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**Literature search results**

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**Search details**

Surgical round proformas utilising the lessons learnt from medicine.

**Resources searched**

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

**Database search terms**: ward* adj2 round*; TEACHING ROUNDS; patient* adj2 round*; (ward OR wards OR medical OR nursing OR nurse OR nurses OR family OR families OR multidisciplinary OR MDT OR doctor OR doctors OR consultants OR consultant OR morning OR attending OR family) adj2 round*; patient* adj2 review*; surg*; exp SURGICAL SPECIALITIES; round*; standard*; proforma*; checklist*; CHECKLIST toolkit*; document*; DOCUMENTATION; record*

**Evidence / Google search string(s)**: (ward OR wards OR medical OR nursing OR nurse OR nurses OR family OR families OR multidisciplinary OR MDT OR doctor OR doctors OR consultants OR consultant OR morning OR attending OR family) (round OR rounds) ("patient review" OR "review of patients") (proforma OR proformas OR document OR documents OR documentation OR checklist OR checklists OR toolkit OR toolkits OR recording OR record OR records OR standard OR standards OR standardisation)

**Summary**

There is quite a lot of research on ward round documentation, not so much on surgical ward rounds. I have included research on medical ward round and generic ward round documentation as you said you wanted to utilise the lessons learnt from medicine. For the purely surgical ward round studies, please see 24, 30, 32, 34, 41 and 47 in the first set of results and 1 and 3 in the additional results in Healthcare Databases – Research.
### Guidelines and Policy

**Department of Health**

*Good Practice Guidelines for GP electronic patient records* 2011

**Professional Record Standards Body**

**Royal College of Nursing**

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

**Royal College of Physicians**

*Developing standards for the structure and content of health records* 2013

*Future hospital: caring for medical patients* 2013

Systems for collecting and recording data should be electronic. Where this is not currently possible it should be a priority to achieve it. In the electronic environment, clinical records must have a standardised structure, so that they can be reused across settings and applications reliably. The RCP Health Informatics Unit has led the development of standards for the structure and content of clinical records. These were approved by 50 organisations representing medical, nursing and allied health professions. We recommend that these standards provide the structure for clinical records, both paper based and electronic, and that they are included as a requirement for procurement of electronic health records (EHRs). The newly established Professional Records Standards Body (PRSB) should become the focus for multidisciplinary record standards in the future.

### Evidence-based reviews

None found.

### Published research – Databases

1. **The rounding tool: Nurse presentation in multidisciplinary rounds**

   **Author(s)** Ortmayer K., Avolio Ricket T., Walblay M., Golden L., Moore M., Mistry K.

   **Citation:** Pediatric Critical Care Medicine, June 2013, vol./is. 14/5 SUPPL. 1(S105), 1529-7535 (June 2013)

   **Publication Date:** June 2013

   **Abstract:** Introduction: Communication is recognized as essential to patient safety. The Joint Commission (TJC) specifically recommends the use of checklists and standardized handoff tools. To meet this mandate and improve information sharing, the Cardiovascular Intensive Care Unit (CVICU) team at Levine Children's Hospital created a standardized "rounding tool." Methods: Following the IHI models improvement framework, key stakeholders reviewed the pertinent patient safety and handoff communication literature and developed a structured communication tool for nursing staff to guide them in presenting multidisciplinary rounds. Subsequent versions were created using frontline provider feedback. In addition to improved communication, outcomes included barriers to implementation and staff satisfaction. Results: Barriers to implementation included culture-change surrounding the historical model of physician/nurse practitioner-led presentations as well as nurses’ reluctance to speak during multidisciplinary rounds. While duration of nurse-to-nurse report and daily rounds initially lengthened, communication became more efficient with time. Postimplementation surveys suggested nurses felt more empowered in sharing ideas, engaged in management decisions, and challenged to increase critical-thinking skills. Due to the tool's success, its use spread to other disciplines; for example, respiratory therapy and anesthesia. Conclusion: A standardized rounding tool led to
Improved multidisciplinary communication in our Pediatric CVICU. Following implementation, daily management goals became clearer and rounding more efficient. Team member engagement, camaraderie and satisfaction improved. Unexpected benefits included the adoption of a similar tool during other patient handoff situations. Associated improvements in hospital efficiency (e.g. CVICU length of stay) and clinical outcomes warrant further study.

Source: EMBASE

2. Why patients need leaders: introducing a ward safety checklist

Author(s) Amin Y., Grewcock D., Andrews S., Halligan A.

Citation: Journal of the Royal Society of Medicine, September 2012, vol./is. 105/9(377-383), 1758-1095 (Sep 2012)

Publication Date: September 2012

Abstract: The safety and consistency of the care given to hospital inpatients has recently become a particular political and public concern. The traditional ‘ward round’ presents an obvious opportunity for systematically and collectively ensuring that proper standards of care are being achieved for individual patients. This paper describes the design and implementation of a ‘ward safety checklist’ that defines a set of potential risk factors that should be checked on a daily basis, and offers multidisciplinary teams a number of prompts for sharing and clarifying information between themselves, and with the patient, during a round. The concept of the checklist and the desire to improve ward rounds were well received in many teams, but the barriers to adoption were informative about the current culture on many inpatient wards. Although the ‘multidisciplinary ward round’ is widely accepted as good practice, the medical and nursing staff in many teams are failing to coordinate their workloads well enough to make multidisciplinary rounds a working reality. ‘Nursing’ and ‘medical’ care on the ward have become ‘de-coupled’ and the potential consequences for patient safety and good communication are largely self-evident. This problem is further complicated by a medical culture which values the primacy of clinical autonomy and as a result can be resistant to perceived attempts to ‘systematize’ medical care through instruments such as checklists.

Source: EMBASE

Available in fulltext from Journal of the Royal Society of Medicine at National Library of Medicine

Available in print at Lincoln County Hospital Professional Library

3. Round and round we go: The development of an effective, sustainable multidisciplinary rounding process

Author(s) Strelczyk K., Vandygriff C.

Citation: American Journal of Infection Control, June 2013, vol./is. 41/6 SUPPL. 1(S67-S68), 0196-6553 (June 2013)

Publication Date: June 2013

Abstract: ISSUE: Regulatory and accrediting agencies have recently increased scrutiny of the environment in hospital surveys. Many findings are cited in "Infection Control" chapters. In early 2012, our acute care hospitals were surveyed by the Centers for Medicare/Medicaid Services (CMS) and cited for a number of environmental issues. There is very little information published or available in Infection Prevention (IP) courses regarding “how to” effectively conduct environment of care (EOC) rounds. Historically, EOC rounds were conducted only twice a year at our hospitals, we had no standardized tool, and no scoring mechanism. In addition, we found that Department Managers (DM) did not realize their responsibility toward assuring a clean and safe environment. PROJECT: We developed 5 teams of experts from IP, Environmental Services (EVS), Plant Operations (PO), and Safety. IPs served as Team Leaders for teams. Schedules were developed to ensure that all clinical areas were rounded upon monthly and all others quarterly. Eleven outpatient areas/clinics were included. A standard operating procedure was developed. A rounding tool was created that provides DM with an overall score, as well as an Action Plan.
DM were asked to utilize the AP section to respond to deficiencies within one week. This electronic tool automatically calculated and fed scores to an aggregate report, providing trending by category and by line item (figure 1). In order to enhance interrater reliability and data consistency, rounding team members received training on each item included in the tool. DM received training on the entire rounding process, including their role. Work orders were placed at the time of rounds for PO issues. RESULTS: DM are now more knowledgeable about their role in assuring a clean and safe environment. Initial review of section scores revealed PO and EVS being the lowest. This information enabled us to focus on the most critical areas and helped justify the addition of much needed staff to the EVS department. LESSON LEARNED: We implemented an effective and sustainable process for environmental rounding that satisfied CMS upon revisit. We are now able to quickly identify and mitigate environmental and IP issues in our facilities. The consistent presence of IP staff throughout the organization and the availability of an electronic, interactive tool have increased awareness of environmental safety and related IP practices from front line staff to administration, medical staff and the Board. (Figure presented).

Source: EMBASE

4. Development of a checklist for documenting team and collaborative behaviors during multidisciplinary bedside rounds

Author(s) Henneman E.A., Kleppel R., Hinchey K.T.

Citation: Journal of Nursing Administration, May 2013, vol./is. 43/5(280-285), 0002-0443;1539-0721 (May 2013)

Publication Date: May 2013

Abstract: OBJECTIVE:: The objective of this study was to develop a reliable and valid checklist for documenting team and collaborative behaviors occurring during multidisciplinary bedside rounds. BACKGROUND:: Teamwork and collaboration are important for providing high-quality patient care, yet there are no objective means of evaluating the occurrence of team and collaborative behaviors during bedside rounds. METHODS:: A checklist was developed and tested on 3 general medical units. Items on the checklist were derived from the literature and our medical center's patient-family-centered values. RESULTS:: The final version of the checklist was determined to be reliable, valid, and easy to use in the clinical setting. CONCLUSION:: Clinicians, administrators, and investigators are encouraged to use and/or modify this checklist for use in their setting. Further research identifying instruments to objectively measure teamwork and collaboration is needed. Copyright 2013 Lippincott Williams & Wilkins.

Source: EMBASE

5. A multidisciplinary ICU communication checklist: A qualitative study

Author(s) Hoad N., Centofanti J., Duan E., Perri D., Waugh L., Cook D.

Citation: Critical Care Medicine, December 2012, vol./is. 40/12 SUPPL. 1(204), 0090-3493 (December 2012)

Publication Date: December 2012

Abstract: Introduction: Extensive communication occurs during daily ICU rounds including a bedside review of a patient's problems, progress and plans. To facilitate accurate, comprehensive and patient-focused management, Daily Goals Checklists (DGC) have been developed. The objective of this study was to examine the attitudes and perspectives of multidisciplinary health care providers about a newly implemented DGC in a tertiary care, academic ICU. Hypothesis: We hypothesized that variable views would be held by different members of the multidisciplinary team on both the importance and utility of the DGC. Methods: In this qualitative study, we conducted individual semi-structured interviews and focus groups of 42 ICU clinicians (20 nurses, 5 respiratory therapists, 3 physiotherapists, 2 pharmacists, 1 dietician, 5 fellows and 6 intensivists). Inductive analysis of the transcribed interviews was used by the multidisciplinary investigative team to identify emerging themes. Results: Clinicians endorsed the DGC as a tool to enhance a structured, comprehensive approach to the innumerable interventions made on critically ill patients. The utility of the DGC was perceived to be greatest for nurses, pharmacists and physicians who attended to
most aspects of the form. For some clinician groups, there were dominant foci - for respiratory therapists: weaning, sedation and fluid plans; for physiotherapists: sedation and central line plans; and for the dietitian: optimizing nutrition. All clinicians suggested more detail for rehabilitation and mobility targets on the DGC. Patient rounds were endorsed as multidisciplinary but the utilization of the DGC was considered primarily an inter-professional communication tool between nurses and physicians. Nurses were wary that the DGC should always enhance rather than replace verbal communication. Conclusions: Prominent users of the DGC (nurses, physicians and pharmacists) endorsed its ability to enrich communication about systematic, comprehensive plans of care. Less engaged users reported utility of the DGC in selected domains. All clinicians were interested in adapting the DGC and further enhancing its integration into practice.

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

6. Impact of a quality measure checklist on patient care and provider satisfaction in a pediatric intensive care unit

Author(s) Lopez M., Mathur M., Deming D., Tinsley C., Wilson M., Pascual M., Abd-Allah S.

