 2005 and 2006. RESULTS: There was a 16.3% decrease in emergency medical
admissions and a 3.9% decrease in emergency surgical admissions. The median length of
stay for emergency medical patients was reduced from 7 to 5 days. The efficiency of the
elective surgical services was also improved. Performance against the 4-hour target
declined but was still acceptable. The number of bed days for admitted surgical and
medical cases rose slightly. There was an increase in the number of medical outliers on
surgical wards, a reduction in the number of incident forms and formal complaints and a
reduction in income for the hospital. CONCLUSIONS: Integrated emergency care has the
ability to use spare capacity within emergency care. It offers significant advantages beyond
the emergency department. However, improved efficiency in processing emergency
patients placed the hospital at a financial disadvantage.

Source: CINAHL
Available in print at Grantham Hospital Staff Library
Available in fulltext from Emergency Medicine Journal at Highwire Press
Available in fulltext from Emergency Medicine Journal : EMJ at National Library of
Medicine

57. Patient safety rounds in a pediatric tertiary care centre

Author(s) Rinke, Michael L, Zimmer, Karen P, Lehmann, Christoph U, Colombani, Paul,
Dover, George

Citation: Joint Commission Journal of Quality and Patient Safety, 2008, vol./is. 34/1, 1553-7250

Publication Date: 2008

Abstract: Patient safety rounds were implemented in a paediatric tertiary care setting.
Completed patient safety issues from three years of paediatric patient safety rounds and
nine months of paediatric surgical safety rounds were analysed. Completed issues were
categorised into both Modified Vincent and University Health System Consortium (UHC)
categorisation schemes to compare and contrast their attributes. The findings were from
January 2003 through January 2006, there were 159 completed patient safety issues, 148
(93%) from general paediatric safety rounds and 11 (seven percent) from paediatric
surgical safety rounds. Using the UHC classification scheme, 35.8% of the issues were
classified as care coordination/records, 27.0% as equipment safety situation/preventive
maintenance, 21.4% as equipment/supplies/devices, 3.8% as error related to
procedure/treatment/test, and 3.8% as medication error. In the Modified Vincent
classification scheme, 63.5% of the issues were classified as environmental factors, 23.3%
as team factors, 6.9% as individual factors, 3.1% as task factors, and 1.9% as patient
characteristics. Paediatric safety rounds were well received by both frontline staff and
senior executives. The discussion was, the use of paediatric safety rounds is a low-
cost intervention that helps to partner senior leaders and frontline staff on patient safety and is
an effective tool for improving patient safety in a paediatric setting. Cites eight references.
[Journal abstract]

Source: HMIC

58. Electronic patient record use during ward rounds: a qualitative study of
interaction between medical staff.

Author(s) Morrison C, Jones M, Blackwell A, Vuylsteke A

Citation: Critical Care (London, England), 2008, vol./is. 12/6(R148), 1364-8535;1466-609X
(2008)

Publication Date: 2008

Abstract: INTRODUCTION: Electronic patient records are becoming more common in
critical care. As their design and implementation are optimized for single users rather than
for groups, we aimed to understand the differences in interaction between members of a
multidisciplinary team during ward rounds using an electronic, as opposed to paper, patient
medical record.METHODS: A qualitative study of morning ward rounds of an intensive care
unit that triangulates data from video-based interaction analysis, observation, and
interviews. RESULTS: Our analysis demonstrates several difficulties the ward round team faced when interacting with each other using the electronic record compared with the paper one. The physical setup of the technology may impede the consultant's ability to lead the ward round and may prevent other clinical staff from contributing to discussions. CONCLUSIONS: We discuss technical and social solutions for minimizing the impact of introducing an electronic patient record, emphasizing the need to balance both. We note that awareness of the effects of technology can enable ward-round teams to adapt their formations and information sources to facilitate multidisciplinary communication during the ward round.

Source: Medline
Available in fulltext from Critical Care at National Library of Medicine

59. How often do physicians review medication charts on ward rounds?.
Author(s) Looi KL, Black PN
Citation: BMC Clinical Pharmacology, 2008, vol./is. 8/(9), 1472-6904;1472-6904 (2008)
Publication Date: 2008
Abstract: BACKGROUND: Prescribing errors are common in hospital settings. Regular review of medication charts is recommended as a way to reduce errors but it is not clear how often this happens. The aim of this study was to determine the frequency with which specialist physicians reviewed medication charts during ward rounds. METHODS: An observer noted how often consultant physicians at Auckland City Hospital reviewed medication charts during ward rounds. The physicians were not aware that they were being observed. RESULTS: Twenty-one physicians were observed over a 26 week period. The general physicians reviewed the medication charts on 77% of occasions (range: 45% - 100%) during routine ward rounds and 65% of the time (range: 41% - 80%) on post admission rounds. Subspecialty physicians who did not see more than 8 patients on their rounds reviewed medication charts more frequently (88%) than those specialties where more than 8 patients were seen on average (61%). CONCLUSION: The physicians did not review medication charts on all ward rounds and there was considerable variation in how often they did this. There is some evidence that the frequency with which charts are reviewed decreases as the number of patients seen increases. More efforts should be made to encourage regular review of medication charts.

Source: Medline
Available in fulltext from BMC Clinical Pharmacology at EBSCOhost
Available in fulltext from BMC Clinical Pharmacology at National Library of Medicine

60. The majority of bold statements expressed during grand rounds lack scientific merit.
Author(s) Linthorst GE, Daniels JM, van Westerloo DJ
Citation: Medical Education, October 2007, vol./is. 41/10(965-7), 0308-0110;0308-0110 (2007 Oct)
Publication Date: October 2007
Abstract: CONTEXT: Frequently, during grand rounds and other medical conferences, bold statements are made regarding 'exotic medical facts'. Such exotic expert opinions are frequently voiced with great conviction and are usually subsequently assimilated by junior staff as medical fact. METHODS: The level of scientific evidence for each exotic expert opinion expressed during daily grand rounds over a 4-month period was evaluated. If, following a short discussion of the statement, any doubt as to the merits of the claim persisted, the person who made the statement was asked to perform a search in the medical literature on the subject. RESULTS: In total, 25 cases of exotic expert opinion were identified during the study period. Of these, 22 statements were made by senior staff and 3 by residents. Careful review of the literature showed only 8 of the statements were actually evidence-based. In 17 cases the available literature actually contradicted the statement (n = 13) or no literature on the subject could be located (n = 4). Although opinions were most
often expressed by staff members, the reviews of their merits were more often performed by residents. CONCLUSIONS: The vast majority of exotic expert opinions expressed by senior staff members during grand rounds are not evidence-based. Thus, great care must be taken to ensure that exotic expert opinion is not accepted as factual without careful review. Furthermore, this study shows that although seniority is (as expected) associated with a higher incidence of voicing exotic expert opinion, it is negatively associated with reviewing the merits of such opinion.

Source: Medline
Available in fulltext from Medical Education at EBSCOhost
Available in fulltext from Medical Education at EBSCOhost

61. What's wrong with the wards?
Author(s) Teale, Katherine
Citation: BMJ, 2007, vol./is. 334/7584(97), 0959-8138
Publication Date: 2007
Abstract: The author, a consultant anaesthetist, gives her view on the reasons for failings in patient care on hospital wards: "lack of trained staff, lack of continuity of care, and poor leadership". She argues that this is an area that doctors can make a difference by "making time on the ward a priority, reviewing patients, guiding the trainees and supporting the nursing staff. [KJ]
Source: HMIC
Available in print at Pilgrim Hospital Staff Library
Available in fulltext from BMJ at Highwire Press
Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library

62. Patient safety rounds: description of an inexpensive but important strategy to improve the safety culture.
Author(s) Campbell DA Jr, Thompson M
Citation: American Journal of Medical Quality, January 2007, vol./is. 22/1(26-33), 1062-8606;1062-8606 (2007 Jan-Feb)
Publication Date: January 2007
Abstract: Patient safety rounds (PSRs) were established at the University of Michigan Medical Center to improve patient safety by opening a new line of communication between the chief of staff and frontline caregivers. Patient safety rounds are biweekly, hour long meetings between the chief of staff and care givers on individual patient care units. In the past 4 years (2002 to 2006), 70 PSRs have been conducted, and more than 900 area staff members have participated. Staff attendance averages 8 to 10 unit or area staff members per session. Patient safety rounds have proven to be a concrete, inexpensive mechanism to enhance patient safety. Benefits have been documented in the improvement in the safety culture and development and implementation of preventive strategies to solve patient safety issues. Key components in the success of PSRs are active medical staff leadership and the engagement of physicians and senior management in the process improvements the PSRs have directed.
Source: Medline

63. Does consultant geriatrician review on post take ward rounds (PTWR) effect elderly patients' length of stay?... British Geriatrics Society: Abstracts of papers presented at the Spring Scientific Meeting, 6-7 April 2006.
Author(s) Jackson A, Warren K
64. Trauma rapid review process: efficient out-patient fracture management.

Author(s): Beiri A, Alani A, Ibrahim T, Taylor GJ

Abstract: INTRODUCTION: Our hospital operates a consultant-led, rapid review process of X-rays and case notes of all musculoskeletal injury patients on a daily basis. This compares with other centres where patients are reviewed in out-patient fracture clinics soon after injury. The aim of this study was to evaluate the effectiveness of this consultant-led, rapid review process compared to standard consultant fracture clinics. PATIENTS AND METHODS: A prospective study of the rapid review process over 4 weeks of all musculoskeletal injury patients was conducted. The total number of patients referred per day, time taken to review these patients X-rays and case notes, number of recalls and reason for recall were documented. This was compared to consultant-led fracture clinics, which included time taken to review patients. RESULTS: A total of 797 patients were processed through the rapid review over 4 weeks: 53 (6%) patients were recalled, 32 (4%) for a change of management and 21 (2.6%) because of lack of information. The mean number of patients referred per day was 28 taking a mean of 28 min; thus the mean time to review one patient was 1.0 min. The mean number of patients recalled per day was two. The mean time taken to review a patient in a standard fracture clinic was 11 min. Therefore, the total time that would have taken to review 28 patients in a standard fracture clinic would be 308 min. CONCLUSIONS: A consultant-led, rapid review process of all patients with musculoskeletal injury is a very efficient process. The rapid review process saves clinic time and resources, minimises delays in clinical decision-making and saves the patient an unnecessary visit to the outpatient department.

Source: Medline


Author(s): Roy A, Heckman MG, Roy V

Abstract: OBJECTIVE: To investigate the relationship between the hospitalist consultant model of care and both length of hospital stay (LOS) and hospital cost for patients undergoing hip fracture surgery. PATIENTS AND METHODS: We retrospectively studied 118 consecutive patients admitted with hip fracture (diagnosis related groups 79.35 and 81.52) between January 1, 2002, and December 31, 2002, at a community-based academic medical center. For each patient, consultations for preoperative medical evaluation and management of postoperative complications were performed by a hospitalist or a traditional medical consultant (nonhospitalist). We defined “hospitalist” as dedicated hospital-based physicians who provide their maximum professional time in inpatient health care delivery and who are completely free of outpatient responsibilities. Time to consultation (TTC), time to surgery (TTS), LOS, and total hospital costs were
determined for each patient by review of the medical records and were compared between hospitalist and nonhospitalist consultants. RESULTS: Both TTC and TTS were significantly lower for hospitalist patients (P < .001 and P = .004, respectively). Although not statistically significant, cost and LOS also were lower for patients receiving hospitalist care. In the hospitalist group, median cost was an estimated dollar 1777 less, and median LOS was 1 day less than in the nonhospitalist group. CONCLUSION: Hospitalist Involvement in the medical management of patients undergoing hip fracture surgery may be associated with decreases in TTC, TTS, LOS, and total hospital cost. The results of this study have implications for consultative medical care of patients undergoing urgent surgery and their health outcomes.

Source: CINAHL
Available in fulltext from Mayo Clinic Proceedings at EBSCOhost


Author(s) Dawson D, McEwen A
Citation: Intensive & Critical Care Nursing, 01 December 2005, vol./is. 21/6(334-343), 09643397
Publication Date: 01 December 2005
Abstract: Background
Source: CINAHL
Available in print at Pilgrim Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library

67. Reliability of ophthalmic accident and emergency referrals: a new role for the emergency nurse practitioner?

Author(s) Ezra DG, Mellington F, Cugnoni H, Westcott M
Citation: Emergency Medicine Journal, 01 October 2005, vol./is. 22/10(696-699), 14720205
Publication Date: 01 October 2005
Abstract: BACKGROUND AND OBJECTIVES: Annual attendances at the accident and emergency (A&E) department of St Bartholomew's and The Royal London NHS Trust exceed 100,000 people of which 6% are ophthalmic. This study evaluated the accuracy of eye referrals from A&E senior house officers (SHOs) and emergency nurse practitioners (ENPs) and the impact any inaccuracies may have had on out of hours work. METHODS: Over a four week period a record of all referrals from the A&E department was made. The doctor receiving the referral made a note of clinical variables as reported by the referring clinician. When the patient was subsequently reviewed by an ophthalmologist, a record was again made of these findings. Any discrepancies were recorded. RESULTS: A total of 67 patients were recruited. ENPs were found to be consistently more accurate than SHOs in every aspect of the assessment, most notably in visual acuity (p = 0.0029), and provisional diagnosis (p = 0.012). Furthermore, had the examination findings been accurate, 58% of all SHO referrals seen after hours would have been triaged to the next available clinic but only 10% of ENP referrals could have been seen at the next clinic session (p = 0.027). CONCLUSION: This study found ENPs to be more accurate than A&E SHOs in history taking, recording visual acuity, describing ocular anatomy, and making provisional diagnoses. A significant reduction in out of hours ophthalmic workload may be achieved in the authors’ unit if ENPs were to see all eye emergencies.

