



Introduction of a structured ward round on CCU at Barts Heart Centre

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Background and Purpose

Guidance from the Royal College of Physicians and the National Institute for Health and Care Excellence (NICE) recommends the use of structured approaches to ward rounds. There is evidence that such approaches increase staff satisfaction, reduce adverse events and reduce length of stay. Locally at Barts we had seen an increased number of adverse events such as prescribing errors and overdue venous cannula checks.

Aim

We proposed introducing a structured ward round to introduce a standardised order of checks and actions to be completed in a set manner with each patient. This aims to improve ward round efficacy, improve delivery of care, and improve the patient's experience.

Methods

This was a study of a pilot pathway performed at Barts Heart Centre for a structured ward round on the coronary care unit. An electronic proforma including 27 mandatory data points to include on the structured ward round (SWR) template was introduced and data collection was audited. Assess outcome of these measure in terms of length of stay, patient safety and staff satisfaction.

Methods

Outcomes included completeness, number of prescribing errors and datixes per months and patient and staff satisfaction. Measured against control wards with no change and data prior to change. Qualitative measures included contextual factors and measures of change and experiences of clinicians. Quantitative measures included length of stay (LOS), monthly "calls for clinical review," and cost of care delivery.

Results

The SWR was introduced on two wards. CCU 1: Prior to implementation and average of 13/27 data points were included at ward round entries. One-month post implementation this had improved to 26/27. Nine months post implementation this was 25/27. On CCU 2 prior to implementation data completeness was 8/27. Three months post implementation this had increased to 25/27.

Pre-implementation 21 datixes were logged in 7 months (Average of 3 datixes/month)
Post-implementation 6 datixes were logged 3 months (Average of 2 datixes/month)

Length of stay was on average 4 days pre-implementation, which was reduced to 3.5 days post implementation. Positive feedback was received from nursing and pharmacy colleagues who highlighted an increased awareness of patient plans and drug chart completion however a formal survey is out for feedback from the nurses and pharmacists on 3A is awaited.

Conclusions

We demonstrated that a structured ward round improves data collection, outcomes and improves patient and staff satisfaction.

Intervention WR - Dr
Issues:
1. Culprit lesion = treatment?
2. Bystander disease?
3. LVEF?
4. Other / Non-intervention issues
PMH:
Today:
Actions completed:
VTE prophylaxis Y/N
Drug chart reviewed Y/N
Cannula > 3 days? Y/N
CVC/ART line? No / Keep / Change / Remove
Urinary catheter? No / Keep / Change / Remove
Treatment escalation? Full escalation / ITU / NIV / ward based care
DNACPR in situ Not discussed / Yes / No

Obs (Type .N):
CBG:
Fluid status: euvolemic / hypovolemic / hypervolemic
OE:
Bloods:
Hb
Cr
eGFR
Cholesterol
HbA1c
Trop
ECG / Rhythm on monitor:

Echo:
Follow up plan and OP investigations:
Impression:
Day plan:
1.
2.

Name
Role
Sleep

Figure 1