Citation: Critical Care Medicine, December 2012, vol./is. 40/12 SUPPL. 1(160), 0090-3493 (December 2012)

Publication Date: December 2012

Abstract: Introduction: The impact of a quality measure checklist on patient care and provider satisfaction in a pediatric intensive care unit (PICU) is uncertain. Hypothesis: Implementing a quality measure checklist and consistent nursing involvement in rounds improves patient care, provider satisfaction, and interdisciplinary communication. Methods: This prospective cohort study was conducted in our 25-bed multidisciplinary PICU. Baseline data collected included PICU length of stay (LOS), invasive line days, urinary catheter days, and mechanical ventilation days to assess patient care and a survey using a 4-point Likert scale to assess provider (nurse, physician, and respiratory therapist) satisfaction with rounds and communication. Two interventions were then implemented: 1) a quality measure checklist was completed before rounds by nurses and each item recorded in the physician progress note and 2) a consistent time and format was instituted for the nurses to review the checklist during multidisciplinary PICU rounds. Pre and post intervention patient care and satisfaction data were compared using Fisher's exact test with significance level at 0.05. Results: Baseline data for 425 patients was compared to 471 patients post interventions. There was a trend toward decreased urinary catheter days (p=0.079). PICU LOS, invasive line and mechanical ventilation days remained unchanged. Providers reporting being "very satisfied" or "satisfied" with rounds increased from 63% to 90%(p=0.001). Satisfaction with understanding of patient goals increased from 65% to 84%(p=0.018). Provider satisfaction with family concerns being addressed increased from 34% to 86% (p<0.001). More providers felt valued - 83% vs 92%(p=0.004), and their input was better appreciated - 88% vs 96%(p=0.045). Conclusions: Consistent use of a quality measure checklist for discussion of patient-care issues during multidisciplinary PICU rounds leads to increased provider satisfaction, improved communication, better understanding of patient goals, and more attention to family concerns. Statistically significant improvement in patient care parameters could not be demonstrated, although there was a trend towards decreased urinary catheter days.

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

7. Residents' perspectives on a daily goals checklist: A mixed-methods study

Author(s) Centofanti J., Duan E., Hoad N., Waugh L., Perri D.

Citation: Critical Care Medicine, December 2012, vol./is. 40/12 SUPPL. 1(150), 0090-3493
Publication Date: December 2012

Abstract: Introduction: ICU rounds in teaching hospitals focus on the management of multisystem patient problems, generating discussions about physiology, diagnosis, therapy, prevention and palliation. The objective of this study was to examine the utilization and attitudes about a recently introduced daily goals checklist (DGC) in a university-affiliated ICU from the perspective of residents. Hypothesis: We hypothesized that ICU residents would use the DGC as a tool to enhance patient care and to stimulate their education. Methods: This was a mixed-methods study. Two investigators conducted field observations to understand how, when and by whom the DGC was used on 80 ICU patient rounds over 6 days. To minimize the Hawthorne effect, ICU clinicians were blinded to the purpose of the resident observer on rounds. Second, we conducted individual semi-structured interviews and focus groups of 14 rotating residents regarding the use of the DGC. These were audio-taped, transcribed and analyzed inductively to identify emerging themes. Triangulation was achieved through 2 data sources, 2 qualitative research methods and a multidisciplinary investigative team. Results: During 80 patient rounds, the DGC was used for 93% of patients, completed by a resident (86% of patients), then verbally reviewed and championed by a resident (83% of patients). It served as a tool engaging bedside clinicians in detailed, individualized care plans. Residents endorsed the utility of the DGC foremost to (1) ensure a systematic comprehensive care plan that minimized errors of omission and commission; (2) serve as a communication aid primarily with nurses; and (3) provide a touchstone for learning evidence based practices. The DGC was considered least helpful to guide weaning and rehabilitation, and to understand complex psychosocial issues. Conclusions: In this university-affiliated ICU, residents were heavily involved in the utilization and completion of the DGC. The checklist was considered by residents to be a multipurpose tool - to facilitate their role on rounds to optimize patient care, further interprofessional communication, enhance patient safety, and prompt teaching opportunities.

Source: EMBASE

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

8. Communicating about medication. Who, what, where, when, how?

Author(s) Urban R., Armitage G., Morgan J., Marshall K., Blenkinsopp A.

Citation: International Journal of Pharmacy Practice, May 2013, vol./is. 21/(20-21), 0961-7671 (May 2013)

Publication Date: May 2013

Abstract: Lack of effective communication poses a threat to patient safety and has the potential to lead to medication error[1], hence the national drive to improve communications regarding medication, especially during transfer between primary and secondary care[2]. During a patient’s hospital admission many decisions about medicines are made and need communicating. This study employed qualitative observational methods to explore current communication between health care professionals (HCPs) regarding their patients’ medication in secondary care. Seventy-three HCPs (doctors, pharmacists and nurses) in three acute Trusts were knowingly observed undertaking tasks involving medicines or related discussions, throughout the patient journey e.g. medicines administration, medicines reconciliation, clerking patients and ward rounds. Staff were observed on ten different wards (one week per ward). A structured framework of effective medicines reconciliation practice was designed following a detailed literature review; these and other related behaviours were recorded using field notes, then thematically coded. This was part of a larger study of the reconciliation process which held ethical approval. All HCPs consented to participate. Themes included ‘approach to process’, ‘healthcare professional involvement’ and ‘patient engagement’; with communication emerging as an underpinning concept. Intra and inter-professional communication regularly occurred between pharmacists, nurses and doctors (GPs, junior doctors and consultants) regarding medicines-related issues. These involved both verbal and written communication (electronic and handwritten), at handovers, on prescription charts, in patient notes, on discharge summaries and observation charts. For all HCPs, communication usually included documenting that a task had been or needed to be undertaken e.g. medication
review, medicines reconciliation or blood monitoring, alternatively that an intervention had been made e.g. dose adjustment or discrepancy identified. However, the information communicated was often inconsistent, incomplete or ambiguous. Frequently, changes to medication would either not be indicated in the patient's notes or would lack detail such as the name or strength of the medication, e.g. 'increase diuretic' or 'decrease BP medication'. Rarely was the reason for the change explicitly stated. Some hospitals had standardised systems for communicating about medication e.g. proformas, e-discharge or specific places to leave messages for the multidisciplinary team, which improved communication. Communication with patients about their medication was inconsistent. Most patients were not informed about changes to their medication regimen. Occasionally this was due to barriers such as language or lack of capacity but often there was no clear reason. Communication regarding medicines-related issues varies. Consistency and understanding of information communicated could be improved through greater standardisation of procedures and documentation e.g. IT systems with forcing functions for mandatory fields. In addition to system changes, HCPs need to understand how the next person in the medicines management pathway is affected by the completeness and quality of information provided and how error can contribute to preventable harm. Where possible, patients should be given the opportunity for increased involvement in discussions regarding changes to their medication regimens to improve medicines optimisation. Results may have been influenced by the Hawthorne effect and observer bias. Further work is being conducted to explore medicines-related communication, during hospital stay and at discharge.

Source: EMBASE

9. Structured rounding checklist improves quality of care in the PICU

Author(s) Ganesan R., Rajakumar P., Conley L., Nelson S., Kane J.

Citation: Critical Care Medicine, December 2011, vol./is. 39/(157), 0090-3493 (December 2011)

Publication Date: December 2011

Abstract: Introduction: The purpose of this study was to implement a daily checklist to improve team member participation on rounds and standardize communication in the PICU. Hypothesis: We hypothesized that a structured checklist would increase nursing participation on rounds and increase the frequency of discussion of nationally and institutionally prioritized PICU clinical process and outcome measures. Methods: Baseline data collection of undisclosed key elements was performed by covert observations during rounds. A comprehensive nurse driven rounding checklist was created. Sample components of the checklist included catheter-associated infection prevention, diagnostic testing, safety statements, and 4 specified daily goals. Tool optimization was achieved after several PDSA cycles. Frequencies of pre and post intervention metrics were assessed. Proportions were compared using 2-tailed Fisher's Exact test. Sustainability was tested by comparing early to late post-intervention data. Results: During the 15 week post-intervention period, 86% of the 1060 eligible checklists were completed. Nursing presence during rounds increased from baseline (83% vs 100%, p<0.001). Discussions related to catheter-associated infection prevention increased post-implementation (14% vs 79%, p<0.001). The frequency of discussions of required diagnostic testing and extubation planning also increased (35% vs 100%, p<0.05; 64% vs 91%, p<0.05). Parental presence during rounds and discussions related to care conferences did not change from baseline. After 15 weeks, neither the frequency of nursing participation nor discussion of infection prevention was statistically different from week 1. Discussion related to diagnostic testing improved from week 1 to week 15 (50% vs 89% p<0.001) while discussion surrounding extubation planning deteriorated in the late post-intervention period (91% vs 25%, p<0.001). Conclusions: Implementation of a daily rounding checklist in the PICU increased multidisciplinary caregiver presence on rounds. Discussion of critical safety and quality measures including catheter-associated infection prevention and diagnostic testing improved. Daily rounding checklists can improve team communication and standardization of care.

Source: EMBASE

Available in fulltext from Critical Care Medicine at the ULHT Library and Knowledge
10. A systematic review of rounding practices in intensive care

Author(s) Lane D., Ferri M., Stelfox H.T.

Citation: Critical Care Medicine, December 2011, vol./is. 39/(28), 0090-3493 (December 2011)

Publication Date: December 2011

Abstract: Introduction: Effective rounding in the ICU is associated with improvements in patient outcomes and greater patient and provider satisfaction. Hypothesis: We describe a systematic review of the literature to identify current ICU rounding practices, facilitators and barriers to information exchange, and tools for improving the process. Methods: We searched Medline, Embase, CINAHL, and the Cochrane library to identify articles pertaining to rounding in the ICU. Both quantitative and qualitative articles were eligible for inclusion. Two reviewers independently extracted relevant data. Results: 4605 articles were identified by the initial search strategy. A review of the citations resulted in data abstraction from 38 articles. Seventeen (45%) focused on rounding structure, addressing issues such as the location or layout of rounds (1), the allocation of time or activities during rounds (3), or the composition of the rounding team (13). Communication was addressed by 16 (42%) of the citations, focusing on the content of rounds (1), the use or transfer of information (8), or the use of tools to improve communication (8). Standardization of rounding practice including the location for discussions, time for rounds, roles among the team, and presentation format were identified as facilitators for rounding. Multidisciplinary team composition and both goal oriented and open discussions were also identified as facilitators. Poor understanding of goals of care, interruptions, missing information, and team members not present during rounds were identified as barriers. Three tools for improving communication (daily goals checklist, rounds checklist, and immediate protocol adherence feedback) and 1 for improving efficiency (mobile computing stations) were identified. Five articles (13%) addressed inter professional relations from provider perspectives. Conclusions: A substantial body of literature exists regarding ICU rounding practices with varying degrees of evidence for facilitators, barriers and tools to improve the rounding process. This review will identify gaps in our current understanding and help to inform future quality improvement initiatives.

