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Ward rounds in medicine

Principles for best practice

A joint publication of the Royal College of Physicians and Royal College of Nursing

October 2012

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Authors
Varo Kirthi, Jane Ingham, Caroline Lecko, Yogi Amin, R Mark Temple, Suzie Hughes, John Soong, Lynne Currie, Lesley Duff, Liz Lees, Gordon Caldwell, Tejal Desai, Roselle Herring, Zeinab Abdi, Kevin Stewart, Linda Patterson, Janet Davies.

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Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE
www.rcplondon.ac.uk

Registered charity no 210508

Royal College of Nursing
20 Cavendish Square
London W1G 0RN
www.rcn.org.uk

Designed by James Partridge, Corporate Communications and Publishing Department, Royal College of Physicians

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1 RCP/RCN joint foreword

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

Despite being a key component of daily hospital activity, ward rounds remain a much neglected part of the planning and organisation of inpatient care. There remains considerable variability in both the purposes and conduct of ward rounds, with nurses often invisible in the process. The importance of these clinical events to patients is often underestimated, along with the direct impact ward rounds have on clinical and emotional outcomes for patients.

Given the importance of this clinical area, work was jointly undertaken by the Royal College of Nursing (RCN) and the Royal College of Physicians (RCP) to establish best practice principles for medical ward rounds. A multiprofessional workshop was used to review research evidence of ward round practices, discuss examples of current best practice and identify principles of high-quality care. Following these deliberations, a series of recommendations for safe and effective delivery of ward rounds were developed, which are set out in this guidance document.

Identifying principles for best practice in ward rounds can improve patient safety, patient experience, shared learning, collaborative working and efficient use of resources. However, the success of the approaches outlined by this document requires a concerted cultural change, with clinical staff, managers and hospital executives all fully engaged and focused on improving the quality of rounds.

In summary, this guidance document carries an important message: ward rounds need to be restored to a position of central importance in how we collectively care for and communicate with patients. Despite the complexity of the processes involved, the significance of opportunities presented on ward rounds is often underestimated. Doctors and nurses need to understand the wider impact of their approaches to ward care, whilst managers and the executive board bear a responsibility to protect time and resources, enabling all members of the multiprofessional team to prioritise the ward round.

The RCN and RCP would like to acknowledge the contributions of all individuals involved in the production of this guidance. ■

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2 Background

There is no single agreed definition of a 'medical ward round'. However, it can be described as a complex clinical process during which the clinical care of hospital inpatients is reviewed.[1] This process includes:

1 establishing, refining or changing the clinical diagnoses
2 reviewing the patient's progress against the anticipated trajectory on the basis of history, examination, NEWS (national early warning score)[2] and other observations, and results of investigations
3 making decisions about future investigations and options for treatment, including DNAR (do not attempt resuscitation) and any ceilings of care
4 formulating arrangements for discharge
5 communicating all of the above with the multidisciplinary team, patient, relatives and carers
6 active safety checking to mitigate against avoidable harm
7 training and development of healthcare professionals.

Despite the necessity for organised, regular, clinical reviews of hospital inpatients, there is a clear paucity of quality indicators and evidence guiding best practice for medical ward rounds. There is considerable variability in the organisation, efficiency, quality and patient experience of ward rounds.

Ward rounds are critical to developing rapport and building trust with patients, while discharging a duty of care. Ward rounds also enable all individuals involved to express a shared aspiration to make the patient the centre of attention, empowered in his or her own care.

Significant advances in diagnostic and therapeutic possibilities over the past few decades have created a complex modern hospital environment. By contrast, traditional ward-round structures are predicated on the premise of a single team being responsible for the care of a patient, from admission to discharge. This is no longer the case. Determining how best to adapt the traditional ward-round process to suit a continually evolving, complex system remains the key challenge.

This guidance sets outs core recommendations and principles for best practice for conducting medical ward rounds, reflecting best available current knowledge of multiprofessional working.[3]

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3 Challenges

a Multidisciplinary working

i Barriers to effective team working

Medical ward rounds require the concerted, coordinated collaboration of several healthcare professionals. However, the modern hospital environment has multiple challenges and barriers to effective team working that must first be negotiated.

