Feature

Initiative to change ward culture results in better patient care

Tejal Desai and colleagues describe the benefits of improving communication between team members by ensuring nurses’ participation in consultant ward rounds

Summary

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

Keywords
Doctor-nurse communication, quality, safety, ward round

WARD ROUNDS are a complex multidisciplinary process because, for each patient, at least 18 essential factors must be considered (Herring et al 2011). The professional conversation that occurs between doctors and nurses is a main feature of the process, and needs to be perfected to avoid iatrogenic harm and increase efficiency.

Professional conversations between doctors and nurses are the cornerstone for good and safe patient care. However, due to the changing culture in the Nhs and reassignment of roles, nurse presence on ward rounds seems to be the exception rather than the rule, yet the level of nursing staff on wards has been shown to have a direct relationship to patient mortality (Needleman et al 2011).

The nursing role has changed immensely since the days of Florence Nightingale. Nurses not only ‘nurse’ the patient, but they also have to cope with paperwork and other ward pressures. Often they are unaware of the importance of their role in the ward round or feel that their presence is unnecessary (Sandler 2007). This culture needs to be altered to enhance patient care.

Doctors are equally to blame for this, because they do not always actively seek the presence of nurses on ward rounds (Salvage and Smith 2000). Doctors are taught how to communicate effectively with patients, but not with other health professionals (Manojlovich 2010). The traditional stereotypes of doctors and nurses need to be broken.

The Caldwell considerative checklist process (CCCP) (Herring et al 2011) was developed at Western Sussex Hospitals NHS Trust to help doctors and nurses improve patient care on the wards (Figure 1).

The end of each subsection of the checklist records whether a nurse was present during that phase. Data were collected on doctor-nurse communication during 146 routine consultant ward rounds between April 2009 and June 2010. Of these, 56 were ward rounds of new patient admissions (post-take rounds) and 90 were routine rounds.

The data are presented here to highlight the paucity of daily professional conversations and to encourage a change of culture on clinical wards.

Worthing Hospital is a district general hospital on the south coast of England and is part of Western Sussex Hospitals NHS Trust. There are roughly 10,000 acute general medical admissions a year, with a separate needs-related geriatrics service. Patients are referred to the hospital’s acute medical unit (AMU) by GPs or after assessment in the emergency department. The hospital does not have a specific short-stay unit and patients admitted to AMU are transferred on to higher care, ward-based specialty teams or discharged.

In the ward-based service where routine rounds take place, consultant physician in endocrinology and diabetes Gordon Caldwell has up to 18 patients on one ward and three patients on another. He conducts post-take ward rounds in the AMU.
once a week, plus one weekend in 14. All of his consultant-led rounds are conducted in two phases: the preparatory stage consists of discussion of patient cases and results in a semi-private area, and the second phase allows the patient to be reviewed at the bedside with one member of the medical team using the CCCP to ensure complete patient review, including noting whether a nurse was present.

The team thought that the gold standard for communication with nurses on ward rounds was having a nurse present and participating during the preparatory discussion and at the bedside. The authors consider that the presence of a nurse on the ward round should be a quality indicator in acute care. This would allow clinicians and managers to work towards performing better. It not only emphasises the importance of professional relationships with each patient, but also supports the notion of teamwork with nurses playing a prominent role.

The CCCP allows the hospital to audit nurse presence on ward rounds while letting clinicians set and maintain associated standards. It has encouraged doctors to take active steps to speak with a nurse on daily rounds and improved the quality and frequency of interprofessional conversations.

**Results**

Table 1 presents data collected from 90 routine and 56 post-take, consultant-led ward rounds using the CCCP to identify frequency and quality of doctor-nurse conversations.

A total of 1,921 patient reviews were undertaken. A nurse was present during the preparatory discussions in 604 (31 per cent) cases and present at the bedside to participate in the professional conversations with the patient in 1,134 (59 per cent) reviews.

The doctors were unable to find a nurse to whom they could report back on the ward in 306 (16 per cent) patient reviews. This occurred most frequently during visits to so-called outlying wards, where there is a greater risk of poor or non-existent communication. In many cases, nurses on these wards do not have the same level of expertise in general medicine as those on our ‘home wards’. However, even on the AMU, the authors were unable to find a nurse to whom to report back in 85 (12 per cent) patient reviews.

These data have been used to make improvements in ward rounds. Rounds are now stopped to find a nurse to whom doctors can at least hand over, if not invite to join the ward round. In the AMU, a noon conference takes place after post-take rounds. The conference is attended

<table>
<thead>
<tr>
<th>Type of round</th>
<th>Number of rounds</th>
<th>Number of patient reviews</th>
<th>Nurse at preparatory discussion</th>
<th>Nurse at bedside review</th>
<th>No report back to nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-take</td>
<td>56</td>
<td>713</td>
<td>166 times</td>
<td>450 times</td>
<td>85 times</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>23.3%</td>
<td>63.1%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Routine</td>
<td>90</td>
<td>1208</td>
<td>438 times</td>
<td>684 times</td>
<td>221 times</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>36.3%</td>
<td>56.6%</td>
<td>18.3%</td>
</tr>
<tr>
<td>Total</td>
<td>146</td>
<td>1921</td>
<td>604 times</td>
<td>1,134 times</td>
<td>306 times</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>31.4%</td>
<td>59.0 %</td>
<td>15.9%</td>
</tr>
</tbody>
</table>
by two consultants, the most senior nurse on duty, junior doctors, a pharmacist and a social worker. Every case admitted to the AMU in the preceding 24 hours is discussed briefly, ensuring that there is always a ‘report back to nurse’.