Source: CINAHL
Available in fulltext from Emergency Medicine Journal at Highwire Press
Available in fulltext from Emergency Medicine Journal at Highwire Press
Available in fulltext from Emergency Medicine Journal : EMJ at National Library of Medicine
68. A survey of ward round practice.

Author(s) Hodgson, Richard, Gayathri, B., Jamal, A.

Citation: Psychiatric Bulletin, 2005, vol./is. 29/5(171-173), 0955-6036

Publication Date: 2005

Abstract: AIMS AND METHOD: A postal questionnaire was sent to consultant psychiatrists in the West Midlands to establish their current ward round practice. This questionnaire addressed ward round etiquette, practical issues and educational function. Consultants received only one mailing. RESULTS: A total of 96 (out of 139) consultants replied (69 per cent response rate). The majority of consultants saw patients on the ward round (97 per cent) and all consultants introduced both themselves and team members to the patient; 72 per cent explained the purpose of the ward round. A median of seven professionals attended the ward round with psychology (6.5 per cent) and pharmacy services (0 per cent) being underrepresented. When consultants added comments, the recurrent themes were that ward rounds were an effective use of professional time but were often daunting for patients. CLINICAL IMPLICATIONS: Our results indicate some uniformity in the conduct of ward rounds. The lack of representation at ward rounds for certain professional groups may adversely affect the range of opinions and therapies for patients. Changes could be made to incorporate the views of users, which would make ward rounds more productive for users and professionals. 11 refs. [Abstract]

Source: HMIC

Available in print at Grantham Hospital Staff Library
Available in fulltext at Psychiatric Bulletin (now Psychiatrist); Notes: Username: ulhtlibraries/Password: library
Available in print at Lincoln County Hospital Professional Library

69. Wireless telemedicine for the delivery of specialist paediatric services to the bedside.


Citation: Journal of Telemedicine & Telecare, 2005, vol./is. 11 Suppl 2/(S81-5), 1357-633X;1357-633X (2005)

Publication Date: 2005

Abstract: A mobile interactive online health system was used to conduct virtual ward rounds at a regional hospital which had no specialist paediatrician. The system was wireless, which allowed telepaediatric services to be delivered direct to the bedside. Between December 2004 and May 2005, 43 virtual ward rounds were coordinated between specialists based in Brisbane and local staff at the Gladstone Hospital. Eighty-six consultations were provided for 64 patients. The most common conditions included asthma (27%), chest infections (12%), gastroenteritis (10%) and urinary tract infections (10%). In the majority of cases, there were partial (67%) or complete changes (11%) in the clinical management of patients. Specialist services were offered by a team of 13 clinicians at the Royal Children's Hospital: 10 general paediatricians, two physiotherapists and one registered nurse. Feedback from all consultants involved in the service and local staff in Gladstone was extremely positive. In 43 videoconference calls there were three technical problems, probably due to an intermittent mains power supply at the regional hospital. There appears to be potential for other rural and regional hospitals to adopt this model of service delivery.

Source: Medline

Available in fulltext from Journal of Telemedicine and Telecare at EBSCOhost

70. Validation of a checklist to assess ward round performance in internal medicine.
BACKGROUND: Ward rounds are an essential responsibility for doctors in hospital settings. Tools for guiding and assessing trainees' performance of ward rounds are needed. A checklist was developed for that purpose for use with trainees in internal medicine.

OBJECTIVE: To assess the content and construct validity of the task-specific checklist.

METHODS: To determine content validity, a questionnaire was mailed to 295 internists. They were requested to give their opinion on the relevance of each item included on the checklist and to indicate the comprehensiveness of the checklist. To determine construct validity, an observer assessed 4 groups of doctors during performance of a complete ward round (n = 32). The nurse who accompanied the doctor on rounds made a global assessment of the performance.

RESULTS: The response rate to the questionnaire was 80.7%. The respondents found that all 10 items on the checklist were relevant to ward round performance and that the item collection was comprehensive. Checklist mean-item scores differed between levels of expertise: junior house officers 1.4 (1.0-1.9); senior house officers 2.0 (1.5-2.9); specialist trainees 2.5 (1.8-2.8), and specialists 2.7 (2.3-3.5); median (range) (P < 0.001). A significant correlation was found between global observer scores and nurse scores (r = 0.56, P < 0.001).

CONCLUSION: The checklist, developed for assessing trainees' performance of ward rounds in internal medicine, showed high content validity. Construct validity was supported by the higher scores of experienced doctors compared to those with less experience and the significant correlation between the observer's and nurses' global scores. The developed checklist should be valuable in guiding and assessing trainees on ward round performance.

Source: Medline
Available in fulltext from Medical Education at EBSCOhost

71. What is the impact of consultant supervision on outpatient follow-up rate?

Author(s) Lo S, Fergie N, Walker C, Narula AA

Citation: Clinical Otolaryngology & Allied Sciences, April 2004, vol./is. 29/2(119-23), 0307-7772;0307-7772 (2004 Apr)

Publication Date: April 2004

Abstract: This study investigated the impact of consultants on recycling rates of patients in the ENT outpatient clinic. A retrospective case review of 4205 consecutive patients who attended ENT outpatient clinics of an UK teaching hospital over a 3-month period was conducted. There was a significant association between grade of medical staff and recycling rate of new patients, and also for review patients. Junior doctors have lower recycling rates in consultant-led clinics compared with clinics in the absence of consultants for both new patients (consultant-led 41.0%, without consultant 60.1%; P < 0.01) and old patients (consultant-led 48.9%, without consultant 65.0%; P < 0.01). Individual consultant’s practice was reflected upon the overall recycling rate of the clinic as a whole (r = 0.94, P = 0.001). In conclusion, individual consultant’s practice dictated recycling rate in the ENT outpatient clinic. Junior doctors were less likely to make follow-up appointments when directly supervised by their consultants.

Source: Medline
Available in fulltext from Clinical Otolaryngology and Allied Sciences at EBSCOhost

72. Improving quality care through a nursing review team.

Author(s) Dugdall, H, Lamb, C, Carlisle, A

Citation: Clinical Governance, Jan 2004, vol. 9, no. 3, 1477-7274 (2004)
Publication Date: January 2004

Abstract: In response to increasing pressure on nursing teams in the Hull and East Yorkshire Trust, a framework was developed to enable a team of senior nurses to review nursing practice in any clinical specialty within the acute trust. The aim of the review was to report on areas of good practice and make recommendations for improvement, based on evidence gathered from patient records, other documentation and interviews with ward staff. The reviews have improved staff morale and quality of patient care and initiated changes in practice. ([BNI unique abstract]) 4 references

Source: BNI

73. Resource utilisation, length of hospital stay, and pattern of investigation during acute medical hospital admission.

Author(s) McMullan R, Silke B, Bennett K, Callachand S

Citation: Postgraduate Medical Journal, January 2004, vol./is. 80/939(23-6), 0032-5473:0032-5473 (2004 Jan)

Publication Date: January 2004

Abstract: OBJECTIVES: To describe the patient demographic characteristics and organisational factors that influence length of stay (LOS) among emergency medical admissions. Also, to describe differences in investigation practice among consultant physicians and to examine the impact of these on LOS.DESIGN: Prospective observational study.SETTING: General medicine department of a teaching hospital in Belfast, UK.PARTICIPANTS: Data were recorded for patients who were admitted as emergencies and reviewed on the post-discharge rounds (PTWR) attended by the investigation coordinator.OUTCOME MEASURES: Non-laboratory investigations requested, LOS, and diagnosis on discharge.RESULTS: Of 830 episodes evaluated, the median LOS was 7 days (interquartile range 3-12 days); this was significantly longer for admissions on Fridays (p = 0.0011) and for patients managed on medical wards (p<0.0001). There was a positive correlation between patient age and LOS (r = 0.32, p<0.0001). Chest radiographs (p = 0.002) and echocardiography (p = 0.015) were associated with a prolonged LOS; no investigations were associated with a shortened LOS. Diagnoses of congestive heart failure, respiratory disease, and cancer were associated with a longer LOS; a diagnosis of angina was associated with a shorter LOS. Considerable variation in investigation ordering, but no difference in LOS, was observed between consultants. High use of a given medical test did not correlate with high use of other tests.CONCLUSION: A systematic means of dealing with the NHS resource crisis should include an improved organisational strategy as well as social care provision. A more unified approach to investigation practice should also have a sparing effect on resources.

Source: Medline

Available in print at Lincoln County Hospital Professional Library
Available in fulltext from Postgraduate Medical Journal at National Library of Medicine
Available in fulltext from Postgraduate Medical Journal at Highwire Press

74. Daily multidisciplinary rounds shorten length of stay for trauma patients.

Author(s) Dutton RP, Cooper C, Jones A, Leone S, Kramer ME, Scalea TM

Citation: Journal of Trauma, 01 November 2003, vol./is. 55/5(913-919), 00225282

Publication Date: 01 November 2003

Abstract: Purpose: Efficient patient care depends on close communication between the trauma team, other surgical providers, nursing, physical therapy, and discharge planners. Communication is hampered by the number of services involved, the workload of each service, and the institution's training mission. We hypothesized that daily multidisciplinary discharge rounds would improve patient flow and increase readiness.
75. Pharmacists on rounding teams reduce preventable adverse drug events in hospital general medicine units.

Author(s) Kucukarslan SN, Peters M, Mlynarek M, Nafziger DA

Citation: Archives of Internal Medicine, September 2003, vol./is. 163/17(2014-8), 0003-9926;0003-9926 (2003 Sep 22)

Publication Date: September 2003

Abstract: BACKGROUND: Previous studies found that medication errors result from lack of sufficient information during the prescribing step. Therefore, it is proposed that having a pharmacist available when patients are evaluated during the rounding process may reduce the likelihood of preventable adverse drug events (ADEs). The objectives of this study were to evaluate the impact of having a pharmacist participate with a physician rounding team on preventable ADEs in general medicine units and to document pharmacist interventions made during the rounding process. METHODS: A single-blind, standard care-controlled study design was used to compare patients receiving care from a rounding team including a pharmacist with patients receiving standard care (no pharmacist on rounding team). Patients admitted to and discharged from the same general medicine unit were included in the study. The main outcome measure of this study was preventable ADEs. Patient records were randomly selected and evaluated by an independent senior pharmacist and a senior staff physician. Interventions made by the pharmacists in the treatment group were documented. RESULTS: The rate of preventable ADEs was reduced by 78%, from 26.5 per 1000 hospital days to 5.7 per 1000 hospital days. There were 150 documented interventions recommended during the rounding process, 147 of which were accepted by the team. The most common interventions were (1) dosing-related changes and (2) recommendations to add a drug to therapy. CONCLUSION: Pharmacist participation with the medical rounding team on a general medicine unit contributes to a significant reduction in preventable ADEs.

Source: Medline

Available in fulltext from Archives of Internal Medicine at Silverchair Information Systems

76. Use of emergency observation and assessment wards: A systematic literature review

Author(s) Cooke M.W., Higgins J., Kidd P.

Citation: Emergency Medicine Journal, March 2003, vol./is. 20/2(138-142), 1351-0622 (March 2003)

Publication Date: March 2003

Abstract: Introduction: Observation and assessment wards allow patients to be observed on a short-term basis and permit patient monitoring and/or treatment for an initial 24-48 hour period. They should permit concentration of emergency activity and resources in one area, and so improve efficiency and minimise disruption to other hospital services. These types of ward go under a variety of names, including observation, assessment, and admission wards. This review aims to evaluate the current literature and discuss assessment/admission ward functionality in terms of organisation, admission criteria, special patient care, and cost effectiveness. Methods: Search of the literature using the Medline and BIDS databases, combined with searches of web based resources. Critical assessment of the literature and the data therein is presented. Results: The advantages and disadvantages of the use of assessment/admission wards were assessed from the current literature. Most articles suggest that these wards improve patient satisfaction, are safe, decrease the length of stay, provide earlier senior involvement, reduce unnecessary admissions, and may be particularly useful in certain diagnostic groups. A number of studies summarise their organisational structure and have shown that strong management, staffing, organisation, size, and location are important factors for efficient running. There is
wide variation in the recommended size of these wards. Observation wards may produce cost savings largely relating to the length of stay in such a unit. Conclusion: All types of assessment/admission wards seem to have advantages over traditional admission to a general hospital ward. A successful ward needs proactive management and organisation, senior staff involvement, and access to diagnostics and is dependent on a clear set of policies in terms of admission and care. Many diagnostic groups benefit from this type of unit, excluding those who will inevitably need longer admission. Vigorous financial studies have yet to be undertaken in the UK. Definitions of observation, assessment, and admission ward are suggested.

Source: EMBASE

Additional results from EMBASE (not included in the results above)

1. Improved patient satisfaction at nurse-led versus consultant-led rheumatology clinics

Author(s) Campbell E., McKee A., Riddell C.

