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Anthony Cohn

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The ward round: what it is and what it can be

The ward round is one of medicine's most enduring rituals. Surprisingly, for an activity that is or should be central to hospital life there is little published reflection on how a ward round should be undertaken to satisfy the conflicting requirements of the participants, or even who the participants should be. A Pubmed search for 'ward rounds' in January 2014 identified 517 articles, which compares poorly to the relatively new concept of laparoscopy with 75264 articles, a ratio of almost 150:1. This could be seen as a sad reflection of how the ward round is valued by the medical fraternity. Over the last few years ward round structure and function has come to the fore, as highlighted by the excellent *Ward rounds in medicine: principles for best practice* jointly published by the Royal College of Physicians and Royal College of Nursing (2012).

In practice many ward rounds follow a pattern that has become an established routine with little thought as to whether they are as effective as they could be. This article will stimulate thought which will ideally be translated into action to improve the overall ward round experience.

What constitutes a ward round?

It is hard to find a comprehensive definition of a ward round. The ideal medical ward round can be described as a time when the patient can discuss his/her symptoms, problems, concerns and aspirations in front of an engaged multidisciplinary team of carers. This team considers the patient's history and in conjunction with the physical examination and the results of investigations conducted so far, presents a diagnosis or differential diagnosis and agrees the management

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plan, treatment options and discharge plan with the patient.

The team can also review the patient's medications and assess how the patient will cope physically and emotionally with the diagnosis and any change of circumstance, ensuring that upon discharge the patient will go to an environment appropriate to his/her needs.

Because of the logistical challenges a ward round seems to be the 'bulk' reviewing of patients, presumably primarily designed for the organizational benefit of the medical team and/or hospital. Historically, according to a previous president of the Royal Society of Medicine, the ward round may have acted as a way of ensuring that the reluctant consultant actually saw his (he would have been male then) inpatients on a regular, if not frequent basis (MacLennan, 1969).

Who is the ward round for?

The answer to this question should be obvious – the ward round should be first and foremost for the patient. Surprisingly the literature considers the patient a passive consumer. There are a few studies seeing if patients like what they get (Molony et al, 2012; Swenne and Skytt, 2014) – it is harder to find any asking what it is that patients want. The patient as participant remains an elusive concept.

Every participant on the ward round could be said to have an interest in it. For the leader of the ward round there is the opportunity for role modelling (Roy et al, 2012) which sometimes can seem to be little more than preening. There are still reports of members of the team being humiliated on the ward round and this clearly fulfils the psychological needs of the bully, although it is shameful that these are not addressed through psychological and disciplinary processes (Paice and Smith, 2009).

Depending on the name given to the ward round, participants may have different expectations. For example, on a 'teaching round', junior doctors and medical students would expect there to be an edu-

cational component beyond observation (Balmer et al, 2012). However, time taken to teach may be seen as an inconvenience to other participants, especially in the face of a growing list of tasks to be performed after the round has finished.

What should a ward round achieve?

As described above the ideal ward round provides an opportunity to take a step back, review the patient's current situation and make a plan for the future (Herring et al, 2012; Royal College of Physicians and Royal College of Nursing, 2012). Achieving all of the above seems ambitious but should nevertheless remain the goal. Checklists seem to increase the likelihood that these goals will be achieved (Herring et al, 2011). There may be other kinds of ward rounds with more specific goals, for example those dealing with specific symptoms such as pain and incontinence or needs such as sleep (Thomas et al, 2012).

Although ward rounds can still be daunting for patients, a suggestion from the 1950s that ward rounds may increase inpatient mortality because of the anxiety they generate (Jarvinen, 1955) reflects, one hopes, an older, more paternalistic period.

Who should be on the ward round?

From a patient perspective the round should contain the professionals that will help the patient make decisions about his/her care and ensure that these actions are implemented. There is unanimity of opinion that a nurse should be on the round (Desai et al, 2011; Lees, 2013), but delivering this in practice seems hard. This may be because nurses have other duties, because drug rounds coincide with ward rounds, or as a result of disempowerment or other reasons (Liu et al, 2013). One small study where family members were allowed on the round showed that the main positive outcome was increased nurse participation (Rosen et al, 2009).