Source: EMBASE

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

11. 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

12. Common practices in the neonatal ward rounds in Australia and New Zealand
Author(s) Sivayoganathan S., Kumar P., Koh T.
Citation: Journal of Paediatrics and Child Health, April 2013, vol./is. 49/(58), 1034-4810 (April 2013)
Publication Date: April 2013
Abstract: Background: Optimal documentation of examination of patients can play a crucial role in medico-legal case. This study evaluates the practices in the ward rounds (WR). Method: Data were collected by a phone survey from the registrars or nurse practitioners (R/NNP) of the NICU in Australia and New Zealand. Results: All the 28 units responded to the survey. Morning WR is done in all neonatal units. A bedside handover happens in 19 units and by paper in 7 units. In 25 units R/NNP presents the patient details for the WR. Neonates are routinely examined by either night or day R/NNP in 27 units and by at least one of the neonatologists in 3 units. Of the 17 units with babies under private care, neonatal examination was done by the R/NNP in 10 units. 17 units have routine teaching during WR with the frequency of teaching being 3 times per week (TPW) in 10 units, 1-3 TPW in 10 units and >3 TPW in 7 units. The WR duration varied from 0.33 to 3 hours (mean 1.75 hours). WR decisions are documented by R/NNP in 26 units. Gowns were worn routinely by neonatal staff in 4 units and by parents in 1 unit. 26 units allow the parental presence during WR. End of the shift handover 16 units (57.1%) is done by bedside and in 10 (35.7%) by paper. Conclusion: The variations in ward round practices among the units in Australia and New Zealand may be important in medico legal cases.
Source: EMBASE

14. Attitudes towards documentation of treatment limitations in a UK intensive care unit
Author(s) Liu S.E., Hewson R.W.
Citation: Intensive Care Medicine, October 2012, vol./is. 38/(S72), 0342-4642 (October 2012)
Publication Date: October 2012
Abstract: INTRODUCTION. Decisions regarding treatment limitations on ICU patients can form an important part of their management plan as continuing and escalating invasive treatment can often be inappropriate, undignified and simply serve to prolong death. There are many ethical issues surrounding such decisions so effective communication to enable consistency of approach is paramount. Currently we don't use a standard form to document treatment or resuscitation limits in our ICU. The hospital-wide DNAR form has been deemed inappropriate for ICU use as issues around resuscitation status in our patients are often too dynamic. Any limitations to treatment are simply documented in the patient's notes. This is contrary to the recommendations of the UK Resuscitation Council [1], though is in line with General Medical Council guidance [2]. OBJECTIVES. The aim was to ascertain the use of treatment limitation forms across UK ICUs to see if our practice is usual and to canvas our own ICU staff to determine local feelings. Ultimately we would determine if our protocols should be updated. METHODS. 50 staff members were asked their views regarding our documentation of resuscitation and treatment limits using a simple 10 point questionnaire. Simultaneously a structured telephone survey of 22 hospitals in the UK was conducted to ascertain what other units did. The sister in charge was spoken to at
each unit to ensure consistency. RESULTS. The most striking result was that 74% of our staff were unhappy with our current system and felt that hospital DNAR forms should be used. Notably, the opinions of the consultants differed widely from the rest of the team (Table 1). (Table Presented) 86% of staff welcomed the idea of a customised ICU limitations form, those against it also felt any kind of DNAR form was inappropriate. Reasons included a worry over focussing on limitations not treatment and that patients are reviewed so regularly it would not be necessary. The advocates felt it would improve clarity and even shorten ward rounds. The phone survey showed 64% of ICUs used the hospital-wide DNAR form. Of the 36% that did not use the form, 50% had an ICU specific combined resuscitation and limitations form. Of the remainder, two had computerised notes where treatment decisions were documented and only our ICU plus 1 other unit used just the patients’ handwritten notes. CONCLUSIONS. Our practice of not having a specific form for resuscitation status is unusual amongst UK ICUs, but more importantly the general feeling amongst staff on our unit is that current documentation is inadequate and the evidence of earlier decisions can be difficult to locate in an emergency. Effective communication of such important matters is vital and in view of this and our findings we will develop and trial a single form for treatment limitations to satisfy the specific needs of the ICU population.

Source: EMBASE

15. Improving communication in a neuro-trauma critical care unit

Author(s) Waters A.A., Bhasker D., Mcconnell H.

Citation: Intensive Care Medicine, October 2012, vol./is. 38/(S70), 0342-4642 (October 2012)

Publication Date: October 2012

Abstract: INTRODUCTION. The importance of clear communication among healthcare professionals is well recognised. Failure in communication can lead to patient harm and increase the length of stay in hospital [1]. In the critical care setting, patient care is dependent on collaboration between the multidisciplinary team; these discussions define the patients’ ‘daily goals’ and guide clinicians’ actions. However, these goals are not always explicitly documented. Evidence suggests that poor documentation impairs understanding of shared goals between doctors and nurses [2]. The implementation of a daily goals sheet has been shown to improve collaboration between team members by establishing a mutual understanding of the plan of care and results in increased quality of care [1, 3, 4]. OBJECTIVES. We aimed to determine whether implementing a daily goals sheet would improve understanding of patient goals in our critical care unit. METHODS. The study setting was a 22 bed neuro-trauma critical care unit. We undertook a descriptive correlational study of common goals verbally stated and documented during ICU ward rounds. 25 patients were sampled prior to the redesign of the daily chart to incorporate a daily goals section and 35 patients following the implementation of the daily goals concept. The bedside nurses’ understanding of patient goals following the ward rounds were noted for all patients prior to and following the introduction of the daily goals sheet. RESULTS. 209 goals were recorded before and 348 goals after implementation of the daily goals sheet. Documentation of verbally stated goals remained the same, whilst the number of goals recalled by nursing staff significantly increased from 53 to 75%. Nurse-recalled goals improved across all categories including a 34% improvement in GI/nutrition goals and a 28% improvement in cardiovascular goals. CONCLUSIONS. Our results suggest daily goals sheets have improved nurses’ understanding of each patient’s daily plan and are a useful communication tool in the ICU setting. Further research should ascertain if these results translate into a significant reduction in adverse outcomes and if the same tool can be used to improve communication with other disciplines.

Source: EMBASE

16. An audit to assess whether standards are met for the recording of information on the newly implemented electronic patient record system at the Duchess of Kent Hospice

Author(s) Mills K.A., Talbot A.
Abstract: Summary Objectives: The electronic patient record system (RIO) was introduced to the Duchess of Kent Hospice (DoKH) in August 2010. It was to be used by both the ward and community multi-disciplinary team (MDT). Standards of documentation had to be agreed and met to ensure good communication and patient safety. Methods: The ward went paperless from Day 1 to avoid duplication of documentation. The system was reviewed after 6 weeks and standards agreed at the MDT meeting. It was decided that on admission every patient should have an admission document completed and scanned onto RIO. The admission summary, investigation results, ward rounds and MDT meetings should be recorded in the progress notes. Two cycles of a prospective audit were performed assessing all 27 patients admitted >6 weeks. Data were collected from RIO and analysed using Microsoft Excel. Results: Twenty-six out of 27 (96.3%) patients had their admission document completed and scanned onto RIO at admission. The document not scanned on admission (because the scanner was broken) was scanned the following day. Twenty-five out of 27 (92.6%) patient admissions were summarized in the RIO progress notes at admission. Seventeen out of 18 (94.4%) patients who were investigated had the results recorded in the progress notes. All (100%) ward rounds and MDT meetings were recorded in the progress notes. Conclusions: Overall the standards were met. When this audit was presented to the MDT the consensus was that RIO had facilitated communication. Concerns were raised about the relevance and verbosity of some documentation. It was also noted that the workability of RIO was dependent on functioning electronic equipment. It was recommended that the audit be repeated three times a year and expanded to include documentation by the community team. Given that electronic patient records will become more prevalent, it is useful to share the teething pains of a new system being implemented.

Source: EMBASE
Available in fulltext from QJM at Highwire Press

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


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

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

**Citation:** Clinical Teacher, October 2012, vol./is. 9/5(334-337), 1743-4971;1743-498X (October 2012)

**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. 2012 Blackwell Publishing Ltd.

**Source:** EMBASE

19. Ward rounds: What goes around comes around

**Author(s)** Herring R., Richardson T., Caldwell G.

**Citation:** The Lancet, February 2013, vol./is. 381/9864(373-374), 0140-6736;1474-547X (February 2013)

**Publication Date:** February 2013

**Source:** EMBASE

20. A nursing intervention: The impact of nurse-led clinical ward round on nursing documentation and clinical practice

**Author(s)** Mason I.A.

**Citation:** International Journal of Stroke, December 2012, vol./is. 7/(65), 1747-4930 (December 2012)

**Publication Date:** December 2012

**Abstract:** Introduction: It was identified, from observations and multi-disciplinary team
feedback, that nursing documentation and related clinical practice was an area that requires development with reference to management of nutrition, bowels and promoting continence. A nurse-led clinical ward round was implemented in May 2011 to provide nursing leadership, guidance and supervision, aiming to raise their profile, improve clinical competence and professional practice, and achieve organisational targets as set out in the stroke quality management standards. The clinical impact is to improve the patients’ experiences by developing the nurses’ knowledge, skills and attitudes in specific stroke nursing care management. Method: A retrospective case notes audit of all stroke admissions to the unit four months preceding the introduction of the ward round and four months post intervention. Data collection will be focused on number of patients weighed within three days of admission, receive weekly nutritional screening and with plans to manage/regain continence, with emphasis on how this is documented and communicated - part of the minimum stroke quality data set. Results: Audit in progress and results will be available by December 2012 for presentation at the UKSF. The discussion of the data will be on evaluating the impact/difference this intervention has had on nursing documentation and resulting clinical practice. Conclusion: Future plans will be to address identified training gaps, plan with the stroke multi-disciplinary team, educational programs to address needs, and explore the impact on learning and practice amongst nursing staff as a result of their participation in the clinical round.

Source: EMBASE

21. A bedside communication tool did not improve the alignment of a multidisciplinary team’s goals for intensive care unit patients

Author(s) Ainsworth C.R., Pamplin J.C., RN D.A.A., Linfoot J.A., Chung K.K.

Citation: Journal of Critical Care, February 2013, vol./is. 28/1(112.e7-112.e13), 0883-9441;1557-8615 (February 2013)

Publication Date: February 2013

Abstract: Purpose: Establishing well-understood daily patient care goals should improve healthcare team (HCT) communication, reduce errors, and improve patient outcomes. The purpose of this study was to test the hypothesis that implementation of a daily goals "Door Communication Card" (DCC) would improve goal alignment between members of the HCT. Methods: As part of a process improvement project, HCT members listed their top care goals for a patient on a given day. After initial data collection, DCCs were placed on patients' doors. Anyone was allowed to write on the card, but the "official" daily goals were recorded during multidisciplinary rounds. One month after introduction of the DCC, HCT members were re-queried about their patients' care goals. Three reviewers independently compared goals and assessed their alignment before and after implementation of the DCC. We collected goals over a 4-month period and selected 5 random days before and after intervention for assessment. Results: The goal alignment among HCT members was low before and did not improve after intervention (Attending-to-Nurse 55% vs 38%, P = .02; Attending-to-Resident 60% vs 54%, P = .43; Attending-to-Primary 35% vs 28%, P = .45; Nurse-to-Attending 52% vs 36%, P = .03; Nurse-to-Resident 55% vs 38%, P = .04; Nurse-to-Primary 37% vs 27%, P = .36; Resident-to-Attending 59% vs 54%, P = .4; Resident-to-Nurse 56% vs 40%, P = .05; Resident-to-Primary 36% vs 24%, P = .16; Primary-to-Attending 34% vs 42%, P = .44; Primary-to-Nurse 42% vs 35%, P = .6; Primary-to-Resident 32% vs 34%, P = .8). Conclusions: Alignment of daily patient care goals among HCT members is low overall and did not improve after implementing a DCC available to all team members. Further study to elucidate the mechanism by which daily goals forms improve patient care is required. 2013.

