The importance of ward rounds: a time to connect?

'It was an early morning ward round, consisting of a registrar, a couple of junior doctors and nursing staff. The registrar's patient encounters were very swift, not unpleasant but aloof, business-like, without warmth. We came to a patient, a late middle-aged woman, reading a book. I can't remember what the book was, but it wasn't trivia, a classic English novel perhaps. Everything I saw about the woman in the next couple of minutes confirmed my preconceptions, she was educated, well-spoken, composed and dignified. There were no relatives present.

'She stopped reading as we, in the round, approached. The registrar said something to the effect of "You know that we have been carrying out tests for cancer. We don't have all the results back, but it looks like that is the best explanation for your situation, and I think the best thing is that we transfer you – they are more experienced at handling this sort of cancer". It was a hepatic tumour of some sort. The woman was perfectly calm. She asked simply something like: "And if it is the cancer you think it is, is that it?" Everyone apart from the registrar was convinced, at the time, that she meant "is that the end for me?" Quite how the registrar interpreted it was never quite clear. All he said was, in effect:"yes, it is", and then returned to the topic of what steps will be taken to enable the transfer. And then he was gone. The whole interaction was probably no more than 3 minutes.'

Everyone on the ward round heard and felt the disconnect with the patient, but could not find a way to point that out to the registrar or respond to the patient's distress. The single most important component of the ward safety checklist is not tick boxing a series of well-rehearsed items, but building in a pause so that those attending can offer an insight or pick up on a missed opportunity, as in this sad case.

How does this relate to clinical practice?

'Nikhedonia' is defined as the pleasurable anticipation of success before any actual work has been done. It is better explained as the triumph of hope over experience and is invariably the basis of governmental responses to national catastrophes. The response to the Francis report will be no different. The NHS response to the Mid-Staffordshire horror will be yet more left brain checklists, more care plans and a tick box for compassion. The ward safety checklist, properly implemented and lead, has the potential to act as a vehicle to enable the rediscovery of lost values.

What really killed 1200 patients in Mid-Staffordshire was an archaic culture that disabled the care team so that they did not recognize and act on obvious signs of patient need.

Between mind-numbing statistics, facts and figures, beyond the odds ratios and confidence intervals, between 'empowering' well-funded initiative after well-funded initiative to ensure that 'it can not and will not happen again' and beyond the rhetoric of 'putting the patient at the heart of the NHS', lies the shadow.

The shadow of inaction, of a descending numbness, that allowed and continues to allow something to happen that should not have happened. And Mid-Staffordshire should not have happened, but it did, and it was far from an isolated incident. Montgomery famously once said that: 'There is nothing more difficult to manage than a subtle withdrawal of enthusiasm'. It was as if human values had been stripped out of the organization.

Too often in health care, when dealing with failure, we find we are dealing with people who have failed to live up to their own standards, never mind those of the organization, let alone those of government. Strategy and planning are irrelevant in the fog of overwhelming everyday clinical demand. How do our professions keep people in touch with their own moral compass?

The place of the ward safety checklist

Blake's dictum states that: 'He who would do good to another, must do it in minute particulars. General good is the plea of the scoundrel, hypocrite and flatterer'.

The ward safety checklist is one such minute particular. At University College London Hospitals, our experience of supporting the implementation of the World Health Organization's Safe Surgical Checklist prompted the expansion of the checklist approach to bedside care, to the rich oddness of what we take for granted (Herring et al, 2011; Amin et al, 2012).

All that we do in medicine, we do out of an abiding confidence in our know-how as a profession – the stakes are high and the liberties taken are tremendous. However, beyond the tests, the machines, the drugs and the procedures, medicine is a profoundly human pursuit, with all the fallibility that being human entails. The ward safety checklist is not designed as a prescription for how ward rounds are carried out. More than any other function, it is a multidisciplinary team-based intervention that helps design the everyday ward culture to cue patient-centred and safe behaviours. Both the safe surgical checklist and ward safety checklist programmes are derivatives of the after action review methodology, which tries to imbue the ability for those on the ward round to find their courage to tell the truth to power and contribute, to the best of their undoubted ability, to improving patient safety.

Staff disconnect

The single most common issue to emerge from training sessions was the depth of the disconnect between medical and nursing staff. Many doctors, of all ranks, resented that they had no nursing support on the round. Some had lost the expectation of such support, and others accepted that a nursing input to their round had largely become a matter of chance.

Conversely, nursing staff would describe senior medical rounds as being irregular and unpredictable, making it impossible to guarantee that an experienced and well-briefed nurse was available to participate. A busy on take or post surgical ward hosting a number of outliers might, it was reported, see seven or eight consultant-led teams during the day, with many more subsidiary junior doctor rounds engaged in follow up.

Some ward sisters had identified predefined slots to medical staff during which properly briefed and experienced nursing could be fully available, but medical uptake of these slots was inconsistent and rounding arrangements remained a common source of tension on the wards. Consistent multidisciplinary team rounds are not a working reality on UK hospital wards and if a relatively simple device such as the ward safety checklist can highlight this inadequacy it will have made a significant contribution to patient safety.

Widespread adoption of the ward safety checklist is dependent, to a significant level, on gaining buy in from senior medical staff. Among those who are resistant, the common responses are that the checks are already consistently done. The evidence does not support this assertion. Others reject the adoption of the checklist because they see it as a challenge to their competence and autonomy, or a misunderstanding of the medical role. There is often an almost reflexive assumption that medical staff have a minor role in assuring 'basic care' (seen as a nursing task) and good 'medical input' is predominantly about decision making and exercising good clinical judgement.

Researchers have found striking differences in the speed with which different medical teams learn despite receiving the same training and coming from highly respected institutions with experience in adopting innovations (Pisano et al, 2001). The surgeon on the fastest learning team was relatively inexperienced compared with the surgeon on the slowest learning team (Gawande, 2008). The difference was in leadership capability, with the most impressive performance coming from the least experienced physician who reflected that 'the surgeon needs to be willing to allow himself to become a partner with the rest of the team so he can accept input'.

Moving forward: leadership is needed

The terrible failures at Mid Staffordshire were not about resources. They were about deep-rooted cultural problems that, to a greater or lesser extent, are ubiquitous and that top-down recommendations will do little to change. They were about people and relationships and an absence of professional leadership, phenomena that are extraordinarily difficult to measure but extraordinarily important.

Culture change will not be achieved by a tsunami of legislation, criminal charges, regulation, inspection, greater ministerial supervision and other controlling methods. It will be influenced by what doctors, nurses and others do in the moment, which, in an environment that constantly manages the high impact of the highly improbable, will invariably be a function of how people feel, which is so often determined by the quality of the leadership. Tools such as the ward safety checklist are only as effective as how they are led. You have to lead by example. In the absence of the old firm system and in a context where people notice everything, introducing the ward safety checklist as a routine everyday safety and patient experience assurance tool is worth serious consideration in the aftermath of the Francis Report. BJHM

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KEY POINTS

- The ward safety checklist offers a structured framework which designs a clinical culture to cue appropriate behaviours.
- It is a multidisciplinary, patient-centred intervention.
- The effectiveness of the ward safety checklist will be a function of how well it is led.

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