Continuity of care has been compromised by: frequent transfers of patients between wards, departments and specialty teams; frequent changes in lead consultants; and poor handover practice. Furthermore, since the introduction of the European Working Time Directive, doctors now spend less time attached to a single team. This combination of factors, compounded by loss of the 'firm structure', has had a profound impact on staff morale, opportunities for learning and patient safety.[4,5] Such evidence is a strong driver to revising traditional ward-round practices.

ii Valuing the team

Multidisciplinary ward rounds are often inadequately prioritised by doctors, nurses and other healthcare professionals, with staffing models reflecting this. However, the delivery of high-quality, patient-centred care requires the concerted efforts of many healthcare professionals, with growing evidence that effective multidisciplinary team working improves patient outcomes.[3,6,7] Organisations should have processes in place for ensuring that adverse factors preventing full multidisciplinary engagement (eg staffing issues) are escalated before the ward round commences.

iii Nurse at the bedside

Nurses have a crucial role on ward rounds, not only sharing key information between the patient and the healthcare team, but also supporting patients in articulating their views and preferences. Absence of a nurse at the bedside has clear consequences for communications, ward-round efficiency and patient safety. Although time pressures have grown for all professions, the responsibility to set aside time for ward rounds should be a collective one for doctors, nurses, pharmacists and therapists. This can and should be negotiated by local teams.

Recommendations for multidisciplinary involvement

- **Ward rounds should be seen as a priority by all members of the multiprofessional team.**
- **A senior nurse should be present at every bedside patient review as part of the ward round.**
- **The senior nursing team should be informed of all key decisions made on the ward round.**
- **Planned, dedicated time should be set aside for multidisciplinary ward rounds.**

iv Communication

Ward rounds require strong leadership, with all members of the team aware of their individual roles and responsibilities, and engaged in the ward-round process. Development of good working relationships between healthcare professionals not only strengthens communication channels but also cultivates a team culture. Frequently, outcomes after the ward round involve actions and information that need relaying to professionals not present on the round. Failure to communicate these actions is one of the principal reasons for discontinuity of care as perceived by the patient.

Evidence from observational studies suggests that explicit communication (for example task allocation, prioritisation of patients and task ownership) facilitates behaviours associated with patient safety (for example prescription of thromboprophylaxis, removal of unused cannulae, etc).[8] All members of the ward-round team should adopt a structured approach to communication, for example SBAR (situation, background, assessment, recommendation) for verbal handover, or a structured proforma for written forms of communication.

Recommendations for effective team working

- **Staffing issues and other adverse factors should be identified before the ward round.**
- **To engage all members of the ward-round team in the process, individual roles and responsibilities should be allocated at the start of the ward round.**

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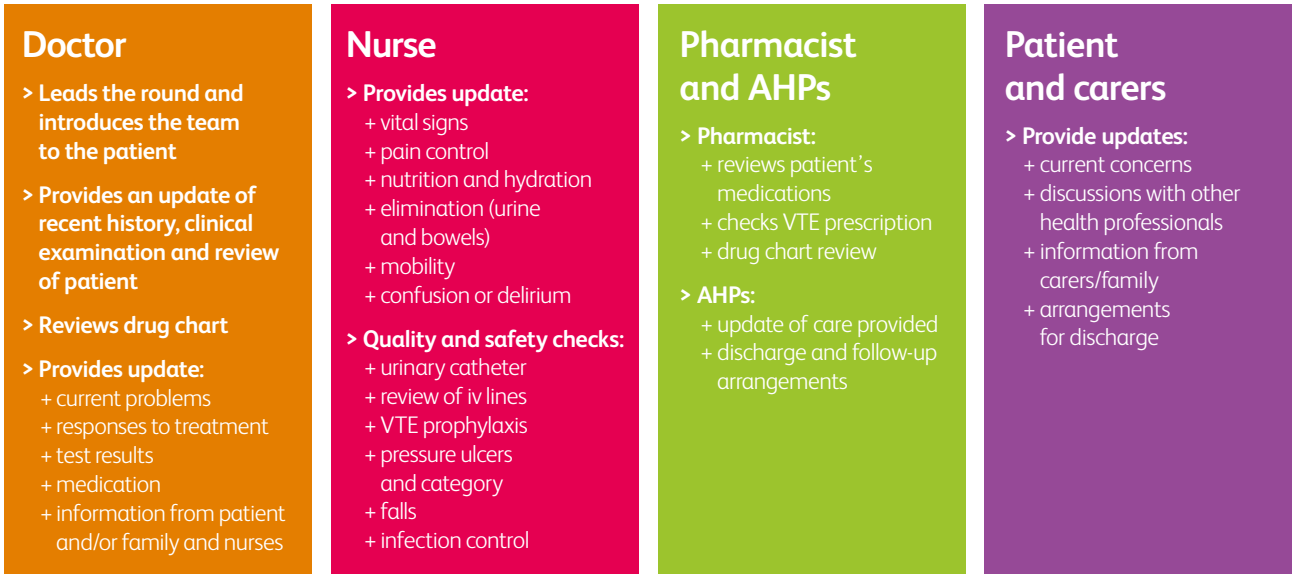
v Team roles