Source: EMBASE

22. Why patients need leaders: Introducing award safety checklist

Author(s) Amin Y., Grewcock D., Andrews S., Halligan A.

Citation: Journal of the Royal Society of Medicine, September 2012, vol./is. 105/9(377-383), 0141-0768 (September 2012)

Publication Date: September 2012
Abstract: The safety and consistency of the care given to hospital inpatients has recently become a particular political and public concern. The traditional 'ward round' presents an obvious opportunity for systematically and collectively ensuring that proper standards of care are being achieved for individual patients. This paper describes the design and implementation of a 'ward safety checklist' that defines a set of potential risk factors that should be checked on a daily basis, and offers multidisciplinary teams a number of prompts for sharing and clarifying information between themselves, and with the patient, during a round. The concept of the checklist and the desire to improve ward rounds were well received in many teams, but the barriers to adoption were informative about the current culture on many inpatient wards. Although the 'multidisciplinary ward round' is widely accepted as good practice, the medical and nursing staff in many teams are failing to coordinate their workloads well enough to make multidisciplinary rounds a working reality. 'Nursing' and 'medical' care on the ward have become 'de-coupled' and the potential consequences for patient safety and good communication are largely self-evident. This problem is further complicated by a medical culture which values the primacy of clinical autonomy and as a result can be resistant to perceived attempts to 'systematize' medical care through instruments such as checklists.

Source: EMBASE
Available in fulltext from Journal of the Royal Society of Medicine at EBSCOhost
Available in fulltext from Journal of the Royal Society of Medicine at National Library of Medicine
Available in print at Lincoln County Hospital Professional Library

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

Author(s) Lepee C., Klaber R.E., Benn J., Fletcher P.J., Cortoos P.-J., Jacklin A., Franklin B.D.

Citation: European Journal of Pediatrics, August 2012, vol./is. 171/8(1239-1245), 0340-6199;1432-1076 (August 2012)

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<sup>2</sup>=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. Springer-Verlag 2012.

Source: EMBASE

24. Pain assessment documentation practices in the neonatal intensive care unit

Author(s) Brunt A.L.

Citation: Anaesthesia and Intensive Care, May 2012, vol./is. 40/3(533), 0310-057X (May 2012)
Abstract: Background and aims: The Royal Children's Hospital (RCH) neonatal intensive care unit (NICU) is a level 4 unit that provides both medical and surgical care to sick neonates. The Pain Assessment Tool (PAT) was developed by Hodgkinson et al in 1994 and piloted on the RCH NICU and validated for the assessing pain in surgical patients. Many patients in NICU require ventilation, surgery or have medical conditions requiring analgesia. Pain should be assessed on a regular basis. However, poor documentation of pain scoring was observed in the NICU. This audit looked at the pain assessment practices on the unit to enable recommendations for changes to improve practice. The main aim of the audit was to assess whether PAT scores were being completed and documented when patients were receiving analgesia. In order to do this, we needed to find out how many patients were receiving analgesia or who had a need for pain assessment (ventilation and surgery). Methods: The comparative audit was taken at three points over a four-year period that focused on the practices of pain assessment on the unit. The bedside nurse allocated to each patient provided information, using the data collection sheet. Results: In 2008 48% were receiving analgesia, 12% ventilated, 12% had PAT scores documented and 4% patients had their pain discussed on the ward round. In 2009 52% were receiving analgesia, 23.8% ventilated, 42.8% had PAT scores documented and 4.76% had their pain discussed on the ward round. In 2011 48% were receiving analgesia, 36% ventilated, 68% had PAT scores documented and 36% had their pain discussed on the ward round. Conclusions: The first audit in 2008 showed that the number of patients who had documented PAT scores did not reflect the number that required pain assessment monitoring. Neonatal pain assessment education was implemented with the aim to improve practices. PAT score lanyards were produced as a reference for staff on the unit. The second audit in 2009 showed a slight improvement in the number of patients who had documented PAT scores. However, only a few patients had their pain management discussed during the ward rounds. Education continued and the importance of discussing PAT scores during ward rounds was highlighted during a management meeting. Neonatal pain assessment guidelines were created and made available to all staff at RCH. The 2011 audit results show overall improvements in the documentation of pain scores and that pain is discussed during ward rounds. Education and auditing of pain assessment should continue in order to maintain and further improve practices of pain management on the unit.

Source: EMBASE

Available in fulltext from Anaesthesia and Intensive Care at EBSCOhost

25. Hourly rounding implementation: A multisite description of structures, processes, and outcomes

Author(s) Rondinelli J., Ecker M., Crawford C., Seelinger C., Omery A.

Citation: Journal of Nursing Administration, June 2012, vol./is. 42/6(326-332), 0002-0443 (June 2012)

Publication Date: June 2012

Abstract: Objective: This study identifies structures, processes, and outcomes associated with hourly nurse rounding. Background: Literature supports that nurse rounding every 1 to 2 hours affects quality outcomes. Evidence is lacking regarding the process of successful implementation. Methods: Using an action research design, project leads implementing hourly rounding at 11 Southern California hospitals agreed to recorded telephone interviews. Transcribed interviews underwent content analysis. Results: Analysis revealed 15 major themes. Structure themes include use of rounding behaviors described through an acronym and collaborative phone call. Processes include a library of tools to use incorporating both patient and staff feedback. Patient satisfaction and patient perception of being well cared for are 2 common outcome themes. Conclusions: This study provides evidence that frequent reevaluation of structures and processes promote achievement of desired outcomes in relation to hourly rounding. The authors recommend abandonment of routinization and adoption of flexibility to sustain successful implementation of hourly rounding. Copyright 2012 Wolters Kluwer Health | Lippincott Williams & Wilkins.

Source: EMBASE
26. Regular ward checks raise standards of care

**Author(s)** Dean E.

**Citation:** Nursing management (Harrow, London, England : 1994), May 2012, vol./is. 19/2(12-16), 1354-5760 (May 2012)

**Publication Date:** May 2012

**Abstract:** This article reports on the introduction of intentional rounding at University Hospitals Coventry and Warwickshire NHS Trust. The approach was piloted and implemented on the initiative of two nurses in wards that ranged from orthopaedic to general medical. Intentional rounding aims to put patients at the centre of care and consists of checking on their condition at hourly or two-hourly intervals, recording their nutritional status and skin integrity, and asking if they need pain relief or help with eating. The introduction of the approach follows concerns about failures in care highlighted by a number of recent high-profile reports.

**Source:** EMBASE

Available in fulltext from Nursing Management - UK at EBSCOhost

27. A prospective observational study to evaluate the contribution of pharmacists to post take ward rounds

**Author(s)** Byrne S., Galvin M., Jago-Byrne M.-C.

**Citation:** International Journal of Clinical Pharmacy, February 2012, vol./is. 34/1(196-197), 2210-7703 (February 2012)

**Publication Date:** February 2012

**Abstract:** Introduction Pharmacists rounding with medical teams has been shown to have positive patient outcomes. A recently introduced clinical pharmacy model at our hospital involves pharmacists attending the post take ward round with the medical team. This study documented the number and nature of pharmacists’ contributions to the ward rounds. Materials & Methods For a series of ward rounds with different medical teams, pharmacists documented their activities on post take ward rounds, describing their activities and classifying them into different categories - medicines reconciliation; medicines information; dose adjustments; antibiotics; thromboprophylaxis and other activities. Results A total of 192 patients were seen by a pharmacist over the course of 12 ward rounds. Medication histories were available before the round for 86.5% of these patients. The mean number of pharmacist activities per post take ward round was 37. Of these activities, 65% were related to medicines reconciliation. The mean number of activities per round not related to medicines reconciliation was 13. There was at least one activity for 81.3% of patients seen by the pharmacist on the ward round. The median time spent on the round was 297.5 min (range = 110-420 mins). Discussions, Conclusion A team based clinical pharmacy model with pharmacist participation in post take ward rounds provides opportunities for pharmacists to contribute to patient care. Although the main reason for attending rounds was to improve medicines reconciliation, other activities are also important. Potential obstacles to pharmacist participation include availability of medication histories and early starts to ward rounds. The results of this study will be used to refine the clinical pharmacy model at Naas General Hospital.

**Source:** EMBASE

28. Putting local pharmacy research into clinical practice

**Author(s)** Jago-Byrne M.-C., Galvin M., Grimes T.

**Citation:** International Journal of Clinical Pharmacy, February 2012, vol./is. 34/1(184-185), 2210-7703 (February 2012)

**Publication Date:** February 2012

**Abstract:** Introduction The clinical pharmacy service in Naas General Hospital (NGH) was until 2010 configured around ward based pharmacists reviewing patient medication profiles.
Activity focused on monitoring and advising on the medications prescribed during the inpatient episode. Medication reconciliation was only undertaken in complex cases. Not all wards were covered including the A&E Department. Patients could remain for 48 h in A&E before reaching a ward, thereby timely access to pharmacy services was inequitable. An Irish government report recommended that healthcare organisations must prioritise the implementation of formal medication reconciliation systems. Materials & Methods Three pharmacy research projects were completed in NGH from 2008 to present. They are listed as follows: 1. Potential Hazards in the Medication Use Process at the Hospital Community Interface & a Strategy to Reduce Them. 2. The Contribution of Clinical Pharmacy to Admission Medication Reconciliation. 3. The Evaluation of Discharge Summary Prescription Forms - Their Role in Reducing Medication Error & Improving Communication at the Hospital-Community Interface. Results The following practice changes were implemented as a result of the studies listed in the methods: STUDY 1 - New discharge prescription form implemented. One layer of transcription eliminated. Drug histories documented for all patients STUDY 2 - Pharmacist in A & E January-June 2010. Attendance at post take medical ward rounds from July 2010. Documentation of gold-standard pre-admission medication list for all patients STUDY 3 - Discharge bleep for proactive review of prescriptions at time of writing. Research projects are currently underway, examining the effect of the resultant reconfiguration of clinical pharmacy services on both process and patient outcomes. Discussions, Conclusion The past three years have demonstrated the power of practice research to assist in the modification of services to improve patient care. When research is specific and current it supports change and facilitates pharmacy managers to sell new ways of working to their staff, other clinical disciplines and management. It will also provide an evidence base to protect current staffing levels in the difficult economic climate that exists in Ireland in 2011.

Source: EMBASE

29. 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

30. Development of an adhesive surgical ward round checklist; a technique to improve patient safety


Citation: Irish Medical Journal, November 2011, vol./is. 104/10(1-3), 0332-3102 (November/December 2011)

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, handover, and patient safety. Successfully implemented in a tertiary level centre in Dublin, Ireland it is easily transferable to other surgical departments globally.

Source: EMBASE

31. A daily goals checklist reduces CLABSI rates in the burn ICU

Author(s) Kenjale H., Craig C.K., Holmes J.H.