Citation: Irish Journal of Medical Science, May 2013, vol./is. 182/(S103), 0021-1265 (May 2013)

Publication Date: May 2013

Abstract: Introduction: Patient satisfaction is increasingly recognised by healthcare providers as an important aspect of healthcare. It influences whether a person seeks medical advice, complies with treatment, and maintains a continuing relationship with a practitioner [1]. This is particularly important for patients with chronic disease such as rheumatoid arthritis [2]. Aims/background: To measure patient satisfaction of the service provided by the rheumatology department in Antrim Area Hospital, comparing doctor and nurse-led clinics. Six areas were examined: general satisfaction, giving of information, empathy with the patient, technical quality and competence, attitude towards the patient, and access and continuity. Method: A previously validated questionnaire [2, 3] which had been tested for reliability (α = 0.97) and stability (Pearson's r = 0.83) was completed anonymously by 42 review patients attending the rheumatology department. Results: The highest satisfaction scores were obtained in the area of technical quality and competence. The least satisfaction was accredited to access and continuity. The biggest difference between doctors and nurses was noted in relation to empathy with the patient. Conclusions: Patients were satisfied with the competence of the service provided. Greater satisfaction was noted consistently across the subscales with nurse-led clinics. In particular, patients reported increased empathy at nurse-led consultations which is interesting in view of data suggesting that prolonged, empathetic consultations have improved clinical outcomes (mean decrease in DAS28>0.5) [4]. This raises again the questions highlighted by Moots and Rogers [5] does the highly medicalized assessment and focus on 'treating to target' preventing doctors from communicating effectively with their patients? A more empathetic approach could result in improved clinical outcomes and improved patient satisfaction. (Table Presented).

Source: EMBASE

2. Let's go round again! Quality improvement through intentional rounding

Author(s) Doyle P., Cox F., Tollyfield R., Seraj A.

Citation: Critical Care, March 2013, vol./is. 17/(S192-S193), 1364-8535 (19 Mar 2013)

Publication Date: March 2013

Abstract: Introduction Harefield Hospital is a 150-bed cardiothoracic tertiary referral centre with transplantation, artificial heart, ECMO and primary angioplasty services. Our 35-bed critical care department consists of 18 intensive therapy unit, seven recovery and 10 high-dependency beds. Intentional rounds or proactive patient rounds were recognised by the Royal College of Physicians and the Royal College of Nursing [1] as structured, evidence-based processes for nurses to carry out regular checks with individual patients at set intervals. The senior nursing team decided to adapt this initiative to the intensive care setting in order to address clinical challenges and provide guidance for shift leaders to
focus on key elements of care. Methods Our intentional rounds, performed once per shift (twice daily), include two components. First, pressure area care-this component involves the shift leader checking whether key elements of pressure sore prevention have been performed. These include completion of the Waterlow risk assessment tool [2], noting the frequency of repositioning, use of lateral positioning and pressure-relieving pads. Second, renal replacement therapy rates-this element was identified as an area for focus after we established that our haemofiltration fluid use per hour of therapy was twice that of a near identical clinical setting. This pattern continued even after adopting similar therapy guidelines. The shift leader was guided to check whether therapy rates had been adjusted in line with latest biochemical results. Results The incidence of pressure ulcers in the 4 months since the initiative began has averaged 2.25 per month compared with 7.8 per month prior to commencement of intentional rounding. Added to the rounding tool at the end of September 2012, RRT rates in the preceding 4 months averaged 31.5 ml/kg/hour over 24 hours, an 11.9% reduction from the previous average of 35.75 ml/kg/hour. If the pattern of RRT was to continue, this could equate to a cost saving of UK£40,000 per annum. Conclusion The use of a modified targeted intentional rounding tool by the nursing shift leader can help ensure that best practice guidelines are adhered to. This strategy can improve patient outcomes and provide potentially significant financial benefits.

Source: EMBASE
Available in fulltext from Critical Care at National Library of Medicine

3. Regular in situ simulation training of paediatric Medical Emergency Team improves hospital response to deteriorating patients

Author(s) Theilen U., Leonard P., Jones P., Ardill R., Weitz J., Agrawal D., Simpson D.

Citation: Resuscitation, February 2013, vol./is. 84/2(218-222), 0300-9572;1873-1570 (February 2013)

Publication Date: February 2013

Abstract: Aim of the study: The introduction of a paediatric Medical Emergency Team (pMET) was accompanied by integration of weekly in situ simulation team training into routine clinical practice. On a rotational basis, all key ward staff participated in team training, which focused on recognition of the deteriorating child, teamwork and early consultant review of patients with evolving critical illness. This study aimed to evaluate the impact of regular team training on the hospital response to deteriorating in-patients and subsequent patient outcome. Methods: Prospective cohort study of all deteriorating in-patients of a tertiary paediatric hospital requiring admission to paediatric intensive care (PICU) the year before, and after, the introduction of pMET and concurrent team training. Results: Deteriorating patients were: recognised more promptly (before/after pMET: median time 4/1.5 h, p<. 0.001), more often reviewed by consultants (45%/76%, p=. 0.004), more often transferred to high dependency care (18%/37%, p= 0.021) and more rapidly escalated to intensive care (median time 10.5/5 h, p=. 0.024). These improved responses by ward staff extended beyond direct involvement of pMET. There was a trend towards fewer PICU admissions, reduced level of sickness at the time of PICU admission, reduced length of PICU stay and reduced PICU mortality. Introduction of pMET coincided with significantly reduced hospital mortality (. p<. 0.001). Conclusions: These results indicate that lessons learnt by ward staff during regular in situ team training led to significantly improved recognition and management of deteriorating in-patients with evolving critical illness. Integration of in situ simulation team training in clinical care has potential applications beyond paediatrics. 2012 Elsevier Ireland Ltd.

Source: EMBASE
Available in fulltext from Resuscitation at the ULHT Library and Knowledge Services' eJournal collection

7. Weekly amyotrophic lateral sclerosis (ALS) patient management conference-pivotal role in patient care quality improvement, educational and community outreach of carolinas neuromuscular/ALS-MDA center disease-specific care certification process

Citation: Amyotrophic Lateral Sclerosis, October 2012, vol./is. 13/(138), 1748-2968 (October 2012)

Publication Date: October 2012

Abstract: Background: Crucial to evidence-based guideline management of the care of patients with amyotrophic lateral sclerosis (ALS) is a structure to implement at a per-patient level adherence to these guidelines. Lessons from other diseases, including cancer and cardiovascular disease, indicate that regular review of the diagnosis, initial and follow-up treatment decisions, treatment deployment coupled with acceptance of and compliance with treatment are efficiently managed with a multidisciplinary clinic model. Patient adherence to treatment over the course of disease and changes in recommended treatment is aided by regular review at a per-patient level. The regular audit of patient care has been shown to increase timeliness of proper diagnosis and treatment. Objective: To describe the structure and function of the Weekly ALS Patient Management Conference at the Carolinas Neuromuscular/ALS-MDA Center in the Department of Neurology at the Carolinas Medical Center in the Carolinas Healthcare System in North Carolina and South Carolina. Methods: Patients from the Piedmont and western mountain regions of both North Carolina and South Carolina with uncertain, as well as established, diagnoses attend the weekly ALS Intake Clinics for a two-day multidisciplinary clinic evaluation. Each new patient’s clinical summary is presented at the Weekly ALS Patient Management Conference by the MD, allowing input from each member of the multidisciplinary clinic team. Treatment plans are formulated and any limitations to initiating these plans are identified by the RN Clinic coordinator/staff. Each week, active patient problems identified by telephone, email or direct contact are reviewed with formulation of potential solutions. Patients with clinical changes that warrant home visits are reviewed by the RN Homecare coordinator. Patients who attend the monthly oneday Ventilator Clinic for patients with tracheostomy and permanent ventilation and who attend the monthly two-day Multidisciplinary Clinic for patients with and without noninvasive ventilation are discussed at the weekly conference prioritized by number of new problems to be addressed. Patient Safety events during clinic, emergency department visits with and without hospitalization, palliative care, hospice and end-of-life referrals and deaths are reviewed. Minutes are kept in rotation by a staff member and circulated by secure email to staff members/allied health/other consultants who participate in the diverse clinic programs but who are not at the weekly conference. Results: In the period 2010 - 2011, 170 new patients were reviewed, of whom 12 had diagnoses other than ALS. Ventilator clinic (31) and Multidisciplinary clinic (204) unique patients provided 124 and 816 encounter discussions. Home visits generated 398 discussions and patient problems generated 832 discussions. There were 8 patient clinic fall-related safety discussions. Deaths(62), hospice referrals (56) and hospitalizations (19) were reviewed. Conclusions: Weekly ALS Patient Management Conference provides mechanism for 1) per-patient diagnosis, treatment plan review, 2) patient clinic review, 3) patient disease milestone review and 4) patient co-morbidity review.

Source: EMBASE

8. Medication reviews

Author(s) Blenkinsopp A., Bond C., Raynor D.K.

Citation: British Journal of Clinical Pharmacology, October 2012, vol./is. 74/4(573-580), 0306-5251;1365-2125 (October 2012)

Publication Date: October 2012

Abstract: Recent years have seen a formalization of medication review by pharmacists in all settings of care. This article describes the different types of medication review provided in primary care in the UK National Health Service (NHS), summarizes the evidence of effectiveness and considers how such reviews might develop in the future. Medication review is, at heart, a diagnostic intervention which aims to identify problems for action by the prescriber, the clinican conducting the review, the patient or all three but can also be regarded as an educational intervention to support patient knowledge and adherence. There is good evidence that medication review improves process outcomes of prescribing
including reduced polypharmacy, use of more appropriate medicines formulation and more appropriate choice of medicine. When 'harder' outcome measures have been included, such as hospitalizations or mortality in elderly patients, available evidence indicates that whilst interventions could improve knowledge and adherence they did not reduce mortality or hospital admissions with one study showing an increase in hospital admissions. Robust health economic studies of medication reviews remain rare. However a review of cost-effectiveness analyses of medication reviews found no studies in which the cost of the intervention was greater than the benefit. The value of medication reviews is now generally accepted despite lack of robust research evidence consistently demonstrating cost or clinical effectiveness compared with traditional care. Medication reviews can be more effectively deployed in the future by targeting, multi-professional involvement and paying greater attention to medicines which could be safely stopped. 2012 The Authors. British Journal of Clinical Pharmacology 2012 The British Pharmacological Society.

Source: EMBASE

9. Improving patient safety: Effective radiology alerts
Author(s) Farrell C., Furniss T., Chattington P., Gopal K.
Citation: Clinical Radiology, September 2012, vol./is. 67/(S15), 0009-9260 (September 2012)
Publication Date: September 2012
Abstract: Background to the audit: Radiology alerts were introduced in response to complaints of failure to highlight abnormal studies to requesting clinicians resulting in instances of less than satisfactory standards of care. Standard, indicator and target: In 2008 the Royal College of Radiologists published standards relating to alerts. 100% of alerts should be acted upon. If no action deemed necessary this should be documented. Methodology: Alerts were audited from 10-16 Jan 2011. Results of 1st audit round: Code: Possible new cancer 30 patients. Appropriate action taken in 96% of cases. 73% did have neoplasm, 16% did not, 10% under ongoing investigation. Code: Urgent management review 34 patients. Appropriate management underway before report issued in 18%, appropriate action initiated in light of report 64%, no action 18% (83% of these gave clinical justification). Code: Follow up examination required 66 patients. Alert was acted on in 76% of cases. 60% of alerts were for repeat CXR. 24% of inpatients discharged before the report was issued. Code: A&E abnormality not 'red dotted' and pathology may have been overlooked 28 patients. 11 managed appropriately. 2 referred for further management after receipt of report. No action taken after report in 15 cases. 9 of these unlikely to be clinically significant but 1 # neck of femur not followed up. 5 patients re-presented to A&E with the same problem. 1st action plan: An A&E consultant has been appointed as radiology lead to prioritise alerts. Re audit planned in 12 months.
Source: EMBASE

11. The ward round assessment tool (WrAT)-a new work based assessment tool
Author(s) Danino J., Kumar S., Skinner D.
Citation: Clinical Otolaryngology, July 2012, vol./is. 37/(45), 1749-4478 (July 2012)
Publication Date: July 2012
Abstract: Objectives: 1 Ensure trainees receive teaching, assessment and feedback on conducting ward rounds. 2 Pilot new WBA and assess competency undertaking ward rounds. 3 Ensure patient centred management, involvement and safety. 4 Ensure effective communication between all staff. Methods: The WrAT is composed in a similar layout to the current work based assessments already in use on the ISCP website and is an amalgamation of the current procedure based assessment (PBA) and mini clinical examination exercise (Mini-CEX) We aimed for the tool to be generic so that all specialities could adopt it. The tool was trialled by otolaryngology trainees across the region were asked to participate. Feedback from both trainees and trainers was collected via two methods. Results: Ten otolaryngology trainees were assessed by various Consultants who observed a routine working ward round. Of the ten trainees, seven received a level 3 appropriate for central ST training and three received level 4 appropriate for certificate for
completion of training. Feedback: Trainees felt the assessment encouraged consultant participation on ward rounds as well as teaching post ward round. Trainers commented that the tool gave them an opportunity to teach. Conclusions: The WRAT will ensure better teaching, supervision and assessment of trainees in an integral part of the surgical day. The tool encourages interaction between trainee and trainer as well as better communication between trainee, junior doctors, patients and nursing staff. We envisage this tool being used in conjunction with web based assessment sites in multiple specialities and can easily be adapted to be speciality specific.