The multidisciplinary team includes doctors, nurses, allied health professionals and pharmacists. Other members may be co-opted into the ward round as appropriate to the patient group. All members of the team should have the opportunity to actively interact as part of the ward-round process. Figure 1 outlines the possible roles for each team member on a multidisciplinary ward round.

Fig 1 Example of team roles on a multidisciplinary ward round. AHP = allied health professional; iv = intravenous; VTE = venous thromboembolism.



Source: Stein JM. *Structured interdisciplinary bedside reviews*. Emory University School of Medicine, 2011. www.crepatientsafety.org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonsteinsession2.pdf

vi Board rounds

Medical staff are now increasingly using 'board rounds', usually held next to an 'at-a-glance' white board, away from the bedside. Board rounds provide an opportunity for multidisciplinary teams not only to prioritise bedside reviews, but also to deal with non-medical issues, such as discharge planning, in a timely fashion. These rounds can also provide a chance for the team to rapidly review any outstanding medical or nursing issues, eg communications between the nursing staff and the relatives, input from other healthcare professionals. Board rounds conducted at the end of the ward round can provide an opportunity for the team to summarise all issues relating to patients' care, identify and prioritise tasks, and delegate responsibilities appropriately. The arrangement of board rounds should address the specific needs of the patient, maximise the effectiveness of time spent by the bedside and minimise any disruption to the process of daily patient reviews.

Recommendations for board rounds

> **Board rounds should be used to facilitate multidisciplinary input and prioritise bedside reviews.**
> **Consultant-led afternoon board rounds can help facilitate planning for next-day discharge.**
> **Board rounds should not replace face-to-face clinical reviews with patients.**

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vii Intentional rounds

Ward-round teams should also be aware of the complementary role of intentional nursing rounds, particularly in acute care settings. Also referred to as 'proactive patient rounds', intentional rounds are structured, evidence-based processes for nurses to carry out regular checks with individual patients at set intervals. This approach not only addresses essential care needs and patient experience, but also helps teams organise their workloads on the ward.[9] Key aspects checked during intentional rounds include the 'four Ps':

Positioning
> Making sure the patient is comfortable and assessing the risk of pressure ulcers

Personal needs
> Scheduling patient trips to the bathroom to mitigate against falls

Pain
> Asking patients to describe their pain level on a scale of 0 to 10

Placement
> Making sure that the items a patient needs are within easy reach

b Structuring the ward round

i Preparation

Before the ward round, a period of preparation is required. Nurses should familiarise themselves with patients' cases and be aware of issues that need to be raised on the round. A phase of pre-ward-round activity, including pre-discussion with the patient where appropriate, will help facilitate this.

ii Pre- and post-round briefings

Finding time to brief the ward-round team is a key leadership task. The value of this in protecting time and resources for rounds should not be underestimated. All members of the ward-round team should be aware of the aims of the ward round, which can vary according to which stage the patient is at during his or her hospital admission (Fig 2). Depending on the requirements of the review, the team can decide whether all decision-making has to happen by the bedside, or whether some functions can be achieved away from the patient and subsequently communicated to the patient/carers via an alternative route.

Similarly, after a patient encounter, brief discussions to review arising actions can ensure appropriate delegation of necessary tasks. Deciding who is responsible for which action is critical to the effectiveness and value of the round. A more comprehensive debrief should be conducted at the end of the ward round.

Recommendations for ward-round briefings

> **Preparation for the ward round should include a pre-round briefing.**
> **All members of the ward-round team should be debriefed after the ward round.**

Fig 2 Types of structured inpatient bedside reviews.