Citation: Journal of Burn Care and Research, March 2011, vol./is. 32/(S120), 1559-047X (March 2011)

Publication Date: March 2011

Abstract: Introduction: Approximately 250,000 inpatient central line associated bloodstream infections (CLABSI) occur annually in the US. CLABSI can prolong hospitalization, increase costs, and increase mortality. According to a 2009 CDC report, CLABSI costs the healthcare system up to ~$2.7 billion/year. The National Healthcare Safety Network (NHSN) has instituted guidelines to reduce the risk of CLABSI that include: hand hygiene, use of maximal sterile barriers, chlorhexidine site preparation, and the use of a Daily Goals Checklist (DGC). The DGC plays an important role in assessing the continued need for a central venous catheter (CVC), along with addressing other ICU interventions that have quality of care implications. Methods: At our institution, a dedicated Infection Control team prospectively monitors and collects CLABSI data, utilizing the CDC criteria for CLABSI. A Burn ICU DGC was designed and implemented on morning rounds starting in November 2008. One component of our DGC specifically addresses a patient's vascular access status and the need for, or continued need of, a CVC. Six-month rolling averages of CLABSI rates (CLABSI/1000 line days) were observed before and after implementation of the DGC. Results: Prior to implementation of the DGC, our 6-month rolling average CLABSI rate was 18.2 CLABSI/1000 line days. Following implementation, our rate has consistently declined, with a total of 14 identified CLABSI since November 2008. As of August 2010, our 6-month rolling average CLABSI rate is 2.5 CLABSI/1000 line days. We have already exceeded our FY2011 target of 3.1 CLABSI/1000 line days (NHSN 50th percentile) and have set our FY2012 goal at 1.2 CLABSI/1000 line days (NHSN 25th percentile). Conclusions: One important cause of CLABSI is the continued presence of the CVC when not absolutely needed for patient care, which may result from a lack of proper communication and planning between the different healthcare providers. A drastic reduction in CLABSI rates
has occurred in our Burn ICU since the implementation of a DGC completed during morning rounds. The deliberate exercise of completing the DGC demands evaluation, discussion, and justification for continuation of a CVC between the different healthcare providers. It has increased our awareness about prolonged CVC use and reduced our line days by prompting removal of the CVC when not absolutely required. This process has translated into a sustained reduction in our CLABSI rates.

Source: EMBASE

32. Development of an adhesive surgical ward round checklist: a technique to improve patient safety

Author(s) Dhillon P., Murphy R.K., Ali H., Burukan Z., Corrigan M.A., Sheikh A., Hill A.D.

Citation: Irish medical journal, November 2011, vol./is. 104/10(303-305), 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, handover, and patient safety. Successfully implemented in a tertiary level centre in Dublin, Ireland it is easily transferable to other surgical departments globally.

Source: EMBASE

33. Development and validation of an observation tool for ICU rounds


Citation: Chest, October 2011, vol./is. 140/4 MEETING ABSTRACT, 0012-3692 (October 2011)

Publication Date: October 2011

Abstract: PURPOSE: Morning rounds in the intensive care unit (ICU) enables multidisciplinary providers to interact and exchange information regarding patient care. ICU rounds are characterized by unique challenges including high acuity illness, frequent interruptions and processing of large quantities of highly dynamic data. These intersecting features complicate attempts to reliably characterize the structure and function of ICU rounds. Most existing studies have surveyed rounds participants, typically outside of the ICU setting. The aim of this study is to develop and validate a rounding observational tool that could be deployed in a working ICU environment by medically trained observers.

METHODS: Investigators designed a survey inquiring about ICU rounding practice and distributed it to all members of the multidisciplinary rounding team in a tertiary teaching hospital. Seventy five surveys were collected for a response rate of 71.4%. Answers were grouped thematically and used as a reference to define 13 discrete rounding tasks in three defined locations (bedside, outside room, remote). Specific definitions and standard of operation for each task were vetted by an expert group and integrated into a web-based tool with multiple timer/event interfaces. After initial training sessions the final version of the tool was calibrated and interobserver variability was calculated. RESULTS: Over a two month period two independent, trained observers performed 16 paired observations of individual providers during 27 hours of ICU rounds. Interobserver variability was assessed showing good to excellent task categorizations (Kappa 0.87). Associated Bland-Altman plots showed consistent agreement of major provider’s specific task duration, such as presentation (p=0.48, mean difference -0.02), discussion (p=0.21, mean difference -0.99), data gathering (p= 0.15, mean difference -0.39) CONCLUSIONS: This novel observation
tool for ICU rounds provides a reliable method to record real time performance of common ICU rounding tasks by multidisciplinary providers. CLINICAL IMPLICATIONS: The observation tool will be used to observe rounding practice in various ICUs in order to characterize the process and to develop strategies and interventions to improve the efficiency of ICU rounds.

Source: EMBASE
Available in fulltext at Chest; Notes: Username: ULHTKIS/Password: Library

34. Checklists to guide multidisciplinary intensive care unit rounds

Author(s) Newkirk M., Pampin J., Kuwamoto R., Allen D., Chung K.
Citation: Chest, October 2011, vol./is. 140/4 MEETING ABSTRACT, 0012-3692 (October 2011)
Publication Date: October 2011
Abstract: PURPOSE: Use of daily checklists during rounds in the intensive care unit (ICU) has previously been shown to improve compliance with evidence based practices, enhance physician-nurse communication, promote consistency of patient care, and improve outcomes. Checklists are often criticized because it is difficult to establish a causal link between checklists and how they exert their effects on outcomes. We sought to investigate how a daily checklist completed during multidisciplinary healthcare team (MDHCT) rounds affects discussions about patients during rounds. METHODS: This process improvement project was conducted in a surgical ICU (SICU) and a burn ICU (BICU) at an academic military medical center. Data were collected for 2 weeks before and 2 weeks after implementation of a "must address" checklist which contained up to 21 questions grouped according to patient population. During the 2 weeks prior to implementation, a recorder documented which items were addressed during MDHCT rounds without checklist items being read out-loud. Following implementation, the recorder documented which items on the checklist were addressed during MDHCT rounds before and after prompting by reading checklist items. RESULTS: Patient discussions addressed more checklist items before prompting at the end of the two week evaluation compared to the two week pre-implementation period (SICU 35% vs. 76%, BICU 43% vs. 71 % P<0.001). All items were addressed more or with the same frequency in both ICUs after implementation. Key items such as central line removal, reduction of laboratory testing, medical reconciliation, medication interactions, lung protective ventilation, sedation holidays and, breathing trials had significant increases. CONCLUSIONS: Implementation of checklists in the ICU setting modifies clinician communication patterns. This is the first clear documentation of an association between checklists and communication exchange during MDHCT rounds. We suspect that improved communication about patient care plans is one mechanism behind their effectiveness. CLINICAL IMPLICATIONS: Because they modify communication, checklists are powerful educational tools in an academic environment. It is imperative that careful consideration be given to their development so they contain appropriate questions.

Source: EMBASE
Available in fulltext at Chest; Notes: Username: ULHTKIS/Password: Library

35. Prompting physicians to address a daily checklist and process of care and clinical outcomes: A single-site study

Citation: American Journal of Respiratory and Critical Care Medicine, September 2011, vol./is. 184/6(680-686), 1073-449X;1535-4970 (15 Sep 2011)
Publication Date: September 2011
Abstract: Rationale: Checklists may reduce errors of omission for critically ill patients. Objectives: To determine whether prompting to use a checklist improves process of care and clinical outcomes. Methods: We conducted a cohort study in the medical intensive care unit (MICU) of a tertiary care university hospital. Patients admitted to either of two independent MICU teams were included. Intervention team physicians were prompted to
address six parameters from a daily rounding checklist if overlooked during morning work rounds. The second team (control) used the identical checklist without prompting. Measurements and Main Results: One hundred and forty prompted group patients were compared with 125 control and 1,283 preintervention patients. Compared with control, prompting increased median ventilator-free duration, decreased empirical antibiotic and central venous catheter duration, and increased rates of deep vein thrombosis and stress ulcer prophylaxis. Prompted group patients had lower risk-adjusted ICU mortality compared with the control group (odds ratio, 0.36; 95% confidence interval, 0.13-0.96; P = 0.041) and lower hospital mortality compared with the control group (10.0 vs. 20.8%; P = 0.014), which remained significant after risk adjustment (odds ratio, 0.34; 95% confidence interval, 0.15-0.76; P = 0.008). Observed-to-predicted ICU length of stay was lower in the prompted group compared with control (0.59 vs. 0.87; P = 0.02). Checklist availability alone did not improve mortality or length of stay compared with preintervention patients. Conclusions: In this single-site, preliminary study, checklist-based prompting improved multiple processes of care, and may have improved mortality and length of stay, compared with a stand-alone checklist. The manner in which checklists are implemented is of great consequence in the care of critically ill patients.

Source: EMBASE

36. Cardiology a ward rounds: Rationale of using a checklist

Author(s) Garg P.

Citation: Clinical Medicine, Journal of the Royal College of Physicians of London, June 2011, vol./is. 11/3(299), 1470-2118;1473-4893 (June 2011)

Publication Date: June 2011

Source: EMBASE

38. Lean analysis of a pediatric intensive care unit physician group rounding process to identify inefficiencies and opportunities for improvement

Author(s) Vats A., Goin K.H., Fortenberry J.D.

Citation: Pediatric Critical Care Medicine, July 2011, vol./is. 12/4(415-421), 1529-7535;1947-3893 (July 2011)

Publication Date: July 2011

Abstract: Objective: A physician group in a pediatric intensive care unit faced challenges when moving to a larger unit. Challenges included increased time for rounds, nonbillable attending physician hours, poor communication with pediatric intensive care unit staff, and meeting resident physician duty hours and teaching requirements. The purpose of this analysis was to identify waste and opportunities for improvement to improve physician efficiency. Design: Human factor (observational data collection) techniques were used to capture >60 hrs of rounding data. Twelve attending physicians and their rounding teams were shadowed to capture rounds on 130 pediatric intensive care unit patients. Rounding events, times, and patient interactions were recorded. Lean methods and scenario analysis were used to analyze the data and identify opportunities for improvement. Rounding events were categorized to determine value-added and nonvalue-added activities. Value-added activities were subclassified as essential or nonessential to morning rounds. Setting: Thirty-bed pediatric intensive care unit in a children's hospital with academic affiliation. Patients or Subjects: Eight attending pediatric intensivists and their physician rounding teams. Interventions: Eight attending physician-led rounding teams were observed for 12 rounding events and a total of 130 patient contacts. Measurements and Main Results: Large variation existed in the rounding process. Nonessential activities was highly correlated with physician preference and created a wide range in rounding time per patient. Essential activities showed the least variation and represents a "lean process." Scenario analysis was used to determine the impact of removing waste and reallocating the nonessential activities outside of rounds. Results of the analysis indicated that rounds could be reduced by 42% and that plan of care completion would be timelier (decreased from a mean of 157 to 82 mins). Conclusions: In a large physician group, essential activities showed the least variation. Practice variation focused on minimizing nonessential activities could have
dramatic impacts on standardizing practice. Further study is indicated to determine whether standardizing rounds to focus on essential activities can lead to more effective processes that require fewer resources while improving outcomes for all stakeholders. Copyright 2011 by the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies.

Source: EMBASE

39. A nurse-led ward round: Its contribution to patient care in an acute stroke setting

Author(s) Catangui E.J., Slark J., Paragas C.