Source: EMBASE
Available in fulltext from Clinical Otolaryngology at EBSCOhost

12. Consultant-delivered care - Is it worth it?

Author(s) Russell A., Webster J., Izegbu V., Hellawell G.
Citation: BJU International, June 2012, vol./is. 109/(41), 1464-4096 (June 2012)
Publication Date: June 2012
Abstract: Introduction: Reduction in trainee service activity via the EWTD and hospital financial pressures to reduce length of stay (LOS) has led to a transition from consultant-led to consultant-delivered care. Reduced elective activity and consequential income loss are cited as barriers to implementation of a consultant-delivered emergency service. We reviewed LOS for acute admissions before and after the adoption of this service in order to quantify potential savings. Methods: Data was recorded prospectively for average LOS for urology inpatients before and after the adoption of a consultant-delivered acute service. Prior to September 2009 the daily care was middle grade led, thereafter the consultant of the week undertook daily ward rounds of all urology inpatients. Results: In the 12 months prior to September, 2009 the LOS for emergency admissions was 3.1 days. The LOS in the subsequent 12 months was 1.69 days. Dr Foster data for the consultant-delivered care period indicated an overall LOS that was 50% of the national average. UK figures estimate 650 emergency urology admissions per annum for an average district general hospital. Extrapolation of inpatient daily costs of £0 results in annual savings of £273,000 due to LOS reduction. Discussion: The transition to a consultant-delivered model of care resulted in dramatic LOS reduction that translates into measurable financial savings. In addition the 48-hour readmission rate dropped to zero. Service commitments may require reduction but planned staff redeployment can minimize service disruption. We have found a measurable financial and clinical benefit to implementing a consultant-delivered emergency service.

Source: EMBASE
Available in fulltext from BJU International at EBSCOhost
Available in fulltext from BJU International (was British Journal of Urology) at the ULHT Library and Knowledge Services’ eJournal collection

13. Potentially inappropriate prescribing in older hospitalised patients - The impact of the STOPP/START criteria on prescribing appropriateness and an evaluation of the setting in which this screening tool is applied - A pilot study

Author(s) Ryan A., Carr B., Treacy V., Byrne S.
Citation: International Journal of Pharmacy Practice, May 2012, vol./is. 20/(18), 0961-7671 (May 2012)
Publication Date: May 2012
Abstract: Potentially inappropriate prescribing (PIP) is particularly common among the elderly and may result in preventable adverse drug reactions, morbidity, mortality, hospitalisation, institutionalisation and wastage of healthcare resources[1-3]. Screening tools to identify PIP have been cited as an easily deliverable strategy to improve prescribing appropriateness in older persons[4]. This study aimed to screen the medications of an older population using the STOPP/START criteria, identify the medicines most frequently implicated in PIP and, to assess the impact of STOPP/START on patients’ Medication Appropriateness Index (MAI) scores. A clinical pharmacist screened hospital
inpatients’ medications using the STOPP/START criteria and alerted the medical team to any PIP identified. In the control group (n = 30), PIP identified was communicated as part of the routine clinical pharmacy service e.g. verbal/written communication. In the study group (n = 30), PIP identified was communicated at the consultant/registrar-led ward round. The clinical pharmacist documented whether the proposed interventions were accepted or declined, and the reason behind the decision. The MAI was used to assess the impact of the STOPP/START criteria on prescribing appropriateness. Ethical approval was obtained from the Clinical Research Ethics Committee of the Cork Teaching Hospitals and University College Cork. The medications most frequently implicated in PIP were proton pump inhibitors, laxatives, neuroleptics, statins and benzodiazepines. The incidences of PIP identified in the control and study groups were 52 and 41 respectively. The level of acceptance of STOPP/START recommendations in the both groups were similar (p = 0.88), with 54% (n = 28) of recommendations accepted in the control group and 51% (n = 21) of recommendations accepted in the study group. Application of the STOPP/START criteria resulted in a 21.9% reduction in the mean MAI score of the control group (3.74 to 2.92; p = 0.00001) and a 12.4% reduction in the mean MAI score of the study group (3.23 to 2.83; p = 0.001), indicating a statically significant improvement in prescribing appropriateness in both groups. A lesser reduction in the mean MAI score was observed in the study group as this group had a lower baseline mean MAI score. Application of the STOPP/START criteria by a clinical pharmacist, either as part of the routine clinical pharmacy service or at the consultant/registrar-led ward round led to a significant improvement in the prescribing appropriateness of hospitalised older patients’ medications. Further multicentre studies involving multiple clinical pharmacists are warranted to determine the usefulness of the STOPP/START screening tool by clinical pharmacists in the hospital setting.

Source: EMBASE

Available in fulltext from International Journal of Pharmacy Practice at EBSCOhost

14. A continuous analysis for patient safety (CAPS) mechanism to secure a daily focus and analysis of patient safety issues to drive system improvement

Author(s) Moghal N.E., Tse Y.

Citation: Archives of Disease in Childhood, May 2012, vol./is. 97/(A155-A156), 0003-9888 (May 2012)

Publication Date: May 2012

Abstract: Aim Traditional adverse event reporting systems under record the true incidence of system errors. Granular detail is often lost from organisation memory due to the time lag for investigation and feedback, disengaging reporters and dissipating the opportunity to learn. We describe a simple method to record errors that keeps the clinical team connected, retaining ownership of system safety, allowing rapid local analysis and focus on system improvements. Method Over three weeks, ward rounds on renal patients on a mixed paediatric subspecialty ward included a consultant-led question about system safety issues for each in-patient. Details of errors were recorded in casenotes under ‘Patient Safety’ then categorised using the mnemonic ‘MR PICO’ (table 1). Interrogation of the system as to why and how each error occurred can be performed at the time. Comparison was made with existing reporting tools. Results Daily CAPS were reliably recorded in all in-patients casenotes during the test period. 63 system errors leading to 18 harm events were recorded over 101 patient days (table 2). 98% of errors were judged preventable. Every in-patient experienced at least one system error. Nine quality improvement projects were generated by learning from selected errors. Compared to CAPS, electronic trust reporting system (DATIX) and paediatric global triggering tool (pGTT) captured only 3-11% of errors. Conclusion Error rates captured by CAPS accurately reflect the true incidence rather than relying on the willingness of staff to report to a remote system. This transparent mechanism secures a daily system safety conversation that we envisage will affect culture change towards an increasingly safer system of care. (Table Presented).

Source: EMBASE

Available in fulltext from Archives of disease in childhood at Highwire Press
15. Impact of standardised documentation on post take ward round

**Author(s)** Newnham A., Hine C., Agwu J.C.

**Citation:** Archives of Disease in Childhood, May 2012, vol./is. 97/(A108-A109), 0003-9888 (May 2012)

**Publication Date:** May 2012

**Abstract:**
Aims Does the acronym "Please Verify Info For Doctors and Please Note Every Plan" (Problems, Vital signs, Investigations, Fluids, Drugs and Patient/Parent concerns, Nursing concerns, Examination, Plan) improve documentation on the post take ward round (PTWR). Does improved documentation affect readmission rate and length of stay?

Methods 50 consecutive notes for all children admitted under a single Consultant Paediatrician from June-September 2010 (pre-acronym) were compared to 50 consecutive notes for children admitted June-September 2011 (post-acronym). The adequacy of documentation on the PTWR including patient demographics was compared between the two cohorts. As a secondary outcome we evaluated whether the length of hospital stay and readmission (within 28 days) varied between the two cohorts. Significance values were calculated using Fisher's exact test and paired T-Test. Results The documentation of problem, investigations, fluids, drugs, patient/parental concerns and nursing concerns all showed significant improvement in recorded documentation after the introduction of the PTWR acronym (table 1). There was no significant change in documentation of vital signs, examination and plan; although these variables all had high documentary compliance prior to the introduction of the acronym. There was no significant difference between length of stay (p=0.8934) or re-admission rates (p=0.2044) between the two cohorts. The patient demographics did not differ significantly between the two cohorts. Conclusion The use of a PTWR acronym significantly improves documentation. This is important as the PTWR is the key forum for exchange of information between doctor, nurse and patient. As the PTWR often defines the focus of management it is essential that we strive to incorporate methods to improve its documentation and hence implementation. (Table Presented).

**Source:** EMBASE
Available in fulltext from Archives of disease in childhood at Highwire Press

16. Implementing new roles: Radiographer led on treatment review - Delivery of a medical model by non medical staff

**Author(s)** Boyle G., Cain M., Hughes L.

**Citation:** Radiotherapy and Oncology, May 2012, vol./is. 103/(S617), 0167-8140 (May 2012)

**Publication Date:** May 2012

**Abstract:**
Purpose/Objective: This abstract briefly discusses the first year of implementation, challenges encountered, analysis and prospects of this role. Background: Clatterbridge Centre for Oncology (CCO) opened a satellite radiotherapy centre, Clatterbridge Cancer Centre Liverpool (CCCL) delivering treatment to three patient groups; breast, prostate and lung. Changes to the health service in the UK provides opportunities for role development, CCCL commissioned three part-time On-Treatment Review (OTR) radiographer roles. This aimed to improve services for patients and develop practice at both clinical and strategic levels. Radiographer-led OTR is not a new concept; but to our knowledge the method used at CCCL is. The method incorporates training, competency based practice that strongly safeguards both patients and staff, with potential for development. Materials and Methods: In order to implement this role, standard requirements for patient review at CCCL were delivered from site specific consultants. From this, working protocols were researched, created and developed to meet the criteria and standard of services provided at CCO. Over a one year period, protocols have been updated and deliberated with members of the MDT and approved by each tumour specific group. Desired competencies were set specific to each patient group. A tough challenge was underway to acquire the knowledge and skills to execute an effective service for patients, delivered by non medical staff, following a medical model, meeting the high expectations of the oncology consultants. An intense period of training, supervision and assessment followed, coupled with achieving Masters level qualifications in clinical examination skills, clinical diagnostics and non medical prescribing. Results: Challenges:
With the implementation of such an innovative model, challenges were expected and inevitably found. Part-time roles allowed limited time for practical training, attending university and fulfilling staffing requirements as treatment radiographers, attributing to a prolonged training process. Establishing professional identity and boundaries proved to be challenging. Concerns of how this new role would integrate were faced by all members of the MDT from consultants to radiographers to specialist nurses. Collaborative working and education of staff groups led to the vast majority of staff embracing the role, with others taking longer to accept and utilise this new service. The role has been in place for one year and we propose to evaluate practice through patient satisfaction surveys and measuring clinical outcomes of the service. We hope to further improve our services as our skill set develops. Conclusions: Despite challenges, an effective OTR service is now executed at CCL, with strong support from medical staff, managers and directors of the trust. The success of this has spurred management to produce a business case to extend the service across both clinical sites.

Source: EMBASE

17. STOPP and START screening tools as supplements to the pharmaceutical medicines review

Author(s) Joergensen M.G.

Citation: European Journal of Hospital Pharmacy: Science and Practice, April 2012, vol./is. 19/2(234-235) (April 2012)

Publication Date: April 2012

Abstract: Background: Inappropriate prescribing is a well-documented problem in older people. The screening tools STOPP (Screening Tool of Older Peoples’ Prescriptions) and START (Screening Tool to Alert doctors to Right Treatment) have been formulated to identify potentially inappropriate medications (PIMs) and potential errors of omission (PEO) in older patients. Literature has shown that pharmacists can use STOPP and START reliably during their everyday practice to identify PIMs and PEOs in older patients. Purpose: To ensure high quality of the prescriptions for patients admitted to geriatric wards. Materials and methods: A clinical pharmacist used the STOPP and START criteria for each patient record of patients admitted to the geriatric ward. The screening tools were also presented to the physicians on the ward by the senior physician and all were given a pocket card with the criteria. The PIMs and PEOs were recorded as if identified by the pharmacist or by the physician. PIMs and PEOs identified by the pharmacist were presented to the physician for further action. The action taken on the PIMs and PEOs identified by the physician were also recorded. Results: In the period May to August 2011 151 patients were reviewed. PIMs were identified in 19% of the patients and most were due to overuse of proton pump inhibitors and long-term use of benzodiazepines. Seventeen percent had PEOs that were mostly related to the cardiovascular system; four identified by the pharmacist and accepted by the physician were due to lack of aspirin in the presence of chronic atrial fibrillation, where warfarin was contraindicated or due to lack of aspirin or clopidogrel in patients with coronary or cerebral disease. Conclusions Using STOPP and START criteria as supplements to the medicines review the clinical pharmacist ensures high quality in the medicines prescribed for geriatric patients, a population for whom it is important to take precautions when prescribing.

Source: EMBASE

18. Consultant led on call Urology Roster reduces length of hospital admission

Author(s) York N., Davidson P., Mark S.