> Initial senior review of patient's immediate medical needs

> Follow-up review by a consultant (the post-take review)

> Schedule daily clinical review

> Pre-discharge review

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iii Scheduling

Appropriate timing of ward rounds is crucial in ensuring that clashes do not occur with other scheduled activities such as drug rounds, mealtimes or visiting hours. Due to the heterogeneous allocation of beds, it is not uncommon for (1) a single ward round to involve visits to several different wards, and (2) different medical teams conducting simultaneous ward rounds in the same ward. This can create resourcing and efficiency issues, eg lack of a senior nursing presence on every ward round and time wasted commuting to wards.

Recommendations for scheduling

- **Consultants and senior nursing staff should negotiate appropriate scheduling of ward rounds.**
- **The allocation of beds should minimise the number of 'outlier' patients for any given team.**
- **Where possible, ward rounds should not occur simultaneously on the same ward.**
- **Consultant-led ward rounds should be conducted in the morning to facilitate timely completion of tasks during the working day.**

iv Resourcing

Before starting the ward round, the team should identify and introduce themselves, determine how many patients there are to be seen and where the patients are located. The workload should be prioritised, identifying unwell patients who may need to be seen first or other patients awaiting imminent discharge.

To optimise the ward-round process, all patient notes, results, request cards and continuation sheets should be made available to the team at a central point, eg a bedside trolley. There is often no dedicated work space for doctors, nurses and other healthcare professionals. This can risk inadvertent breaches in confidentiality, reduce ward-round efficiency and also endanger patient safety. The ward-round team should have designated desk space to work, including exclusive, protected access to an IT device to access electronic data.

Recommendations for resourcing

- **The ward-round team should have prioritised access to IT facilities, patient notes and desk space, and also have a designated area to discuss patient care away from the bedside.**

v Training, education and audit

Being a ubiquitous feature of daily inpatient care, ward rounds present a vital opportunity for all healthcare professionals to participate in education, training and clinical audit.[10] Responsibility lies with consultants and senior nursing staff to ensure that ward rounds are appropriately introduced, structured and led to provide educational opportunities for all trainees. Collecting and facilitating access to local outcome data can streamline clinical audits and promote collaborative improvements to patient care.

Recommendations for training, education and audit

- **Ward-round organisation should be included in the local induction for all new healthcare staff.**
- **Training and education needs should be identified and promoted on ward rounds.**
- **Facilitating access to local outcome data will promote improvements to care from clinical audit.**

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c Patients' and carers' roles

i Communicating with patients

Ward rounds present a vital opportunity to build trust and rapport with patients. Healthcare professionals should not underestimate the importance of interactions on the ward round from the patient's perspective. Even if a particular patient is not due to be seen on the ward round, it should not be assumed that the patient knows and understands why. Patient anxiety is often focused on what information is not given, rather than what is communicated.

Frequently the patient and/or carer is ill-prepared for the ward round. Providing adequate information through sheets of frequently asked questions and leaflets on diagnostic tests can help prepare patients for the discussions with the ward-round team. Patients should also be informed of who will be seeing them on the ward round, and provided with a point of contact (eg the ward sister), with whom they can raise questions after the ward round.