Citation: International Journal of Stroke, December 2011, vol./is. 6/(59), 1747-4930 (December 2011)

Publication Date: December 2011

Abstract: Introduction: Stroke is a devastating condition. TheRCP (2008) highlights the fact that integrated stroke care can improve patient care. Nurses, being part of the multidisciplinary team, provide 24/7 stroke care from assessment to evaluation of the patient's condition. To improve the way nurses manage stroke patients in an acute setting, a nurse-led ward round is initiated to look at essential nursing care. Method: The Imperial College Healthcare Trust stroke nursing team of a clinical nurse specialist, a ward manager, and a charge nurse have organised a weekly stroke nurse led ward round on March 2011. The team take rounds to each stroke patient in the ward to assess, examine and evaluate the essential nursing care; oral care, skin integrity, continence, bowel/ bladder management, and current stroke outcome measures (barthel, MRs, BMI and mood assessment). During the rounds the team address nursing issues, make appropriate nursing goals and discuss the plans with the nurses. Results: Within three months of implementation, mouth care was regularly assessed and evaluated for presence of an oral thrush, pressure sore was prevented, medications such as laxatives, analgesia causing constipation and antiplatelets were reviewed, a bladder training to stroke patients was initiated as early as possible, stroke patients were assessed weekly using stroke outcome measures. Documentation has also improved. Conclusion: A nurse-led ward round has addressed nursing issues in a timely fashion. It also improves communication between and among nurses. It empowers the nurses to make decisions within their professional arena. Its contribution has an impact on patient care through prevention of stroke complications.

Source: EMBASE

40. 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 using 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.
41. In-patient record keeping in oral and maxillofacial surgery (OMFS) units in the West of Scotland: are we getting closer?

Author(s): Syyed N., Sood V., Holland I.

Citation: British Journal of Oral and Maxillofacial Surgery, June 2011, vol./is. 49/(S104), 0266-4356 (June 2011)

Publication Date: June 2011

Abstract: Background: Good quality record keeping is emphasised by the GMC, GDC and defence unions which have their associated guidelines. It is required, not only to keep a record of all treatment performed and adequate referrals, but also for the growing medico-legal implications. Aim and objectives: 1. To review the standard of record keeping. 2. To identify areas of deficiency. 3. To make recommendations for improvement and assessing outcomes. Method: 60 patient records were reviewed by a single investigator from three OMFS units, six months apart, looking at the same group of junior doctors. The standard of record keeping was compared against the CRABEL scoring system. Results: Overall adequacy for round 1 of the record keeping was 77% (range 42-96%). A number of areas were deficient during the first audit cycle, in particular; initial clerking and ward round entries. This was a consistent finding amongst all units. Record keeping was reinforced to the staff and the initial clerking pro-formas were modified and their use emphasized. The standard of record keeping did improve after the second audit cycle with the overall adequacy rising to 84% (range 64-96%). However, similar discrepancies were discovered during the 2nd cycle but to a lesser degree. Conclusions: Deficiencies in record keeping will always be present. Implementation of simple techniques and continual reminding/education of the importance of good record keeping may lead to improvement. Furthermore, randomised checks can be initiated to ensure records are being kept.

Source: EMBASE

42. Effects of nursing rounds on the quality of nursing documentation in oncology department of shahid sadeghi hospital

Author(s): Dehghani M., Nazmiya H., Dehghan A., Forat Yazdi M., Mirjalili M., Vafainasab M., Zare M., Borumand M., Vaghefi S., Ramazini A.

Citation: Pediatric Critical Care Medicine, May 2011, vol./is. 12/3 SUPPL. 1(A75), 1529-7535 (May 2011)

Publication Date: May 2011

Abstract: Introduction: Nursing documentation is an important part of clinical documentation. The documentation of the nursing process is an important but of ten neglected part of clinical documentation. Documentation is important for efficient communication within the healthcare professional team and for quality assurance. However, documentation of the nursing process is frequently lacking quality. This study aimed to examine whether the can improve documentation quality. Methods: A prospective intervention study with two time measurements was applied to receive answers to the quality of nursing documentation. Nursing documents were audited at two different points of time before and after nursing rounds. Results: The results show that nursing rounds can help improve the documentation of the nursing and fulfill legal requirements for documentation Conclusions: Interventions to improve documentation quality therefore need to be planed continuously and are a constant challenge.

Source: EMBASE

43. Keeping 'kids safe': Facilitating best practice in the PICU

Author(s): Ullman A., Long D., Horn D., Woosley J., Coulthard M.G.

Citation: Pediatric Critical Care Medicine, May 2011, vol./is. 12/3 SUPPL. 1(A16-A17),
Abstract: Background: The use of checklists in high risk areas, where errors can have severe implications for safety, have shown to reduce rates of error and increase adherences to best practice. In the PICU, seemingly innocuous actions or omissions can also result in serious consequences, eg. Leaving a CVL insitu when no longer required can potentiate a blood stream infection. Aim: In order to assess the efficacy of the 'KIDS SAFE' PICU mnemonic checklist in improving discussion and implementation of best practice principles, a quasi-experimental, time series design study was conducted. Results: Inclusion of all of the eight principles in the 'KIDS SAFE' checklist led to a statistically significant improvement in ward round discussion (p<0.05). Areas of clinical practice that were either newly introduced (eg. negotiated care agreements) or previously under acknowledged for their clinical importance in paediatrics (eg. head of bed elevation, pressure ulcer risk management) showed a statistically significant improvement in implementation post ward round (p<0.05). There was no statistically significant increase in handover duration after adjusting for number of patients (p=0.229). While there was mixed feedback regarding responsibility for the initiation of the checklist, multidisciplinary staff reported they felt it improved the care provided to patients (92.3%) and overall PICU management (84.6%). Implications: Given the complex and multidisciplinary nature of the PICU, comprehensive communication during ward rounds and clinical handovers is paramount. 'KIDS SAFE' is a tool that can be used by the team to ensure the quality of multidisciplinary communication, facilitating the reduction of human and system error by omission.

Source: EMBASE

44. Discuss now, document later: CIS/CPOE perceived to be a 'shift behind' in the ICU

Author(s) Collins S., Bakken S., Vawdrey D., Coiera E., Currie L.M.

Citation: Studies in Health Technology and Informatics, 2010, vol./is. 160/PART 1(178-182), 0926-9630;1879-8365 (2010)

Abstract: Effective communication is essential to safe and efficient patient care. We aimed to understand the current patterns and perceptions of communication of common goals in the ICU using the distributed cognition and clinical communication space theoretical frameworks. We conducted a focus group and 5 interviews with ICU clinicians and observed 59.5 hours of interdisciplinary ICU morning rounds. Clinicians used a CIS/CPOE system and paper artifacts for documentation; yet, preferred verbal communication as a method of information exchange because they perceived that the documentation was often not updated or efficient for information retrieval. These perceptions that the CIS/CPOE is a "shift behind" may lead to a further reliance on verbal information exchange, which is a valuable clinical communication activity, yet, is subject to information loss. Electronic documentation tools that, in real time, capture information that is currently verbally communicated may increase the effectiveness of communication. 2010 IMIA and SAHIA. All rights reserved.

Source: EMBASE
Available in fulltext from Studies in Health Technology and Informatics at EBSCOhost

45. Reducing falls in the stroke population of an acute care hospital: A performance improvement approach

Author(s) Stuart D., Rairigh-Wolfenbarger J., Jennings C., Tidwell J., Coggins D., Reed A., Rose D.

Citation: Stroke, April 2010, vol./is. 41/4(e255), 0039-2499 (01 Apr 2010)

Abstract: Background and Issues: Falls among stroke patients during hospitalization are a
major concern. The National average is 2.23 versus 7 South Neuro/Stroke Unit was 2.91. Risk factors include, being in a strange environment, altered mental status, altered nutrition, and confusion, muscle weakness, including balance and gait issues. The Neuro/Stroke Unit at the University of Tennessee Medical Center in Knoxville, Tennessee, launched a performance improvement (PI) team to address the falls rate among stroke patients. The PI team tested methods to reduce falls through evidence based practice. 

Methods: The team elected to use a 90 day, Plan, Do, Study Act model (P.D.S.A.). A "Near Miss" form was created to keep a daily log of at risk patients who attempted to get out of bed without assistance. This log was monitored in two week increments during the three P.D.S.A. cycle and evaluation. Strategies used to develop performance improvement plan included review of the most recent literature and brainstorming. The team determined that a valid more realistic approach was to alter the traditional unit routines rather than altering a characteristic of the population. The three P.D.S.A. cycles were: 1. Reschedule routine vital sign monitoring to allow more flexibility for staff to be available during high risk periods. 2. Coordinated patient assessment rounds prior to high risk periods. 3. Reference cards for float personnel including stroke risk factors, warning signs and patient care standards.

Results: A baseline measurement of "near misses" was evaluated for the period prior to the first P.D.S.A. cycle. The baseline count was 139 "near misses". At the end of the three P.D.S.A. cycles the "near miss" count was 10. In addition, the average monthly fall rate for 2008 was 2.91 and for the 90 day P.D.S.A. cycle the average monthly rate was 1.67.

Conclusions: The result of this project indicates that when staff restructures daily nursing care and activities to accommodate special needs of the stroke patient, fall rates and "near misses" can be dramatically reduced. The nursing team is more aware of the process of fall risk assessment, prevention and outcomes. This first hand knowledge has allowed the staff to focus more on developing a comprehensive plan of care which includes thorough education, more frequent, timely assessments, and ultimately, a safer environment.

Source: EMBASE

Available in fulltext from Stroke at Highwire Press
Available in fulltext from Stroke at the ULHT Library and Knowledge Services' eJournal collection

46. 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
47. A door communication tool did not improve the alignment of a multidisciplinary team’s goals for intensive care unit patients

Author(s) Pamplin J., Allen D., Linfoot J., Ainsworth C., Chung K.

Citation: Critical Care Medicine, December 2010, vol./is. 38/(A244), 0090-3493 (December 2010)

Publication Date: December 2010

Abstract: Introduction: Communication errors remain a major patient safety issue. Intensive care units (ICU) are high-risk environments where medical errors occur frequently. Establishing well understood daily patient care goals should improve multidisciplinary healthcare team (MDHCT) communication and may reduce errors in this environment. Hypothesis: Implementation of a daily goals “Door Communication Card” (DCC) will improve goal alignment between members of the MDHCT. Methods: This project was conducted in a 20-bed transitional model surgical ICU in a 450-bed academic military medical center. To establish a baseline frequency of goal alignment, we asked MDHCT members to "list your top four major goals" for a patient on a given day. Team members queried were the ICU attending, the bedside nurse, the on-call ICU resident, and the primary surgical chief resident. After initial data collection, DCC’s were placed on patients’ doors. Anyone was allowed to write on the card, but the “official” daily goals were recorded during multidisciplinary rounds (MDR). Goal discrepancies noted during MDR were reconciled with phone calls. One month after introduction of the DCC, MDHCT members were re-queried about their goals. Three reviewers (a nurse, an ICU attending, and a resident) independently assessed goal alignment. Results: We collected goals over a 4 month period and selected 5 random days before and after intervention for assessment. The goal alignment betweenMDHCT members was low before and did not improve after intervention (Attending-to-nurse36% vs. 29.6%, p = 0.0267; Attending-to-Resident 36.6% vs. 34.3%, p = 0.554; Attending-to-Primary 26.1% vs. 24%, p = 0.7971; Nurse-to-Attending 33.3% vs. 27.6%, p = 0.0373; Nurse-to-Resident 35% vs. 32.3%, p = 0.1307; Nurse-to-Primary 26.5% vs. 23.2%, p = 0.3558; Resident-to- Attending 38.4% vs. 35.5%, p = 0.3079; Resident-to-Nurse 35.5% vs. 29.4%, P = 0.0558; Resident-to-Primary 25.1% vs. 18.4%, p = 0.0516; Primary-to-Attending 25.7% vs. 28.4%, p = 0.5272; Primary-to-Nurse 27.5% vs. 30.5%, p = 0.7856; Primary-to-Resident 23% vs. 24.1%, p = 0.6255). Conclusions: Alignment of daily patient care goals between MDHCT members is low overall and did not improve after implementing a DCC available to all team members.