Citation: BJU International, April 2012, vol./is. 109/(55), 1464-4096 (April 2012)

Publication Date: April 2012

Abstract: Introduction and Objectives: There is emerging evidence that greater clinical involvement of consultants in on call duties reduces length of hospital stay (LOS). Our department implemented changes involving more consultant input into acute hospital care in August 2010. The on call consultant performs daily ward rounds (0745 am to 0830 am) on all urology inpatients and responds daily to all referrals from other hospital specialties.
The registrar (resident) accepts referrals from the emergency department and general practitioners. We present the findings comparing hospital stay data prior to and following this change of practice. Methods: A retrospective analysis of LOS data for 12 months prior and 12 months post change of practice was obtained from hospital administration and analysed. Basic demographic data was used to compare groups at baseline. Comparisons were made between acute and elective inpatients and the financial implications calculated. Results: The two patient groups (12 months pre and 12 months post change) were similar at baseline. The average age was 64.0 pre vs. 63.9 post change, and 29% vs. 27.8% were female. Since the implementation of consultant led on call service the average LOS decreased from 45 to 39 hours. While the average elective surgery LOS reduced by 4 hours, the acute patients’ LOS reduced by an average of 7 hours. The average per hour ward cost (in 2011 dollars) is NZD168.86. This corresponds to savings of $1182 per acute patient, and a saving of $675 per elective patient. Since the roster change there were comparatively more discharges 0-1 days following admission and fewer long stays of >=2 days. There were 5 deaths during admission pre change compared to 3 post change. Conclusion: Our study supports existing evidence that a consultant led urology service decreases LOS and bed occupancy. It results in quicker discharges allowing for either increased throughput or cost saving.

Source: EMBASE
Available in fulltext from BJU International at EBSCOhost
Available in fulltext from BJU International (was British Journal of Urology) at the ULHT Library and Knowledge Services’ eJournal collection

19. Multi-faceted effort to improve hospitalized senior care at a large tertiary teaching medical center

Author(s) Soryal S., Padua K.
Citation: Journal of the American Geriatrics Society, April 2012, vol./is. 60/(S227), 0002-8614 (April 2012)
Publication Date: April 2012
Abstract: Our model of care was created to improve senior care in a large tertiary care hospital focusing on three different efforts. The first effort is implementing the ACE Concept on almost all hospital floors. The Acute Care for The Elders concept focuses on prepared environment with standard equipment for seniors, patient centered interdisciplinary care, medical review by a geriatrician as part of the interdisciplinary team, and early discharge planning. Our ACE Concept was implemented on sixteen different medical floors (fourteen of them were medical surgical floors, one medical intensive care unit, and one inpatient rehab unit). Geriatricians lead the team utilizing an innovative electronic medical record tool called ACE tracker, which in real-time identifies high risks patients for complications in the hospital. The second effort was the collaboration with the hospitalist group by attending the morning rounds once a week in a geriatric hospitalist rounds discussing patients who are in the hospital who are 80 years and older. The geriatrician will also use ACE tracker to identify high risks patients for complications and use the opportunity as an educational time for group of nine hospitalist. The third effort was to start ACE consult service and accept referrals from admitting physicians to help manage complex patients in the hospital. Most of the reasons for referrals were to manage delirium, agitation, dementia, functional decline, frailty, polypharmacy, identify goals and plans of care, and discharge planning. Physicians who requested referrals were hospitalist, family practices physicians, internal medicine physicians, cardiologists, psychiatrists, critical care specialists, neuro-surgeons, and orthopedic surgeons. After one Year the ACE program showed improvement in processes of care by decreasing Foley catheter use, reducing restraint use for non-ICU floors and increase in PT/OT and social service referrals. The Geriatrics hospitalist round have helped the hospitalists as they care for seniors and they expressed their satisfaction thru a survey conducted. The ACE program has seen 478 consults in its first Year and Geriatricians were able to show cost savings for patients seen on consult service( 252 $ per patient ) and reducing length of stay by one day.

Source: EMBASE
Available in fulltext from Journal of the American Geriatrics Society at EBSCOhost
21. Families: the newest members of the ICU multidisciplinary team

**Author(s)**: Santhirapala R., Lipton J., Hall T., Breeze R., Molokhia A.

**Citation**: Critical Care, March 2012, vol./is. 16/(S176), 1364-8535 (20 Mar 2012)

**Publication Date**: March 2012

**Abstract**: Introduction We have started inviting the relatives of our patients to remain present during our multidisciplinary team ICU ward round. The aim is to improve their understanding of the complex activity on an ICU and reduce inconsistencies in communication. In the UK it is becoming expected practice that patient satisfaction is an endpoint we should be measuring and improving [1]. Assessing this on the ICU is often very difficult due to the confounding factors inherent to critical illness. We often seek assent from families for procedures and to provide some history as a surrogate to patient interview. We think the care we provide should encompass both the patient and their family. This is already accepted practice in the paediatric ICU setting [2]. Communication between family and clinical staff, ideally on a daily basis, is clearly imperative and a systematic approach to improve this is good practice. Increasing insight into relatives’ perceptions and expectations will aid the delivery of high-quality care. We believe that involving relatives in the ward round will be of benefit for us in our professional relationships with them and improve their understanding during an extremely difficult time. Methods This was a prospective study over 2 months formally inviting up to four families per day to be present for that part of the ward round involving their relative. Subsequently they were asked to complete a questionnaire anonymously on the experience. Results The results that reflected 31 ward round attendances were unanimous: every family agreed that their attendance had a positive impact, alleviating misconceptions about the intensive care environment and clarifying the processes involved in the care of their relative. The survey also revealed that attendance at the ward round provided an excellent opportunity to have their questions answered by consultants. All those invited wished to attend and all respondents said the experience was valuable and they would like to attend again. Comments included: ‘Explanations very helpful to deal with the stress of the situation’ and ‘Reassuring to have information delivered professionally and compassionately’. Conclusion In this single-centre survey we have demonstrated that inviting families to ICU ward rounds is feasible and we believe that this intervention could improve family satisfaction on the ICU. We are investigating the impact of this intervention with a detailed comparative survey, which we will present in the future.

**Source**: EMBASE

Available in fulltext from Critical Care at National Library of Medicine

24. Use of check-and-challenge for a medical ward-round checklist improves patient safety

**Author(s)**: Thomson P., Chima N., Bisset L., Thomson. G.

**Citation**: European Journal of Internal Medicine, October 2011, vol./is. 22/(S92), 0953-6205 (October 2011)

**Publication Date**: October 2011

**Abstract**: Background: Emergency medical admissions to our hospital are reviewed within 8 hours by a consultant led ward-round. Omission of important actions on this ward-round can compromise patient safety. Based on the success of the WHO Surgical checklist, we investigated whether a medical ward-round checklist, completed by a team member who was empowered to challenge the ward-round leader, could reduce omissions on the post take ward-round. Methods: We identified actions which improve reliability and developed a checklist of these to be used as each patient is reviewed by the consultant (Fig 1). We initially conducted an observational study of 26 patients for whom the checklist was not used and compared this with 57 patients using a checklist check-and-challenge approach where the consultant was challenged to complete all items not done. Results: Reliability improved significantly when a team member was empowered to challenge the checklist. All domains improved, especially discussion with nursing staff (61.5% vs. 96.5%). Conclusion: A checklist, combined with empowerment of a team member to challenge the
ward round leader, improved completion of key actions and thus safety and reliability. It may be particularly beneficial in improving communication with nursing staff on the ward round. (Figure Presented).

**Source:** EMBASE

### 25. Morning report-An innovative way to train foundation trainees in leadership and patient safety initiatives during geriatric medicine placement in an acute rehabilitation unit

**Author(s)** Mukherjee S., Rajeev M., Eades C.

**Citation:** European Geriatric Medicine, September 2011, vol./is. 2/(S45-S46), 1878-7649 (September 2011)

**Publication Date:** September 2011

**Abstract:**

**Introduction.** Foundation training in UK is a two-year training programme where newly qualified trainee doctors are trained in both clinical and generic skills enabling them to manage acutely ill patients. Leadership skills and patient safety are an important part of the learning curriculum of trainee doctors. Patient Safety Initiatives (PSI) is in place to ensure safe patient journey in hospital. Morning Report (MR) is an integral part of PSI for better handover between teams and improving patient flows. This allows foundation trainees to enter reflective practice log in their learning e portfolio and use during their appraisal and personal development action plan meeting with their educational supervisors.

**Method.** MRs done every morning during weekdays at the start of the day. It comprises a virtual ward round of all patients on the acute rehabilitation ward with full multidisciplinary team (comprising of consultants and registrars, physiotherapists, occupational therapists, social workers and nursing matron) input into patients’ management plan. Patients’ clinical pathways are updated in real time and foundation trainees have first hand interaction with all members of the team. Decisions regarding end of life care, do not resuscitate decisions and cross referrals to other specialties are also reviewed. Trainees lead the discussion on their patients, formulate discharge planning, update results and interact with other members of the multiprofessional team enhancing team building. Drug reviews and update on functional improvements in the patients including carer update and social interaction and placements are also carried out.

**Results.** Feedback and focus group interviews with Foundation trainees have revealed that trainees find this an educational forum to demonstrate leadership skills, team working and develop communication skills. Education supervisors find MR useful to assess trainees on clinical knowledge and communication skills and also use this for case based discussion and evaluating trainees’ reflections and learning, particularly patient safety initiatives.

**Conclusions.** With the European Working time regulations and shorter training time, MR is a useful alternative to ward rounds for teaching and evaluation of foundation doctors in leadership skills and PSI in geriatric medicine. Trainees found this very useful as part of planning complex discharge planning.

**Source:** EMBASE

### 27. The ward round - Pulling together

**Author(s)** Kirshenblat J.

**Citation:** Australian and New Zealand Journal of Psychiatry, May 2011, vol./is. 45/(A40), 0004-8674 (May 2011)

**Publication Date:** May 2011

**Abstract:** The consultation-liaison ward round is a hallowed hospital tradition. This paper examines the ward round from a number of perspectives including contemporary models of learning based on principles of computational and cognitive science, and Wilfred Bion’s theory of groups and group experiences. The aim of the paper is to demonstrate that the ward round is a legitimate object for study. The paper will show that: (a) the ward round can be conceptualised as a model of thinking that has important implications for clinical work; (b) the ward round is a key activity that transforms novice psychiatrist trainees into expert psychiatrists; (c) the ward round is a political arena that encloses professional tensions, power relationships and ideological tensions and their current states of play within an hospital; and (d) the ward round is an indispensable collective activity with roots in
evolutionary biology and it is the most important activity conducted by a consultation-liaison service because of its clinical, political and ethical dimensions.

Source: EMBASE
Available in fulltext from Australian and New Zealand Journal of Psychiatry at EBSCOhost
Available in fulltext from Australian and New Zealand Journal of Psychiatry at EBSCOhost

30. Does the use of a pro forma improve documentation of the post-take ward round?


Citation: QJM, April 2011, vol./is. 104/4(358-359), 1460-2725 (April 2011)

Publication Date: April 2011

Abstract: Introduction: Crucial decisions about acutely unwell patients are taken during the post-take medical ward round. Thus, we developed a one-sided pro forma containing important factors that are commonly considered and audited documentation levels both before and after it was introduced. Methods: In October 2009, the notes of 30 patients admitted under Acute General Medicine were reviewed for documentation of the post-take details shown under 'Results' section. Following this, a simple one-sided pro forma was developed using these criteria. This was then introduced into routine clinical practice and a repeat audit of 76 admissions was undertaken. Results: Frequency of documentation of the following factors without and with the pro forma is presented as a percentage with P-values for comparison. Date, 100.0 vs. 98.7, P = 0.717; time, 83.3 vs. 92.1, P = 0.182; consultant, 100.0 vs. 100.0, P = 1.000; history, 83.3 vs. 100.0, P = 0.001; problem list, 36.7 vs. 73.7, P < 0.001; diagnosis, 76.7 vs. 88.2, P = 0.137; plan, 100.0 vs. 98.7, P = 0.717; bloods, 53.3 vs. 75.0, P = 0.030; electrocardiograph, 80.0 vs. 82.9, P = 0.726; chest radiograph, 60.0 vs. 80.3, P = 0.031; nursing instructions, 30.0 vs. 47.4, P = 0.103; need for thromboprophylaxis, 63.3 vs. 88.2, P = 0.003; resuscitation status, 13.3 vs. 56.6, P < 0.001; signature, 93.3 vs. 100.0, P = 0.078. Discussion: Documentation of many factors was initially poor, particularly a problem list, blood and chest X-ray results, specific nursing instructions, need for thromboprophylaxis and resuscitation status. The use of a pro forma improved documentation of 11 of the 14 audited items, six of which were statistically significant. Specific nursing instructions and resuscitation status continued to be poorly documented. Conclusion: The routine use of a pro forma increases documentation of clinical decisions taken during the post-take ward round. The pro forma has been adopted for routine use in the Department of Acute General Medicine at the John Radcliffe Hospital.

Source: EMBASE
Available in fulltext from QJM at Highwire Press

32. Implementation of a considerative checklist to improve productivity and team working on medical ward rounds

Author(s) Herring R., Caldwell G., Jackson S.