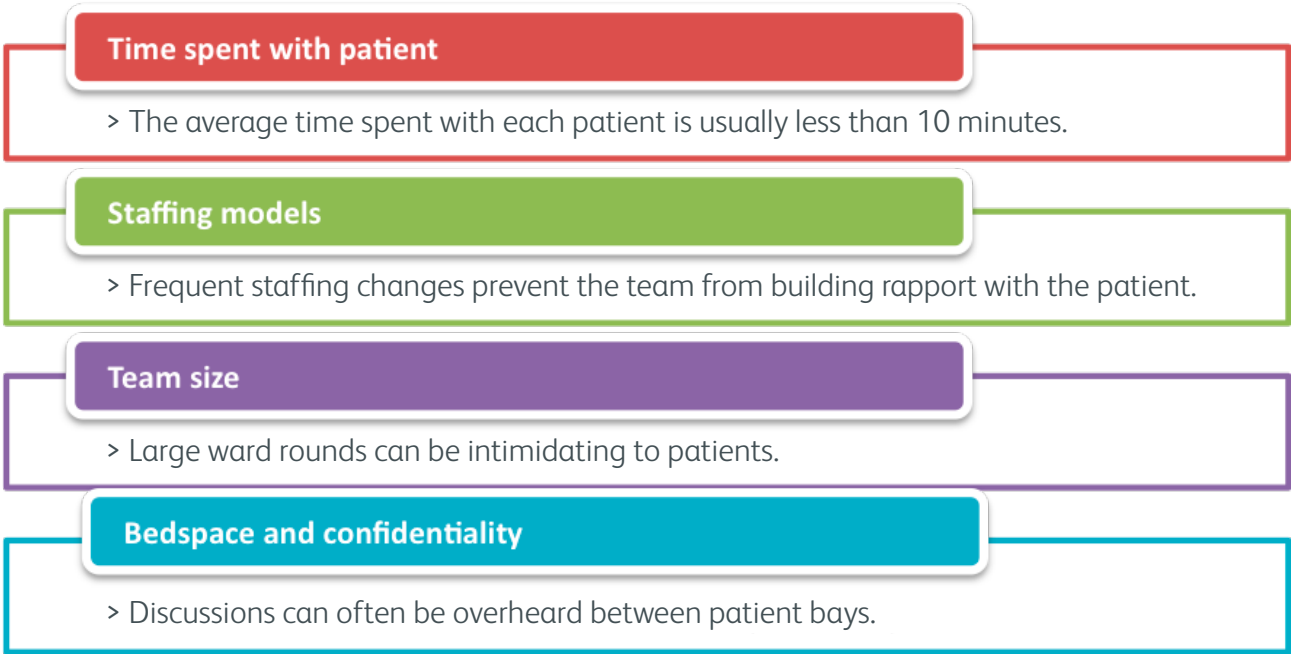
Dedicating time by the bedside to provide clear explanations about symptoms and disease severity, and to answer even the simplest of questions can remove a patient's fear and anxiety, and aid recovery. Communicating information in an easily comprehensible manner can also support shared management with the patient, and build scope for future self-management at the point of discharge. In taking this approach, less time is wasted revisiting cases where information has been missed or misunderstood. Similarly, producing a written summary of important information discussed on the ward round can be an invaluable aid for the patient, carer or relative to read and revisit at a later point.

Opportunities should be provided to discuss the patient's care (with consent) with relatives or carers in a confidential setting, away from the bedside. Allowing relatives and carers to 'book' to see consultants at a mutually convenient time can facilitate good communications and mitigate potential disputes, particularly when such individuals are unable to attend the ward round. Figure 3 highlights some common barriers that impair communications with patients.

Recommendations for communicating with patients

- **Patients should be encouraged to prepare in advance for ward rounds.**
- **Patient, carers and relatives should be provided with a 'summary sheet', detailing in a clear manner information discussed on the ward round that can be revisited at a later point.**
- **Consultants should allow relatives to arrange to see them at mutually convenient times.**

Fig 3 Barriers to communicating with patients.[8]



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ii Protecting vulnerable patients

Inpatient populations increasingly consist of frail older patients, with estimates of the prevalence of dementia as high as 25% in this cohort.[11] Healthcare professionals should be aware that capacity is context specific. Patients with dementia and learning disabilities should be supported as far as possible to make decisions about their care, with dedicated time provided to communicate information to carers and relatives. If a patient lacks capacity to make specific decisions about his or her care, multidisciplinary team meetings and careful discussions with carers and relatives should guide the team to make decisions in the patient's best interests.

Nurses and junior doctors are well positioned to ensure that their patients' needs are identified and articulated during the ward round, and actions taken to address these needs are appropriately documented and communicated in subsequent ward rounds. This should not replace the collective responsibility that all healthcare professionals bear towards patient care. Nurses should gain as much information as possible about the patient before the ward round, including background history from the patient's usual residence and key worker.

Recommendations for protecting vulnerable patients

- **All members of the ward-round team should be introduced to the patient.**
- **Nurses and doctors should ensure that all patient needs are identified and articulated during ward rounds, and subsequent actions recorded and communicated back to the team as well as to the patient and their family/carers.**
- **Patients with dementia and learning disabilities should be supported to make decisions about their care as far as possible.**

iii Confidentiality and dignity

Confidentiality and dignity are very much influenced by the ward layout and available space. Bedside discussions with patients behind curtains do not always preserve confidentiality, particularly when ward-round times coincide with visiting hours. Similarly, discussing patient information in open spaces, such as by the nurses' station or next to the ward board, may also result in breaches in confidentiality. All members of the ward-round team should be aware of the immediate environment when discussing patient information. Guarding patient dignity in a public environment should be a key priority on ward rounds, eg by using coded curtain pegs or signs.