Source: EMBASE

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

48. A daily checklist can change intensive care unit hand hygiene culture

Author(s) Pamplin J., Kuwamoto R., Bradstreet H., Linfoot J., Chung K., Grathwohl K., Antonio S.

Citation: Critical Care Medicine, December 2010, vol./is. 38/(A145), 0090-3493 (December 2010)

Publication Date: December 2010

Abstract: Introduction: Hand washing compliance remains a major challenge to sustain in many hospitals. Many human factors and ergonomic approaches have been taken to...
enhance provider compliance with hand washing prior to and after touching patients and their proximate environments. Daily patient checklists in the intensive care unit (ICU) have previously been shown to improve compliance with a variety of evidence based interventions. Hypothesis: Adding a question to the daily ICU checklist about hand washing compliance before touching patients will improve healthcare team members' compliance and reduce central line associated bloodstream infections (CLABSI). Methods: This process improvement project was conducted in a 20-bed surgical ICU in a 450-bed academic military medical center. Data was collected for the three months before and three months after adding the following question to our daily ICU checklist: "Has anyone seen anyone else touch the patient without washing their hands in the past 24 hours?" Only two answers were allowed, "yes" or "no." The question was asked during multidisciplinary ICU rounds (MDR) for every patient as a part of our daily review checklist. If the question was answered "yes," we subsequently asked for a name of the offender and recorded it. Hand washing or alcohol dispenser usage prior to touching a patient or his immediate surroundings was considered compliant. The "offender list" was not published. Results: Hand washing compliance as measured by a third party observer from infection control significantly increased from 69% to 88% (p< 0.0001). We also observed a cultural shift in team member interactions: team members - including nurses, attendings, residents, technicians - began stopping each other from entering patient rooms unless they had confirmation that the provider had used alcohol hand cleanser or had washed their hands. The intervention was associated with a decline in CLABSI rates/1000 central line days (< 13.7 vs. 2.7, p < 0.09). Conclusions: A simple intervention can drastically improve overall hand-washing compliance in an intensive care unit and is thus far associated with a short term decrease in CLABSI.

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

49. 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
50. Improving teamwork during bedside rounds: Using daily goals and best practices

**Author(s)** Adamson M., Kure L., Duncan B., Holmes N., Amaral A.A.

**Citation:** Critical Care, 2010, vol./is. 14/(S152), 1364-8535 (2010)

**Publication Date:** 2010

**Abstract:** Introduction: Communication between healthcare professionals is a key step for patient safety, its failure accounting for over 60% of root causes in sentinel events [1]. Bedside rounds are important for teamwork communication and can be improved by an explicit approach [2] and by process-oriented information tools to organize and direct interprofessional rounds [3]. Methods: As part of a quality improvement project, we conducted an observation of the documentation of daily goals (DG) and best practices (BP) in a step-down unit (both tools have been previously added to patient flowsheets), before and after the introduction of a structured rounds process and team education. Our hypothesis was that these important tools were used before rounds, without input from all team members. Rounds were observed on two separate periods and the observer would take notes of whether DG and BP were documented or not and whether discussion took place before documentation. Differences in proportions between the two periods were analyzed with Fisher's exact test. P <0.05 was considered significant. Results: We observed 100 bedside interactions on each period. Documentation remained unchanged for DG (pre 55% vs post 53%, P >0.05) and BP (pre 57% vs post 48%); however, the second period had an improved documentation after team discussion (DG: pre 2% vs post 31%, P <0.001; BP pre 0% vs post 33%, P <0.001). Conclusions: The intervention aided in increasing documentation after discussion, implying an increased communication among the interprofessional team. About 50% of patients still will not have documentation after bedside rounds. Patient information was not collected, therefore our study is limited in providing information on clinical outcomes. Further research should focus on how to best implement these tools, how to qualitatively assess the content of daily goals and to demonstrate effects on patient-centered outcomes.

**Source:** EMBASE

Available in fulltext from Critical Care at National Library of Medicine

51. Does a post-take ward round proforma have a positive effect on completeness of documentation and efficiency of information management?

**Author(s)** Wright D.N.

**Citation:** Health Informatics Journal, 2009, vol./is. 15/2(86-94), 1460-4582;1741-2811 (2009)

**Publication Date:** 2009

**Abstract:** The post-take ward round (PTWR) involves the assessment of the latest intake of patients into the hospital. At a busy 400-bed city hospital it had been noted that PTWR notes had, in some cases, become overly brief and uninformative. Previous research had shown that proformas can improve the completeness of the records. So a new proforma was designed and introduced. Its impact on completeness of information was assessed by carrying out an audit of PTWR notes both with and without the proforma. The results showed statistically significant improvements in documentation when the proforma was used. They also showed an improvement in areas of efficiency of record management: for example, the proforma reduced the time taken to retrieve information from the notes, and most users said it saved them time recording in the notes and assimilating information and helped them to speed up patient transfers.

**Source:** EMBASE

52. Development and implementation of an ICU quality improvement checklist

**Author(s)** Simpson S.Q., Peterson D.A., O’Brien-Ladner A.R.

**Citation:** AACN advanced critical care, April 2007, vol./is. 18/2(183-189), 1559-7768 (2007 Apr-Jun)
**Publication Date:** April 2007

**Abstract:** Hospitals, especially their intensive care units, are not particularly safe for patients. Life-threatening mistakes and omissions in care can and do occur. To deter omissions and mistakes wherever possible, our medical intensive care team developed a checklist of care issues that must be addressed daily for every patient in our intensive care unit. The checklist augments our daily, multidisciplinary quality rounds and informs all personnel when important items have been missed. It is too soon to tell whether the checklist has had an impact on our survival rate or length of stay, but we have documented clear improvement in our attention to these core intensive care issues. In addition, our team's collegiality and team bonding are enhanced by using an evidence-based tool to achieve our care goals. We share our checklist, so that others can use and/or adapt it in their pursuit of optimal care for their critically ill patients.

**Source:** EMBASE

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53. **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. 5/4(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 (AMU) 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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54. **Paperwork for the busy interventionalist: The basic six**

**Author(s)** Smouse H.B., Harty P.

**Citation:** Seminars in Interventional Radiology, December 2006, vol./is. 23/4(319-328), 0739-9529 (December 2006)

**Publication Date:** December 2006

**Abstract:** Communication and patient care go hand in hand. Unfortunately, due to time constraints direct verbal communication with health care providers in every instance is not practical; it is also inefficient. Documentation is mandated by the Joint Commission on Accreditation of Healthcare Organizations and hospital bylaws. It reduces ambiguity and actually speeds communication between physician and hospital staff. Standard paperwork is recommended in most cases. Forms for patient admission, history and physical examination, daily patient rounds, preprocedural orders, consent form, discharge summary, and discharge orders allow the busy interventionalist to multitask with reasonable efficiency and fewer mistakes. Copyright 2006 by Thieme Medical Publishers, Inc.

**Source:** EMBASE

Available in fulltext from Seminars in Interventional Radiology at National Library of Medicine

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55. **A pilot study to test the use of a checklist in a tertiary intensive care unit as a method of ensuring quality processes of care**

**Author(s)** Hewson K.M., Burrell A.R.

**Citation:** Anaesthesia and Intensive Care, June 2006, vol./is. 34/3(322-328), 0310-057X (June 2006)
Publication Date: June 2006

Abstract: This pilot study aimed to test the use of a checklist as a method of ensuring that certain processes of care are performed routinely and systematically in a tertiary intensive care unit. The pilot involved the development of a process indicator checklist, its implementation and review. The checklist contained 16 items sourced from the literature or deemed important by local clinicians. Checklists were completed on the morning round for all adult patients admitted to the unit for approximately one month. Baseline and evaluation surveys were conducted with medical staff to assess both the benefits and shortcomings of using the checklist. Results demonstrated good compliance in completing the checklist (81%) and that when checked, certain aspects of care were not always delivered when appropriate. At the conclusion of the study the majority of medical staff believed that care in the intensive care unit actually improved with the use of the checklist, and all thought that it assisted in ensuring that good quality care was delivered. The checklist is a useful tool that can be readily applied to facilitate best practice and quality in everyday clinical care, ultimately leading to better health outcomes for patients.

Source: EMBASE

Available in fulltext from Anaesthesia and Intensive Care at EBSCOhost

56. Real time patient safety audits: Improving safety every day

Author(s) Ursprung R., Gray J.E., Edwards W.H., Horbar J.D., Nickerson J., Plsek P., Shiono P.H., Suresh G.K., Goldmann D.A.

Citation: Quality and Safety in Health Care, August 2005, vol./is. 14/4(284-289), 1475-3898 (August 2005)

Publication Date: August 2005

Abstract: Background: Timely error detection including feedback to clinical staff is a prerequisite for focused improvement in patient safety. Real time auditing, the efficacy of which has been repeatedly demonstrated in industry, has not been used previously to evaluate patient safety. Methods successful at improving quality and safety in industry may provide avenues for improvement in patient safety. Objective: Pilot study to determine the feasibility and utility of real time safety auditing during routine clinical work in an intensive care unit (ICU). Methods: A 36 item patient safety checklist was developed via a modified Delphi technique. Safety audits were performed using the checklist during and after morning work rounds thrice weekly during the 5 week study period from January to March 2003. Results: A total of 338 errors were detected; 27 (75%) of the 36 items on the checklist detected >=1 error. Diverse error types were found including unlabeled medication at the bedside (n = 31), ID band missing or in an inappropriate location (n = 70), inappropriate pulse oximeter alarm setting (n = 22), and delay in communication/information transfer that led to a delay in appropriate care (n = 4). Conclusions: Real time safety audits performed during routine work can detect a broad range of errors. Significant safety problems were detected promptly, leading to rapid changes in policy and practice. Staff acceptance was facilitated by fostering a blame free “culture of patient safety” involving clinical personnel in detection of remediable gaps in performance, and limiting the burden of data collection.

Source: EMBASE

Available in print at Grantham Hospital Staff Library

Available in fulltext from Quality and Safety in Health Care at National Library of Medicine

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

Author(s) Herring, Roselle, Caldwell, Gordon, Jackson, Steve

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

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 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. [Abstract]

**Source:** HMIC

### 58. IBCD: Development and Testing of a Checklist to Improve Quality of Care for Hospitalized General Medical Patients.

**Author(s)** Aspesi, Anthony V., Kauffmann, Greg E., Davis, Andrew M., Schulwolf, Elizabeth M., Press, Valerie G., Stupay, Kristen L., Lee, Janey J., Arora, Vineet M.