Citation: Clinical Governance, 2011, vol./is. 16/2(129-136), 1477-7274 (2011)

Publication Date: 2011

Abstract: Purpose - In the changing environment of the National Health Service (NHS) medical ward rounds have become increasingly complex. With complexity comes the inevitable risk that things will go wrong. Serious failures in care can have important consequences for individual patients, their families, cause distress to health care staff and undermine public confidence in the NHS. The paper's aim is to introduce the concept of a medical ward round considerative checklist to improve ward round processes, effectiveness, reliability and efficiency, aid team working and foster better communication. Design/methodology/approach - The checklist includes aspects of ward round preparation, the consultation, progress assessment, discharge planning and handover. It is a "considerative checklist" as it not simply checking if an essential component has been done but rather that it has been considered, discussed, action identified and communicated
effectively and involves an "at the point of care check and correct" process. Findings - The introduction of the checklist has provided a systemic approach to medical ward rounds, provided reassurance that quality care is given, aided active participation from all health care professionals/ITs/IT and reignited team work. It has streamlined handover, improved patient and professional communication, improved medical documentation and provided an audit tool for ongoing improvement. Research limitations/implications - The diversity of general medicine makes standard measures of quality of care such as length of stay, morbidity and mortality outcomes hard to measure; however, qualitative data can be obtained. Originality/value - The authors have developed a systemic ward round approach which ensures attention to quality and safety at the point of care, encourages team working and improvements can be documented. 2011 Emerald Group Publishing Limited. All rights reserved.

Source: EMBASE

34. The feeding issues multidisciplinary team-effect on selection and outcome of patients referred for percutaneous endoscopic gastrostomy in a tertiary referral centre in the uk

Author(s) Niriella M.A., Gao R., Lim Y.C., Sheih S., Woodward J.M.

Citation: Proceedings of the Nutrition Society, 2011, vol./is. 70/(E302), 0029-6651 (2011)

Publication Date: 2011

Abstract: Decisions relating to Percutaneous Endoscopic Gastrostomy (PEG) are often complex. In 2006, a multi-professional committee was set up in Addenbrooke's Hospital chaired by a palliative care physician. Gastroenterology and elderly care medicine are represented at senior level, with speech and language therapists, dieticians, nutrition support and endoscopy nurses also present. This study aims to determine the effect of the Feeding Issues Multidisciplinary Team (FIMDT) on patient selection and outcome. A retrospective analysis of patient records was performed for all patients receiving PEGs in the periods before and after the institution of the FIMDT. We reviewed all patients who have had PEGs for feeding purposes for a four and a half year period prior to and a three and a half year period after establishment of FIMDT. Reasons for patients not receiving PEG placement after discussion at the FIMDT were documented. Statistical significance was analysed by student t-test. 308 patients from the Pre-FIMDT period and 388 patients from the Post-FIMDT period were included. 261/388 patients (Male - 61%, Female - 39%; mean age - 60 years) from the post-FIMDT period (74/year) had PEGs compared to 308 patients (Male - 52%, Female - 48%; mean age - 63 years) in the Pre-FIMDT period (68/year). The commonest indications were stroke, neurodegenerative (ND) diseases and head and neck (H & N) cancers (Pre-FIMDT 33%, 22%, 18% vs. 16%, 18%, 32% in the post-FIMDT period respectively) (Figure 1). The cumulative mortality at one, three, six and twelve months post-PEG was 7%, 19%, 27% and 40% in the pre-FIMDT period compared to 5%, 14%, 20% and 30% in the post-FIMDT period. The reduction in mortality at six and twelve months was statistically significant (p value 0.03 and 0.01 respectively). The reduction in cumulative mortality was highest for stroke patients (Pre-FIMDT 14%, 47%, 73%, 100% vs. Post-FIMDT 6%, 19%, 28%, 36% at one, three, six and twelve months respectively) (Figure 2). Of the 127/388 patients referred to FIMDT who did not undergo PEG insertion, 55 were not indicated, 24 were unfit, 23 were referred on for Radiologically Inserted Gastrostomy (RIG) and 25 were appropriate but did not receive a PEG due to technical difficulty, refusal, or death. Therefore 102/388 (26%) patients originally referred to the FIMDT were deemed inappropriate for PEG placement. The FIMDT resulted in a more selected population for PEG placement with an associated significant reduction in cumulative mortality at 6 months and 12 months. This was most pronounced among patients with stroke. (Figure presented).

Source: EMBASE

35. Trans-disciplinary therapy assessments on a hyper-acute stroke unit: The way forward?

Author(s) Govender P., Avery C., Beardmore A., Fletcher A., Garrett A., Jay E., Mohapatra S.
Introduction: Stroke is the largest single cause of severe physical disability in adults in the UK with patients suffering from a range of impairments based on the primary pathology within the brain. Early detection of impairments and prompt intervention will facilitate successful outcomes at a later stage. Method: In order to meet the increasing patient demand at King's hyper-acute stroke unit and to enable prompt therapy intervention, King's therapy staff initiated a trans-disciplinary assessment tool. The tool, based on the NIH Stroke Scale, clearly identifies key impairments, facilitates ongoing referral and assists with early decision making to support patients moving through the stroke pathway. Results: One senior therapist was able to complete patient assessments on ward rounds. Patients not appropriate for further intervention were immediately identified and discharged. Patients who would benefit from in depth individual therapy intervention were clearly identified. Meaningful information available from the completion of the trans-disciplinary assessment further ensured that resources needed to maximise the impact of ongoing intervention eg. number of staff needed to effectively intervene, location of intervention and recommended seniority of therapist, were identified early. Conclusion: Trans-disciplinary therapy assessment tools are an effective way to support early detection of impairments, enable efficient utilisation of resources and support positive long term outcomes for patients.

Source: EMBASE

36. Proactive geriatric assessment for older patients in orthopaedic wards

Author(s) Craig A., Fail M., McTavish G.

Citation: Osteoporosis International, November 2010, vol./is. 21/(S517-S518), 0937-941X (November 2010)

Abstract: Introduction: The best model of care for older patients with fragility fractures is unclear. Guidelines recommend collaboration between orthopaedic surgeons and geriatricians, but do not stipulate how services should be delivered. In our teaching hospital geriatricians visited orthopaedic wards twice weekly. Patients requiring inpatient rehabilitation were referred by orthopaedic staff once sufficiently stable. Methods: We introduced a thrice weekly ward round in orthopaedic wards. In the trauma ward, we attended a multidisciplinary team meeting. We proactively reviewed every patient over 65 pre and post surgery. In general wards, we reviewed more patients, earlier in their stay. Patients had relevant examination by a senior geriatrician. We advised on medical complications, prescribing, investigations, prognosis and discharge planning. We analysed 112 patient reviews. Median patient age was 77 years. 46% had hip fractures. 26% had other fractures. 28% had orthopaedic diagnoses but no fracture. Of patients eligible for surgery, 15% were reviewed preoperatively by the geriatrician. 79% of patients had significant medical illnesses or complications (80% with fracture, 69% without fracture). 26% had infection, 17% had delirium and 17% had cardiac complications. All medications were reviewed. 56% had prescriptions changed. 37% had investigations requested by the geriatrician. We audited the mean length of stay (LOS) for older patients before and after the service change. (Table presented) Conclusion: In orthopaedic wards: & Most older patients with and without fractures had medical illness. & Proactive geriatric assessment changed medical management in most cases.

Source: EMBASE

Available in fulltext from Osteoporosis International at EBSCOhost

37. Effects of an attending physician system on acute neurology provision in plymouth

Author(s) Sadler M., Edwards S., Weatherby S., Mohd Nor A., Allder S.

Citation: Journal of Neurology, Neurosurgery and Psychiatry, November 2010, vol./is.
Abstract: Introduction We admit around 2500 patients per year with neurological emergencies including stroke directly under our care. In 2006 we introduced an attending physician model for inpatient care. Since then, we have been studying and improving this system. Methods A review of 600 consecutive inpatients stays using a standard tool to analyse why the patients were in hospital. Starting with these data, we tried new ways of working. During this time we have continually monitored bed utilisation, conducted audits of staff and patient satisfaction and tried several iterations of how we work. Results Before the attending system, patients waited in hospital for senior clinical review or diagnostic tests. With daily consultant ward rounds and continuous senior availability in decision making, average bed occupancy fell from 33 to 19 beds and improved care for patients with short length of stay. This led us to incorporating stroke patients into the system. This was not successful, so we have now developed two parallel systems. This has significantly improved quality of care for stroke patients while reducing bed utilisation. To maintain sustainability a variety of operational changes have also needed to be introduced. Conclusions The nature of the input and work pattern of consultants significantly affects the quality of care and bed requirements of our service. To achieve a high-quality efficient service requires genuine team working, accurate data and operational management support.

Source: EMBASE

Available in fulltext from Journal of neurology, neurosurgery, and psychiatry at Highwire Press

38. Re-organisation and development of a Consultant led cardiology service leads to substantial reductions in length of stay and all cause mortality in acute coronary syndromes

Author(s) Balachandran K.P., Schofield R., Sankaranarayanan R., Helm K., Crowe C., Singh R., McDonald J., Chuen M.J.

Citation: European Heart Journal, Supplement, October 2010, vol./is. 12/(F69), 1520-765X (October 2010)

Publication Date: October 2010

Abstract: Background: We reorganised our services in October 2007 with all acute admissions sent to one site. This allowed the development of a 24/7 Consultant led cardiology service (3 interventional and 3 non-interventional Cardiologists). Management of a new 10 bedded CCU was taken over by the Cardiologists who also provided a daily ward round in the Medical Admissions Unit (MAU) and the general cardiology ward. The emphasis was on early recognition of the high to intermediate risk patients who were most likely to benefit from assessment and management directed by Consultant Cardiologists.

Methods: We performed an audit of all patients admitted with an acute coronary syndromes (ACS) between two periods: Group 1 - between October 2006 to September 2007 and Group 2 - between October 2007 and September 2008. The data was obtained from MINAP database. We looked at the following end points - length of stay, in-hospital and 30 day post discharge all cause mortality. Results: 633 patients were admitted in between '06-'07 and 748 patients between '07-'08. The mean age was higher (70.3 vs 68.2 years; p=0.006) and there was a greater proportion of women (42% vs 35%; p=0.008) in Group 1. There was no difference between the two groups in terms of number of diabetics or hypertensives at admission. There was significant reduction in length of stay from a median (IQ range) 7 (5-11) days to 5 (3-9) days; p < 0.0001. The number of transfers to the regional tertiary centre for acute angiography increased from 95 (15%) to 241 (32.2%); p < 0.0001. The in-hospital mortality reduced from 15.6% (n= 99) to 7.2% (n=54); p<0001. The 30 day post discharge mortality reduced from 19.4 (n =123) to 10.2 (n =76); p< 0.0001. The reductions in mortality and length of stay remained significant after adjustment for demographic and risk factor variables. Conclusion: The development of a modern and comprehensive Consultant Cardiologist led service directed towards early recognition and appropriate management of patients admitted with acute coronary syndromes is associated with impressive reductions in all cause mortality. This improvement in outcomes occurred
with an equally impressive reduction in hospital length of stay.

Source: EMBASE
Available in fulltext from European Heart Journal Supplements at Highwire Press

39. Daily goals augment effective communication in the multidisciplinary ICU team

Author(s) Hacon J., Hutchins D., Paddle J., Powell C.

Citation: Intensive Care Medicine, September 2010, vol./is. 36/(S154), 0342-4642 (September 2010)

Publication Date: September 2010

Abstract: INTRODUCTION. The use of a daily goals chart has been shown to improve communication between the multi-disciplinary team leading to an increase in understanding of daily patient goals and a decrease in length of patient stay on the intensive care unit (ICU) [1]. We have used a daily goals chart on our ICU since 2004. We wanted to assess the value of this initiative in a general adult ICU. METHODS. The Royal Cornwall Hospital is a large UK district general hospital. We conducted the survey over a 4 week period in the ICU. Each day, after the morning multidisciplinary ward round, the consultant in charge was asked to give the main goals for each patient. These were compared with those written on the daily goal chart, or stated by the house medical and nursing staff. They were graded as complete match (100% of consultant goals matched), partial match (99-50% matched) or non match (<50% matched). RESULTS. 73 surveys were conducted. The daily goals sheet matched the consultant completely on 32 (44%) occasions and partially on 29 (40%) occasions. In comparison, the combination of house medical and nursing staff had complete match on 47 (67%) occasions and partial match on 19 (27%) occasions. House medical staff had a 95% complete or partial match, house nursing staff had a 88% complete or partial match. CONCLUSIONS. Overall house staff understanding of the goals set on the ward round is far better than that recorded on the goals chart. The goals related by medical and nursing staff showed differences that reflected their differing clinical priorities. Combining results of all staff led to higher levels of complete match than either group independently. Low levels of non-matches indicate that there is good overall understanding and communication within the team. Use of daily goals charts is an effective aid to augment communication on the ICU multidisciplinary ward round.

Source: EMBASE
Available in fulltext from Intensive Care Medicine at EBSCOhost

40. How non-medical prescribing improved patient care on a surgical ward

Author(s) Sassi-Jones K.