Recommendations for protecting confidentiality and dignity

- **Bedside curtains must be fully drawn before any physical examination of the patient.**
- **Patients should be appropriately exposed only for the duration of a physical examination.**
- **Organisations should ensure that clinical teams have appropriate facilities to ensure patient confidentiality; do not assume that discussions behind curtains remain private.**

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‘Having plenty of pre-ward round information to read really helped me prepare for the ward round. The pre-discharge ward round was very detailed, and I left hospital with a clear plan and the knowledge that I was in safe hands.’ A patient’s perspective

d Managing decisions and tasks

i Reviewing essential care needs

Ward rounds must include a holistic assessment of the patient's needs, reviewing nutrition, hydration and mobilisation, while also ensuring appropriate management of pressure areas, falls and delirium.

ii Record keeping

Reviews and decisions need to be properly recorded, not only for medico-legal reasons, but also to ensure continuity of care. Patients report varying and inconsistent plans as one of the most frustrating aspects of care. All members of the wider multidisciplinary team should use unified electronic or paper documentation to record all communications with the patient, carers, relatives and other healthcare professionals, based on relevant national guidance.[12,13] Every entry should have a time, date and identifiable author. All patient records should be kept in a central location, accessible to all members of the multidisciplinary team. Multidisciplinary notes should be used for setting daily goals, recording progress reports and noting down any questions relating to patients' care. Discussions with patients, carers or relatives should also be centrally documented in the multidisciplinary notes.

Recommendations for record keeping

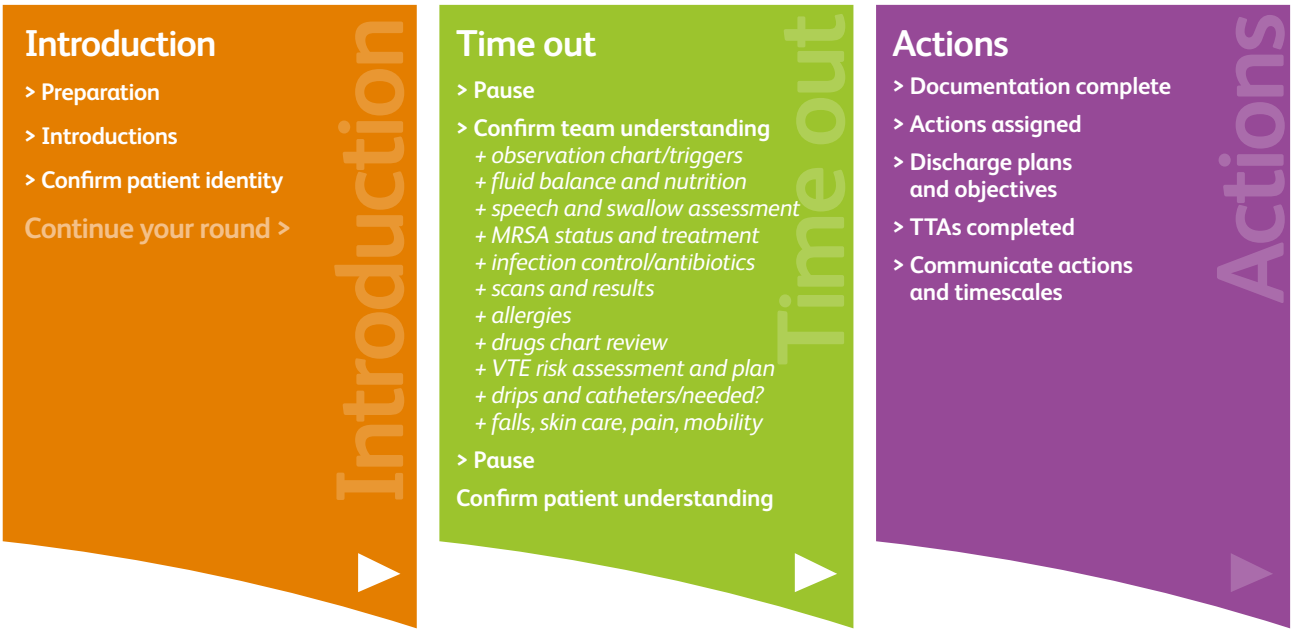
> **Patients' records should be kept centrally to promote effective communication and team working.**
> **All key decisions and actions made on the ward round should be clearly documented.**

iii Safety checklists

Ward rounds should prioritise quality, patient experience and patient safety. Mistakes are more likely in a complex, chaotic environment such as a hospital ward, but a systematic human factor approach to identifying omissions and mistakes can reduce error.[1,14] Common issues arising from ward rounds include medication errors, omission of venous thromboprophylaxis and poor prescription of intravenous fluid therapy.[8]