**Citation:** Joint Commission Journal on Quality & Patient Safety, 01 April 2013, vol./is. 39/4(147-156), 15537250

**Publication Date:** 01 April 2013

**Abstract:** Background: Several studies have demonstrated the usefulness of medical checklists to improve quality of care in surgery and the ICU. The feasibility, effectiveness, and sustainability of a checklist was explored. Methods: Literature on checklists and adherence to quality indicators in general medicine was reviewed to develop evidence-based measures for the IBCD checklist: (I) pneumococcal immunization, (B) pressure ulcers (bedsores), (C) catheter-associated urinary tract infections (CAUTIs), and (D) deep venous thrombosis (DVT) were considered conditions highly relevant to the quality of care in general medicine inpatients. The checklist was used by attending physicians during rounds to remind residents to perform four actions related to these measures. Charts were audited to document actions prompted by the checklist. Results: The IBCD checklist was associated with significantly increased documentation of and adherence to care processes associated with these four quality indicators. Seventy percent (46/66) of general medicine teams during the intervention period of July 2010-March 2011 voluntarily used the IBCD checklist for 1,168 (54%) of 2,161 patients. During the intervention period, average adherence for all four checklist items increased from 68% on admission to 82% after checklist use (p < .001). Average adherence after checklist use was also higher when compared to a historical control group from one year before implementation (82% versus 50%, p < .0001). In the six weeks after the checklist was transitioned to the electronic medical record, IBCD was noted in documentation of 133 (59%) of 226 patients admitted to general medicine. Conclusion: A checklist is a useful and sustainable tool to improve adherence to, and documentation of, care processes specific to quality indicators in general medicine.

**Source:** CINAHL

### 59. The safe and effective delivery of ward rounds.

**Author(s)** Tingle, John

**Citation:** British Journal of Nursing, 22 November 2012, vol./is. 21/21(1282-1283),
60. Adopting a systematic approach to the hospital wardround... "Implementation of a considerative checklist to improve productivity and team working on medical ward rounds" 16 (2).

Author(s)
Citation: Clinical Governance: An International Journal, 01 June 2011, vol./is. 16/2(0-0), 14777274
Publication Date: 01 June 2011
Source: CINAHL

61. Innovative solutions: optimal patient outcomes as a result of multidisciplinary rounds.

Author(s) Wilson FE Jr., Newman A, Ilari S
Citation: Dimensions of Critical Care Nursing, 01 July 2009, vol./is. 28/4(171-173), 07304625
Publication Date: 01 July 2009
Abstract: Multidisciplinary rounds have been shown to improve patient outcomes. The use of a standardized tool in one institution led to a pharmacy cost savings of more than 50,000 dollars and a decrease of 1.5 days for patients receiving mechanical ventilation.
Source: CINAHL

62. Improving nurse-physician communication and satisfaction in the intensive care unit with a daily goals worksheet.

Author(s) Narasimhan M, Eisen LA, Mahoney CD, Acerra FL, Rosen MJ
Citation: American Journal of Critical Care, 01 March 2006, vol./is. 15/2(217-222), 10623264
Publication Date: 01 March 2006
Abstract: OBJECTIVE: To evaluate the effect of a standardized worksheet on physicians' and nurses' perceptions of their understanding of goals of care and on patients' length of stay in an intensive care unit. METHODS: A worksheet was completed daily during multidisciplinary rounds and was posted at each bedside in the medical intensive care unit at Beth Israel Medical Center in New York. Information recorded included tests or procedures, medications, sedation, analgesia, catheters, consultations, nutrition, mobilization, family discussions, consents, and disposition. Attending physicians, residents, and nurses completed a questionnaire before implementation of the worksheet and 3 times afterwards. Responses were scored on a 5-point scale (1 = understand nothing, 5 = completely understand). Continuous variables were analyzed by using a t test; categorical variables, by using a chi(2) test. RESULTS: Before the worksheet was implemented, scores for understanding goals were 3.9 for nurses and 4.6 for physicians. Scores increased to 4.8 for nurses (P = .001) and 4.9 for physicians (P = .03) 6 weeks later, an improvement that remained at 9 months. Both groups showed significant improvement in communication scores that lasted for 9 months. Most responders wanted to continue using the worksheet. During the study, the mean stay in the unit was 4.3 days, down from 8.4
days for the analogous 9-month period in the preceding year (P=.02). CONCLUSION: Nurses' and physicians' perceptions of their understanding of the goals of care and of communication between them were improved and stays in the unit were shortened when the worksheet was used.

Source: CINAHL

Available in fulltext from American Journal of Critical Care at Highwire Press

Available in fulltext from American Journal of Critical Care at EBSCOhost

63. Real time patient safety audits: improving safety every day.

Author(s) Ursprung R, Gray JE, Edwards WH, Horbar JD, Nickerson J, Plsek P, Shiono PH, Suresh GK, Goldmann DA

Citation: Quality & Safety in Health Care, 01 August 2005, vol./is. 14/4(284-289), 14753898

Publication Date: 01 August 2005

Abstract: BACKGROUND: Timely error detection including feedback to clinical staff is a prerequisite for focused improvement in patient safety. Real time auditing, the efficacy of which has been repeatedly demonstrated in industry, has not been used previously to evaluate patient safety. Methods successful at improving quality and safety in industry may provide avenues for improvement in patient safety. OBJECTIVE: Pilot study to determine the feasibility and utility of real time safety auditing during routine clinical work in an intensive care unit (ICU). METHODS: A 36 item patient safety checklist was developed via a modified Delphi technique. The checklist focused on errors associated with delays in care, equipment failure, diagnostic studies, information transfer and non-compliance with hospital policy. Safety audits were performed using the checklist during and after morning work rounds thrice weekly during the 5 week study period from January to March 2003. RESULTS: A total of 338 errors were detected; 27 (75%) of the 36 items on the checklist detected >or=1 error. Diverse error types were found including unlabeled medication at the bedside (n = 31), ID band missing or in an inappropriate location (n = 70), inappropriate pulse oximeter alarm setting (n = 22), and delay in communication/information transfer that led to a delay in appropriate care (n = 4). CONCLUSIONS: Real time safety audits performed during routine work can detect a broad range of errors. Significant safety problems were detected promptly, leading to rapid changes in policy and practice. Staff acceptance was facilitated by fostering a blame free "culture of patient safety" involving clinical personnel in detection of remediable gaps in performance, and limiting the burden of data collection.

Source: CINAHL

Available in print at Grantham Hospital Staff Library

Available in fulltext from Quality and Safety in Health Care at National Library of Medicine

Some additional results to those above, from Medline

1. A Considerative Checklist to ensure safe daily patient review.

Author(s) Mohan N, Caldwell G

Citation: The clinical teacher, August 2013, vol./is. 10/4(209-13), 1743-4971;1743-498X (2013 Aug)

Publication Date: August 2013

Abstract: BACKGROUND: Ward rounds are complex clinical activities, and are an integral part of hospital life. Failures in care can have a direct consequence on patient safety. Recently, simulation ward rounds have allowed medical students and junior doctors to practise their skills in a safe environment, yet there is no commonly accepted and taught framework on how to conduct a ward round. CONTEXT: After the success of the WHO Surgical Safety checklist in reducing patient morbidity and mortality, Dr Gordon Caldwell designed a Considerative Checklist for his ward rounds to ensure a comprehensive patient review. Although it does not ensure that the clinical decision-making is adequate, it does
ensure that various hospital protocols have been adhered to, for example assessing patient venous thromboembolism (VTE) risk and prescribing prophylaxis. I spent 8 weeks as a part of Dr Caldwell's medical team, and during this time I was assigned the role of 'checker'. This role allowed me to actively participate in the ward rounds, and gave me a framework for the ward round that was easy to learn and follow. IMPLICATIONS: Clinical checklists have become integral to improving patient outcomes, and Dr Caldwell's checklist could be used to improve patient safety while they are in-patients. The Considerative Checklist could be a vital tool in teaching this skill to students and junior doctors, but further qualitative and quantitative research is required to investigate whether using the checklist improves student performance, learning and engagement on the wards, and whether this improves patient outcomes. 2013 John Wiley & Sons Ltd.

Source: Medline

3. 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

10. Prompting physicians to address a daily checklist and process of care and clinical outcomes: a single-site study.

Author(s) Weiss CH, Moazed F, McEvoy CA, Singer BD, Szleifer I, Amaral LA, Kwasny M, Watts CM, Persell SD, Baker DW, Sznaider Jl, Wunderink RG

Citation: American Journal of Respiratory & Critical Care Medicine, September 2011, vol./is. 184/6(680-6), 1073-449X;1535-4970 (2011 Sep 15)

Publication Date: September 2011

Abstract: RATIONALE: Checklists may reduce errors of omission for critically ill patients. OBJECTIVES: To determine whether prompting to use a checklist improves process of care and clinical outcomes. METHODS: We conducted a cohort study in the
medical intensive care unit (MICU) of a tertiary care university hospital. Patients admitted to either of two independent MICU teams were included. Intervention team physicians were prompted to address six parameters from a daily rounding checklist if overlooked during morning work rounds. The second team (control) used the identical checklist without prompting.

MEASUREMENTS AND MAIN RESULTS: One hundred and forty prompted group patients were compared with 125 control and 1,283 preintervention patients. Compared with control, prompting increased median ventilator-free duration, decreased empirical antibiotic and central venous catheter duration, and increased rates of deep vein thrombosis and stress ulcer prophylaxis. Prompted group patients had lower risk-adjusted ICU mortality compared with the control group (odds ratio, 0.36; 95% confidence interval, 0.13-0.96; P = 0.041) and lower hospital mortality compared with the control group (10.0 vs. 20.8%; P = 0.014), which remained significant after risk adjustment (odds ratio, 0.34; 95% confidence interval, 0.15-0.76; P = 0.008). Observed-to-predicted ICU length of stay was lower in the prompted group compared with control (0.59 vs. 0.87; P = 0.02). Checklist availability alone did not improve mortality or length of stay compared with preintervention patients.

CONCLUSIONS: In this single-site, preliminary study, checklist-based prompting improved multiple processes of care, and may have improved mortality and length of stay, compared with a stand-alone checklist. The manner in which checklists are implemented is of great consequence in the care of critically ill patients.

Source: Medline

15. Using post-take ward rounds to facilitate simple discharge.

Author(s) Lees L, Allen G, O'Brien D

Citation: Nursing Times, May 2006, vol./is. 102/18(28-30), 0954-7762;0954-7762 (2006 May 2-8)

Publication Date: May 2006

Abstract: This article discusses the evolution of simple discharge/transfer destination labels into a post-take ward round form. The aim was to improve the clarity of the management plan and discharge/transfer decisions including an estimated length of stay on the post-take ward rounds taking place on the emergency admissions ward.

Source: Medline

Available in print at Lincoln County Hospital Professional Library
Available in print at Grantham Hospital Staff Library
Available in print at Pilgrim Hospital Staff Library
Available in fulltext from Nursing Times at the ULHT Library and Knowledge Services' eJournal collection

18. Do post-take ward round proformas improve communication and influence quality of patient care?.

Author(s) Thompson AG, Jacob K, Fulton J, McGavin CR

Citation: Postgraduate Medical Journal, November 2004, vol./is. 80/949(675-6), 0032-5473;0032-5473 (2004 Nov)

Publication Date: November 2004

Abstract: The post-take ward round is a critical time for reviewing the initial history, examination and results, and the stage at which further treatment and investigations will be determined. However documentation of this ward round is often inadequate, so the benefits of decision making are lost. The documentation of 95 ward rounds was assessed for key items of information before and after the introduction of a proforma sheet. The introduction of the proforma led to a significant improvement in the documentation of a diagnosis, management plan, prophylaxis for deep vein thrombosis, and resuscitation status (p<0.05), which will have a significant impact on patient care.

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**
Available in fulltext from *Postgraduate Medical Journal* at **Highwire Press**

**Published Research - Google Scholar**

*From 1st fifty results:*

None above those included in the previous section.