Citation: Clinical Pharmacist, September 2010, vol./is. 2/9(S4-S5), 1758-9061 (September 2010)

Publication Date: September 2010

Abstract: Prior to non-medical prescribing (nmp), doctors were responsible for the prescribing of inpatients medication. Prescribing duties was often not seen as a priority, due to other work commitments (theatre, out-patient clinics, and on-call). This often led to delays in prescribing patients regular medication on admission; current medication charts expiring and not being rewritten; delays in prescribing take home medication and thus patients discharge; and delays in prescribing and reviewing acute perioperative medication (eg, analgesia, antibiotics, antiemetics and laxatives). These examples potentially meant patients missed medication doses and/or received the incorrect medication. An in-house medicines reconciliation audit found that less than 70% of patients had their medication reconciled within 24 hours of admission. A review of reported prescribing errors (in-house) identified 27 errors over a six month period. Four of these errors related to the prescribing of anticoagulants and five to the prescribing of antimicrobials. In support of The Hospital at Night concept,1 an audit (in-house) investigating the role of junior medical staff on night duty, found that one third of their time was spent completing routine tasks, such as rewriting inpatient medication drug charts and the prescribing of warfarin doses for patients unknown to them. OBJECTIVES To introduce and assess the impact of a pharmacist prescribing on
an acute vascular surgical ward at a 600-bed district general hospital. METHOD In July 2008 the first non-medical pharmacist prescriber at The Royal Glamorgan Hospital began prescribing at ward level. Data on all prescribing events, including medication prescribed and the circumstances under which it was prescribed (inpatient chart, take home prescription, during consultant ward round etc) were recorded for the first three months by the prescriber. Any medication prescribed was documented in the clinical notes and discussed with a member of the medical team providing care for that patient. With the exception of controlled drugs, the nmp could prescribe any licensed medication from The BNF, within her area of competence or specialty as per guidance on nmp issued by The Royal Pharmaceutical Society of Great Britain. RESULTS A total of 309 prescribing interventions were recorded by the pharmacist. One hundred and sixty-four (53%) events involved prescribing patients regular medication, either on admission or when a (Table Presented) new drug chart was required, and 68 items were prescribed on the patient's discharge prescription. A total of 77 (25%) new items were prescribed, which have been tabulated according to their British National Formulary (BNF) therapeutic class (Table 1).2 DISCUSSION The top three categories of new items prescribed (Table 1) were closely linked to the following topical and key target areas relating to patient safety initiatives. Control of infection Clostridium difficile infection: How to deal with the problem (Department of Health);3 Surgical Site Infection (NICE);4 Antimicrobial Stewardship (1000 Lives Campaign).5 These publications aim to reduce the incidence of healthcare associated infection, and highlight the importance of rationalising antibiotic prescribing. Medication Safety Medicines Reconciliation (NICE/NPSA): Recommends that pharmacists should be involved in medicines reconciliation as soon as possible after admission;6 Making it Safer for Patients Taking Anticoagulation (NPSA): highlights the importance of pharmacist involvement in the management and dosing of patients on anticoagulants.7 Anticoagulation Thromboprophylaxis (NICE);8 Warfarin Prescribing and Monitoring (NPSA).7 Other benefits of the role included prompter prescribing of the inpatient medication chart upon admission, and facilitation of the discharge process, enabling take-home medication to be prescribed and assembled sooner. In many instances the pharmacist identified and prescribed medication that had been unintentionally omitted on admission by the clerking doctor. Service users were asked their opinion on the new role of the pharmacist, and positive feedback was received. An audit (in-house) of prescribing on the surgical ward demonstrated 100% compliance against prescribing standards for the nmp, compared to an overall compliance of less than 75%. To date no nmp errors have been reported. The perceived benefits of the role from the nmp's perspective are numerous including the prompt prescribing and review of both acute and chronic medication; the education of junior doctors through the sharing of good practice; and an enhancement to the role of the clinical pharmacist providing better integration at ward level and increased job satisfaction. Work is needed to assess the true impact of this service on patient outcomes. The author has also used her experiences to help produce a trust wide policy on non medical prescribing to help guide future nmp's.

Source: EMBASE

41. The impact of a new model of acute care delivery on the emergency dermatology referrals

Author(s) Vlachou C., Lwin T., Tatnall F., Batta K., Murdoch M., Dyche J.

Citation: British Journal of Dermatology, July 2010, vol./is. 163/(66), 0007-0963 (July 2010)

Publication Date: July 2010

Abstract: In 2000, two district general hospitals, A and B, merged to form a single NHS Trust, but both continued to function as acute hospitals. As part of the rationalization of acute hospitals, hospital B closed and acute admissions were moved to A. To accommodate this, a 120-bed acute admissions unit (AAU) was built. The AAU model of acute care demands daily consultant review of admissions to allow rapid discharge of patients. We have investigated how closure of an acute service affects dermatology emergency and inpatient referrals in the remaining site, and whether daily consultant review of referrals is achievable. In the 6 months before the closure of hospital B we prospectively monitored all inpatient referrals at hospital A and then repeated this exercise after B closed and A became the acute site. The results showed 160 referrals at hospital A in the 6 months prior to hospital B closure, and 404 after (150% increase). Analysis of
these 404 referrals showed the following: 26% of all referrals were hospitalized because of their skin condition; 47% were ward referrals, 36% came from the AAU; 86% of referrals were seen on the same day and 73% of these were reviewed by a consultant. Almost half (47%) required continued ward review. Reviewing the diagnoses, the commonest category related to problems on the lower legs (total 35%) - cellulitis (18%), leg ulcers (9%), venous eczema (5%) and lymphoedema (3%). Interventions included: skin biopsy (16%); specialist nursing input (19%) particularly including Doppler assessment and compression bandages. Following transfer of emergency admissions to hospital A, the expectation was that referrals to dermatology would double; however, our audit has shown that referrals have increased by 150%. This increase may be attributed to the AAU model of care, which demands early consultant opinions and may enhance the profile of specialties such as dermatology. Although consultants can review the majority of new referrals, 100% same day review was not achieved in spite of two additional consultant sessions being funded to support inpatient dermatology. Leg ulcers and ‘red swollen leg’ referrals comprised a significant proportion (35%) of our referral workload and frequently required dermatology nurse input. The emphasis in developing our acute dermatology service has been focused on expanding the consultant grade; however, our audit suggests that in addition to consultant sessions, additional dermatology nursing hours are required to support the assessment and management of these lower limb disorders.

Source: EMBASE
Available in fulltext from British Journal of Dermatology at EBSCOhost

42. Reduction in prescription and administration errors on paediatric intensive care with "zero-tolerance prescription"

Author(s) Booth R., Darby D., Sturgess E., Taberner-Stokes A., Petros A., Peters M.

Citation: Archives of Disease in Childhood, April 2010, vol./is. 95/(A44-A45), 0003-9888 (April 2010)

Publication Date: April 2010

Abstract: Prescription errors are frequent on intensive care units. The perception of prescribing as a low status task rather than an essential element of therapy, perceived time pressure and distractions may all be contributory factors. The authors altered practice on our tertiary paediatric intensive care unit in two stages: formal consultant review of prescription charts on daily ward rounds and requesting re-write for any errors was introduced with the aim of raising the status and visibility of prescription as a task. Subsequently, a dedicated prescription desk was provided and prescription elsewhere was not permitted. Staff were not permitted to interrupt a prescriber at this desk. The authors termed these combined interventions "zero-tolerance prescription" (ZTP) following a similar approach in Cardiff. The authors undertook an observational study of the impact of these on prescription error rates over 6 months in a tertiary paediatric intensive care unit.

Methods: Prescription and administration errors have been recorded prospectively on a daily basis by our ward pharmacist against 44 criteria. These include "clinical errors" (dosage, route of administration, frequency) and non-clinical errors (signature illegible, unapproved names or abbreviations etc). Total errors adjusted for ICU occupancy (errors per occupied PICU day) are presented for three periods: (A) baseline, (B) consultant checking prescription charts and (C) full ZTP. Comparisons are made between mean error rates with t-tests. (Figure Presented) Results: (A) Baseline mean error rate over 12 weeks was 1.8 errors per occupied PICU bed day (95% CI 1.5 to 2.1). (B) In the 20 weeks following formalised consultant checking of charts, this was reduced to 1.4, errors per occupied PICU bed day (1.1-1.6) (p=0.0035 vs A). (C) Following the introduction of the full ZTP, protocol error rate was 1.1 (0.8-1.3) (p=0.001 vs A, and p=0.05 vs B) over a 10-week period. This constitutes relative risk 0.59 for error. Infusion prescriptions errors were most improved A) 0.3 day (0.2-0.4) per occupied PICU bed vs C) 0.1 (0-0.2), p=0.02 (relative risk 0.45). Comment: In this unblinded study, the ZTP package was associated with a significant and prolonged reduction in errors. The impact of these changes is likely to be highly influenced by local factors but merit consideration on PICU.

Source: EMBASE
Available in fulltext from Archives of Disease in Childhood at National Library of Medicine
43. Impact of geriatric consultation on the number of medications in hospitalized older patients

Author(s) Harisingani R., Saad M., Katinas L.
Citation: Journal of the American Geriatrics Society, April 2010, vol./is. 58/(S50), 0002-8614 (April 2010)
Publication Date: April 2010
Abstract: Purpose: Geriatric consultation teams provide comprehensive assessment of older adults and focus on prevention and management of common geriatric syndromes and medication management. This study aims to determine the impact of the geriatric consultation on the number of medications in hospitalized older adults and its corresponding financial impact. Methods: This is a retrospective chart review of patients seen by geriatric consultants between January and October 2008. The data collected included patients’ demographics such as comorbidities, ADL dependency, number of diagnoses on admission, and number of diagnoses identified by the geriatric consultant. The number of medications prescribed before hospitalization, at time of consult and discharge, and the number and category of medications adjusted by the geriatrician were also noted. The monthly cost of the pharmaceutical interventions was computed based on the drugstore.com cost of acquisition of drugs. Results: A cohort of 62 patients were reviewed with a mean age of 84.6 (+/- 7.3) years and 79% women. The most common admitting reasons were neuropsychiatric, malnutrition, respiratory, and musculoskeletal issues. The patients presented with an average of 5.6 (+/- 2.1) comorbidities of which hypertension, dementia, and musculoskeletal disorders were the most common. The most common reasons for geriatric consultations were neuropsychiatric, nutritional and gait-related issues. The geriatric consultant identified 2.96 (+/- 1.5) additional diagnoses of which debility, delirium, and pain were the most prevalent. The average number of medications on admission was 7.7 (+/- 3.7) and at discharge was 9.5 (+/- 2.12). The average number of medications adjusted by the geriatric consultant was 2.96 (+/- 2.12); 1.4 (+/- 1.6) of these adjustments were included in the discharge plan. The most common classes of medications were pain medications (22%), nutrition (13%) bowel regimens (8.5%), antipsychotics (8%), and osteoporosis (8%). The cost impact of the pharmaceutical intervention ranged between (-$343 to $2607) with an average of $102 (+/- 368). Conclusion: Geriatric consultations increased the total number of medications and the cost of medications used by elderly patients. Geriatric consultation identified unrecognized geriatric syndromes.
Source: EMBASE
Available in fulltext from Journal of the American Geriatrics Society at EBSCOhost

45. Evaluation of a pilot service to reduce the length of stay of patients with diabetes

Author(s) Neupane S., Mathews A.A., Krishnan S.M.
Citation: Diabetic Medicine, March 2010, vol./is. 27/2 SUPPL. 1(147), 0742-3071 (March 2010)
Publication Date: March 2010
Abstract: Objectives: A significant proportion of hospital beds in the NHS are occupied by patients with diabetes. These patients stay longer irrespective of the cause of admission thereby increasing bed occupancy and financial burden to the NHS. Our aim was to assess the impact of regular specialist diabetes team input in reducing Length Of Stay (LOS). Methods: A pilot service by the specialist diabetes team, consisting of a consultant diabetologist and a diabetes specialist nurse was rolled out from July 2008. This involved formal weekly ward rounds for inpatients with diabetes in medical, surgical and orthopaedic wards. A retrospective audit of all diabetes inpatients from January 2008 to January 2009 was conducted. Data was collected electronically from the hospital coding database. Results: A total number of 1727 episodes of inpatient admissions with diabetes were identified. The 1062 day case episodes were excluded. 11% had Type 1 diabetes and 89% had Type 2 diabetes. During the study period the average LOS of the remaining 665
episodes was 8.06 days (Range - 1 to 135). 6 months prior to this pilot service the average LOS was 8.5 days. The average LOS reduced to 7.6 days, during the 6 months after commencing the service. Average LOS for common diabetes related admissions were: diabetic ketoacidosis - 5 days, hypoglycaemia - +/- days, and diabetic foot ulcer - 28 days.

Conclusion: Our audit clearly demonstrates that a regular weekly ward round by the specialist diabetes team significantly reduces length of stay of inpatients with diabetes. This reduction in the bed occupancy in turn will have considerable positive impact on resources of NHS.

Source: EMBASE
Available in fulltext from Diabetic Medicine at the ULHT Library and Knowledge Services' eJournal collection
Available in fulltext from Diabetic Medicine at EBSCOhost

46. Improved diabetes care for inpatients in the Emergency Departments (ED) following the introduction of a prospective specialist diabetes service

Author(s) Thynne A.D., Allard S., Cummings M.H.