Safety checklists empower all members of the team to participate in ensuring that key components of the structured bedside review are not overlooked by the team.[1] All bedside reviews should address common safety aspects such as thromboprophylaxis, intravenous fluid prescriptions, drug chart review, review of lines and pain evaluation; checklists can make this process more robust. An example is shown in Fig 4.

Fig 4 Ward safety checklist by University College London Hospitals.[15] MRSA = methicillin resistant *Staphylococcus aureus*; TTA = to take away (medication).



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It should be noted in addition that designing, issuing, recommending or even mandating a checklist rarely has an impact on its own. It requires a supportive programme of education, communication and culture change.

Recommendations for ward-round safety

- **Drug charts must be reviewed by doctors for each patient during the ward round.**
- **Ward-round teams should utilise locally adapted checklists to reduce omissions, improve patient safety and strengthen multidisciplinary communication.**

iv Discharge planning

Discharge planning is an integral part of ward rounds and patient involvement should be encouraged. This includes setting an estimated date for discharge, with appropriate multidisciplinary input, such as physiotherapy, occupational therapy and social services support. All too often patients are relied on to convey complex and nuanced information to colleagues and services in the community, without clear verbal or written instructions from the hospital team.

Taking a planned approach to discharge helps prevent readmission.[16] This could include: (1) a pre-discharge board round to clarify outstanding issues that require resolution; (2) conducting a discharge meeting in a separate room in the presence of the multidisciplinary team and representatives of the patient; and (3) taking a checklist approach to ensure that key safety aspects of the discharge process are not overlooked. Before discharge, the patient should be provided with a thorough, detailed plan on how to manage his or her care outside hospital. Relatives and carers should be notified of the discharge date and time at least a day in advance, ideally with more notice.

Recommendations for discharge planning

- **Patients and carers should be involved in discharge planning at an early stage.**
- **Teams should use a structured approach to discharge (eg a pre-discharge board round).**
- **Medications and outstanding issues should be carefully reviewed, using a checklist method.**
- **Hospital teams should ensure clear verbal and written communication of the discharge plan.**
- **Post-discharge follow-up arrangements should be clearly communicated to the patient.**

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4 Summary

The medical ward round is a fundamental, yet all too often neglected, component of daily clinical activity. In the complex ward environment, the daily process of reviewing patients requires careful preparation, prioritisation, attention to detail and continuous re-evaluation. Furthermore, all medical ward rounds should be tailored to the needs and wishes of the individual patient, promoting shared decision-making and self-management. Implicit in the recommendations outlined by this document is the depth of cultural change and clinical engagement required to deliver high-quality care. All healthcare professionals have a responsibility to protect and prioritise quality, patient experience and safety on medical ward rounds.

Key points

- **Ward rounds are complex clinical processes that extend beyond a bedside review of care.**
- **They present a key opportunity to involve patients in their care, building trust and rapport.**
- **There is still significant variability in the conduct and purpose of ward rounds.**
- **Nurses provide the hub of patient care, and their involvement in the daily bedside clinical review is central to the effectiveness of the ward round.**
- **An organised and disciplined approach to ward rounds, with appropriate preparation, scheduling and review, improves patient safety and experience, while promoting efficient use of time and resources.**
- **Safety checklists reduce omissions and variation in practice, while strengthening team communication, performance and patient experience.**
- **Engendering and sustaining improvements to traditional ward round practices require strong clinical leadership, with all healthcare professionals fully engaged in improving patient care and effecting culture change.**

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Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE

www.rcplondon.ac.uk

Tel: +44 (0)20 3075 1649

Royal College of Nursing
20 Cavendish Square
London W1G 0RN

www.rcn.org.uk

Tel: +44 (0)20 7409 3333

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