Communication is oral and written: all members of the multidisciplinary team now keep their notes in the same drawer for each patient, although the files for doctors’ notes remain separate from the physiotherapy, occupational therapist and nurse notes.

Discussion

The hospital has continued to use the CCCP on ward rounds and a brief initial analysis of the data suggests that the number of daily professional conversations has increased. Senior nurses have committed to providing a nurse at the bedside for every consultant-led ward round. If a nurse is present, he or she should be an active participant and contribute to professional conversations. Later, the nurse is able to return to clarify issues with patients and relatives, and allay fears and concerns. The nurse then hands over important aspects of care to the next nursing shift.

Since June 1 2010, the ward-round team in the AMU has been able to report back to a nurse 100 per cent of the time via the daily noon conference. However, this is only to the lead nurse, who then communicates the information to the relevant nurses on the ward. On 148 occasions (76 per cent), we also had a nurse at the bedside; the shortfall seems to have been the result of staff shortages. By presenting our initial data collected using the CCCP to the nurses, AMU staff now try to provide one nurse per post-take ward round.

On August 9 2010, Dr Caldwell’s specialty cases were moved to a single-unit ward where data were collected on 44 consultant rounds involving 797 patient reviews. We were able to speak to a nurse before the ward round on 193 occasions (24 per cent). A nurse was present at the bedside on 541 occasions (68 per cent) and we were able to report back to a nurse after the ward round on 192 occasions (94 per cent).

This shows how the combination of the CCCP and working on a single-unit ward can improve the frequency of professional conversations between doctors and nurses. We now need to start having a nurse presence on junior doctor ward rounds. Anecdotally, patients have stated that they feel ‘safer’ and that nothing is overlooked when the CCCP is used on ward rounds.

These data demonstrate an urgent need to change the culture on our wards to improve professional conversations between doctors, nurses and patients. The authors suspect that similar problems are common in other hospitals, but that senior managers have not realised the paucity of communications between frontline healthcare professionals. Without this foundation in place, the whole structure and process of patient care can become unstable.

Industries, such as aviation and motor racing, use debriefings and checklists to improve safety (Salas et al 2001). They have an excellent safety record and can be used as a blueprint to help us improve patient safety. Doctors have been slow to adopt such teamworking processes, although one checklist that is widely used in the medical profession is the World Health Organization Operating Theater Checklist (National Patient Safety Agency 2009). With proper use, this has been shown to reduce mortality in surgery. Something as cheap, simple and straightforward as communicating with nurses could help to improve patient safety.

We live in a culture in which each specialty has its own set of patient notes, but there is considerable debate between allied health professionals in our hospital about keeping interdisciplinary patient notes. For example, the Chartered Society of Physiotherapy (CSP) advocates using them so long as the notes conform to CSP standards (CSP 2000). However, this may be a barrier to effective communications between health professionals. A multidisciplinary team trolley, such as the one...
used by our team, can be one way to overcome communication difficulties.

Our figures confirm that health professionals are poor at handing over to colleagues, which can compromise patient safety. Our performance in finding a nurse on our ward at any point of the ward round has increased due to use of the CCCP; this obliges us to at least try to find a nurse before, during and after the bedside review.

The consultant soon became aware that the use of the CCCP encouraged the team to search out nurses with whom to talk, and that this was a change in practice. Relatives often approach nurses as the first point of contact on a ward. If nurses are not present on the ward round, this may make it harder for them to understand the clinical thinking of doctors, leading to miscommunication to patients and relatives.

One school of thought (Callander-Grant 2000) is that bringing back the role of clinical matron would enforce structure and guidelines in the nursing team, ringfencing time in a nurse’s schedule to regularly attend ward rounds. This team has considerable support from senior nurses who have tried to increase their nursing presence on ward rounds. We will continue to use CCCP on ward rounds to ensure we have 100 per cent nurse presence. Once this target is reached, we will continue to use CCCP to ensure standards are maintained.

Conclusion

Poor communication is often the cause for many official complaints, as well as preventable deaths (Martin et al 2010) – nurse presence has been shown to be related to inpatient mortality (Needleman et al 2011). High quality professional conversations between doctors, nurses and patients are the cornerstone of patient safety.

The data presented in this article demonstrate worrying deficiencies in the quantity and quality of professional conversations between doctors and nurses on ward rounds.

A noon conference on the AMU has resolved some of these issues. We propose that the presence of a nurse on the ward round should be used as a national quality indicator, which would drive clinicians and managers to improve the quantity and quality of such professional conversations.

Patient safety is paramount. We have demonstrated a quick and effective method to improve patient care and communication between healthcare professionals. Good, effective communication, oral and written, is vital to enhancing patient safety and providing an optimum service to our patients.

Implications for practice

- Professional conversations between doctors, nurses and patients are paramount for patient safety.
- The traditional stereotypes of doctors and nurses not communicating must be broken.
- Using a checklist, such as the Caldwell considerative checklist process, can help to enhance doctor-nurse professional conversations.
- Time needs to be ‘ring-fenced’ for nurses to attend regular ward rounds.

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References


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