Citation: Diabetic Medicine, March 2010, vol./is. 27/2 SUPPL. 1(143), 0742-3071 (March 2010)

Publication Date: March 2010

Abstract: Background and method: Our previous audit identified the level of diabetes care within the Emergency Departments (ED [MAU/SAU]) was sub-optimal. Following this audit, a pilot prospective diabetes service was introduced which involved daily visits to all patients with diabetes within the ED by either a consultant or specialist nurse. Six months after the pilot commenced a repeat audit was undertaken examining the care of 50 patients over a two week period and compared with findings in the original audit. Results of re-audit following introduction of prospective daily diabetes service compared with baseline: Ward staff were more aware of patients with a diagnosis of diabetes and identified 100% with the condition to the diabetes team compared with 86% previously. Readmission rates of patients with diabetes decreased by 66% (p< 0.001) and admissions directly related to diabetes have also reduced by 14%. Improved glucose assessment on admission was also observed (52 to 98% p< 0.05). Previously, 78% of patients were defined as having poor glycaemic control but only 6% were referred for specialist assessment. During this pilot, 100% of patients were assessed by the specialist team and 74% required interventions such as adjustment of insulin or writing management plans. Inappropriate use of intravenous sliding scales decreased from 70 to 25% (p< 0.05). Adverse incidents were identified/actioned in 44% of patients reviewed. Conclusions: A prospective daily diabetes service to the ED has been beneficial for both staff, patients and trust. Through this service patients with diabetes have received timely assessment, specialist input and appropriate discharge planning effectively optimising patient journeys.

Source: EMBASE
Available in fulltext from Diabetic Medicine at the ULHT Library and Knowledge Services' eJournal collection
Available in fulltext from Diabetic Medicine at EBSCOhost

47. Structured multi-disciplinary review for patients previously unknown to have high foot-risk: The Wolverhampton community diabetes foot screening program

Author(s) Krishnasamy S., Huddart S., Hogan P., Singh B.M., Baskar V.

Citation: Diabetic Medicine, March 2010, vol./is. 27/2 SUPPL. 1(133), 0742-3071 (March 2010)

Publication Date: March 2010

Abstract: Introduction: Our preliminary evaluation found only 19% of patients with high foot risk had care supervised by our Specialist Foot Service. Such patients are now automatically referred into the high risk service. We now evaluate the utility of multi-disciplinary review of such newly referred high risk patients. Methods: Patients attended bi-
monthly high risk foot clinic. We determined their Diabetes Process Score (DPS): ranging 0 (fully complete) to +/- (full failure) and Diabetes Outcomes Score (DOS): 0 (good outcome in all domains) to 10 (adverse outcome in all domains). Results: Results are of the first 6 months of activity (n = 119). Attendance was 77%. Defaulters’ DPS was 1.1 +/- 1.2 vs. 1.0 +/- 1.4, p = NS and DOS 5.5 +/- 1.3 vs. 3.9 +/- 1.9, p < 0.001. Concordance between referred and actual high foot risk was 58% with others re-categorised into intermediate/low risk. DOS was adverse in high foot risk (4.9 +/- 1.7 vs. 2.6 +/- 1.6, p < 0.001). Overall, patients received 2.2 +/- 0.9 foot interventions (1-5) and 1.4 +/- 1.1 medical interventions (0-4) with greater needs in high-risk group. Outcomes following consultation: 21% followed up for foot and medical needs (36% high vs. 0% intermediate/low risk), 28% for medical needs only (29% vs. 27%), 1% for foot needs only (2% vs. 0%) 50% discharged to community for foot and medical needs (33% vs. 73%). Conclusion: This pilot review of previously unknown high foot risk patients by specialist foot team found such patients to also have adverse medical risks and substantial foot and medical intervention needs. There was poor concordance (58%) between screened and actual foot risk.

Source: EMBASE
Available in fulltext from Diabetic Medicine at the ULHT Library and Knowledge Services’ eJournal collection
Available in fulltext from Diabetic Medicine at EBSCOhost

48. Time to first review of new admissions to critical care by the consultant intensivist

Author(s) Dhrampal A.
Citation: Critical Care, 2010, vol./is. 14/(S157), 1364-8535 (2010)
Publication Date: 2010
Abstract: Introduction: The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommends that all new admissions to the ICU should be reviewed by a consultant intensivist within 12 hours [1]. This early review may reduce the ICU length of stay (LOS), but does not appear to affect mortality [2]. Patient severity of illness (APACHE II scores) may also influence patient outcome. Methods: The database of our clinical information system (MetaVision, IMDsoft) was interrogated and 116 new consecutive critical care admissions were retrospectively reviewed. We ascertained the time to first review (in hours) by a consultant intensivist from MetaVision entry logs. Patient outcomes including mortality and LOS were also captured for patients reviewed early (<12 hours) and late (>12 hours). The admission APACHE II score was also calculated. Continuous and ordered categorical variables are expressed as the median and analysed by the Mann-Whitney U test. Outcome binary variables were analysed by the chi-squared test. P < 0.05 was considered statistically significant. Results: The early reviewed group (n = 53) had a median first review time of 4.35 hours (IQR 1.70 to 6.90), median LOS of 46 hours (IQR 22 to 86) and mortality of 17% (n = 9). The late review group (n = 63) had a median first review time of 16.55 hours (IQR 14.35 to 18.88), median LOS of 25 hours (IQR 20 to 46) and mortality of 1.6% (n = 1). The median admission APACHE II score for the early group and late group was 14 (IQR 10 to 24) and 10 (IQR 8 to 16), respectively. There was no significant difference in LOS between the two groups (P = 0.137, two-sample Mann-Whitney U test). The early group had a significantly higher mortality (P = 0.03, chi-squared test) and admission APACHE II score (P = 0.04, two-sample Mann-Whitney U test). Conclusions: We were unable to demonstrate that early consultant intensivist review of new critical care admissions reduces the LOS or mortality. Despite early consultant intensivist review, this group had a significantly higher mortality. A significantly higher severity of illness in the early group may account for this higher mortality.

Source: EMBASE
Available in fulltext from Critical Care at National Library of Medicine

49. Geriatric ward rounds by video conference: A solution for rural hospitals

Author(s) Gray L.C., Wright O.R., Cutler A.J., Scuffham P.A., Wootton R.
Abstract: Objective: To evaluate the acceptance and cost of a ward-based geriatric consultation service delivered via a mobile videoconferencing system. Design and setting: Prospective observational study conducted in the geriatric unit of Toowoomba Base Hospital, Queensland, comparing a specialist consultation service delivered by videoconference (VC) with a "traditional" in-person service. The VC system was established in January 2007 and evaluated over an 18-month period. Patient satisfaction with the service was assessed by questionnaire during a 1-week period in September 2008. Main outcome measures: Hospital acceptance of the service; patient satisfaction with the service; comparative cost of providing in-person and VC-mediated consultations. Results: Uptake of the service increased progressively throughout the study period. Patient acceptance levels were high. The cost of video consultations for a 12-patient ward round and case conference was less than the cost of in-person consultations if the total road distance travelled by the specialist (Brisbane to Toowoomba and back) was 125 km or longer. Conclusion: Consultations via VC are an acceptable alternative to in-person consultations, and are less expensive than in-person consultations for even modest distances travelled by the clinician.

52. Including pharmacists on consultant led ward rounds to improve patient care

Author(s) Miller G., Franklin Dean B., Jacklin. A.

Abstract: Background: In UK hospitals, traditional ward pharmacy services are provided by pharmacists undertaking daily visits to their allocated ward(s), where they monitor prescriptions, mainly on a retrospective basis. Pharmacists discuss medication related issues and make recommendations to medical staff where necessary; this is typically termed an intervention. As many interventions are made to resolve a prescribing error or to improve quality of care, it is important that interventions are made as soon as possible after prescribing, or preferably, at the point of prescribing. With the traditional service, there can be a delay between the prescription being written and a pharmacist's intervention taking place. Strategy for Change: We have been increasing the number of specialist pharmacists who routinely attend consultant led ward rounds.; Measurement of Improvement: Design: Prospective, non-randomised, controlled study. Setting: Five inpatient medical wards at two teaching hospitals. Study aim: Compare the number, nature and clinical importance of interventions made by pharmacists attending consultant led ward rounds in addition to providing a clinical ward pharmacy service (study group), with those made by pharmacists providing a traditional clinical ward pharmacy service alone (control group).; Result of Assessment: A mean of 1.73 physician accepted interventions were made per patient for the study group, compared to 0.89 for the control (Mann Whitney U, p<0.001). There was no difference between groups in the nature or clinical importance of the interventions. Each consultant led ward round lasted on average 115 minutes, during which one physician accepted intervention was made every eight minutes, compared to one every 63 minutes during a ward pharmacist visit which had a mean duration of 68 minutes.; Lessons and Messages: Pharmacists attending consultant led ward rounds in addition to undertaking a ward pharmacist visit make significantly more interventions per patient, thereby reducing preventable medication errors and optimising treatment.

Source: EMBASE

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Abstract: Background: Polypharmacy and inappropriate drug use are risk factors for adverse drug reactions (ADR) and poor compliance in older cancer patients. Drug evaluations in the past have not focused on this group. An evaluation of the prevalence of PIMs, pharmacist interventions, and the number and type of medications was performed. An educational component helped patients with drug management to increase adherence, avoid drug-drug and drug-disease interactions. Methods: A geriatric clinical pharmacist reviewed patient’s medications, assessed understanding of their drugs, evaluated adherence, reviewed for PIMs (Beer’s criteria), identified possible ADR and side effects, and provided detailed instructions. The pharmacist collaborated with the oncologist to determine appropriate therapy for the patient. Only patients over the age of 65 were eligible for this clinic. Consults were performed from March 2008 to June 2008, this includes new and follow up visits. An additional retrospective chart review was performed on 100 patients >= 65 years of age seen from July 2007 to November 2007. Results: There were 154 patients who underwent a prospective consultations; 74 yrs (65-91; 58% female). The interventions were: an alternative agent was recommended (31pts/20%), drug - drug interactions identified (15/10%), problems with adherence (58/37%), drugs discontinued (54/35%), additional medication (64/42%), dose change (17/11%) and cost issues (19/12%). More then one issue was addressed during visits. In the retrospective study, median age 72 (65 - 90), 48% were females; medications: median 8 (range 0-23). Most common classes of medications were anti-hypertensives (52%), vitamins/herbals (46%), proton pump inhibitors (32%) and lipid lowering agents (29%). The prevalence of PIMs was 11%. The most common were propoxyphene, high doses of long-acting benzodiazepines and diphenhydramine. Conclusions: A geriatric medication management evaluation resulted in 50% of patients requiring specific interventions and identification of PIMs in 11% of patients. This type of intervention can optimize care by increasing adherence and avoiding adverse drug events and their serious sequelae.

Source: EMBASE

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54. Timing of first review of new ICU admissions by consultant intensivists in a UK district general hospital

Author(s) Mullen P., Dawood A., White J., Anthony-Pillai M.

Citation: Critical Care, 2009, vol./is. 13/(S191-S192), 1364-8535 (2009)

Publication Date: 2009

Abstract: Introduction: Patient outcome has been linked to the timing of the first senior medical review in emergency medical admissions to hospital, and after ICU admission [1,2]. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 2005 report revealed that in participating UK ICUs 75% of new ICU patients had a consultant intensivist review within 12 hours of admission [3]. This is now a recommended standard, although data were only available for 40% of patients, and neither supportive patient outcome data nor pre-ICU review timings were cited. Methods: By retrospective review of patients' ICU medical notes, we studied the length of time to first consultant intensivist review before and after ICU admission in 122 consecutive patients. We also examined mortality and length of stay (LOS) outcomes in patients reviewed early (<2 hours) and late (>2 hours) after ICU admission. Continuous data are expressed as the median (IQR). Results: Overall, data were available for 96 patients reviewed after ICU admission (median = 6.0, IQR = 1.1 to 14.7 hours), 79 (82%) of these reviews being early (median = 3, IQR = 0.5 to 7.5). ICU mortality for the early group was 31.6% during a median ICU LOS of 1.8 days (IQR = 0.9 to 7.9). Median review time for the late group (n = 17) was 21 hours (IQR = 18.5 to 28.4), with an ICU mortality of 23.5%, during a median ICU LOS of 8.1 days (IQR = 2.1 to 14). The early group had a significantly shorter ICU LOS (P = 0.007, two-sided Mann-Whitney test) than the late group, and there was no significant
proportional difference in ICU mortality between the two groups. Furthermore, before ICU admission, 56/122 patients (46%) had been reviewed by a consultant intensivist (median = 2.2, IQR = 1.2 to 4.0 hours), and in many patients this constituted the only such review prior to 12 hours into ICU admission. Conclusions: Review by a consultant intensivist is common before aICU admission. Early review after ICU admission may be associated with a shorter length of ICU stay. Timing of the first review is likely to be influenced by many factors, other than NCEPOD recommendations.

**Source:** EMBASE

Available in fulltext from Critical Care at National Library of Medicine

59. Does a post-take ward round proforma lead to sustainable improvements in quality of documentation for patients admitted to the medical assessment unit?

**Author(s)** Kamara A., Henderson S., Rodrigo C., Dulay J.

**Citation:** Acute Medicine, 2006, vol./is. 5/3(108-111), 1747-4884;1747-4892 (2006)

**Publication Date:** 2006

**Abstract:** This study assessed the quality of post-take ward round (PTWR) documentation, specifically looking at twelve criteria, in the medical assessment unit (MAU) prior to, 3-months and 2-years after introducing a PTWR proforma. 216 case records were analysed; 40 prior to, 40 three-months and 146 two-years after introducing the PTWR proforma. There was a significant improvement in eight criteria three-months after introducing the PTWR proforma. These improvements were sustained two-years later and significant improvements made in a further 3 criteria (1 at p < 0.05 and 2 at p < 0.01).

**Source:** EMBASE

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