Studies over the last 50 years have shown the benefits of pharmacists attending rounds, with more rational and cost-effective prescribing as a result (Conroy-Smith et al, 2011). Despite this their presence remains a rarity, given the false economy of not employing enough of them. There are

benefits from having other professionals including therapists, dieticians, social workers, ethicists (Sokol, 2009) and psychologists. When finding the right balance, it is important to remember that an overpopulated round can become intimidating for the patient.

Paediatric ward rounds inevitably include the patient's family. In other specialties visitors are usually excluded during ward round time. It would seem sensible to allow patients to have relatives present as they would be during an outpatient appointment but there is little evidence of this happening in practice.

A ward round with multidisciplinary participants should not be seen merely as a bigger audience for a prima donna performer. It can be challenging keeping all parties interested and focussed, balancing giving everyone a voice with the pressure to make and implement decisions. Having some clear ground rules can help with this. A cutting, yet undoubtedly true observation is that the multidisciplinary team is often a misnomer – there is a subtle yet significant difference between working as a group and a team. We like to call ourselves the latter while more commonly acting like the former (Bharwani et al, 2012). Genuine team working requires deliberate effort, specific training and regular appraisal.

Who should lead the ward round?

Guidance from the Royal colleges (Royal College of Physicians and Royal College of Nursing, 2012) recommends that a consultant should see every new patient within 24 hours of admission. From a patient and organizational perspective there are advantages to having consultant-led ward rounds. These produce shorter length of stays, lower inpatient mortality (Singh et al, 2012) and bring other efficiencies such as reduced use of investigations.

Historically the ward round may have been a mechanism that ensured the consultant visited the hospital at least on a weekly basis, but the benefits of consultant ward rounds may be dose dependent with an added advantage of performing more than one a day (Ahmad et al, 2011). This has raised concern that junior doctors may be stifled and unable to develop their own ward round skills (Eccersley and Tan, 2012) or simply find the ward round of

little value (Qureshi and Swamy, 2008). Conversely medical students seem to prefer a senior dominated round.

When should ward rounds happen?

There is no evidence regarding the optimal time of the ward round. The main goal is to ensure that all participants have adequate time to fully participate. Ideally this should include the patient and his/her advocates.

Where should the ward round happen?

A ward round might have multiple components which can take place in different locations. For example there may be a discussion round where all patients are discussed at length following which a smaller bedside round takes place. Patient interaction is usually, by default, at the side of the patient's bed with the assumption that confidentiality is maintained by the outstanding soundproofing provided by the hospital curtains.

Patients value privacy; those in single rooms give more information than those in four-bed wards (van de Glind et al, 2008) and if ambulant the patient may prefer to be seen in a separate room rather than on the ward (New, 2008). There may be organizational barriers to achieving this, but they should not be insurmountable. Where direct contact is difficult, new technology such as videoconferencing can provide a workable solution.

How long should a ward round take?

If a medical checklist is followed, an effective ward round should dedicate about 15 minutes to each patient (Creamer et al, 2010), and this is echoed by the Royal colleges' report. In practice it seems that most patients are seen for 5 minutes or less (Veigel et al, 2012). More experienced doctors perform quicker ward rounds, with seemingly the same crude outcomes as the slower ones of their junior colleagues (Gill et al, 2013).

If calculating the amount of time required to conduct a ward round, wasted time is of much consequence, e.g. finding notes and results and travelling between wards, and can take 20% of the total ward round time. Operational research has been largely overlooked but could offer great

rewards to hospitals in general, and wards round in particular (Pinheiro, 2009). There are no studies looking at patients' demands, so the ideal amount of time as decided by patients remains unknown.

Because ward rounds are invariably time limited the amount of time available for each patient varies with the number needed to be seen. This differs from a clinic setting when patients are each allocated a more or less fixed time and in theory, can be given extended appointments depending on clinical need.

Who should be seen by whom in what order?

The order in which patients are seen can be driven by different factors. If the ward round has a predetermined route, then nurses can have some idea of when the round will come to their patients which can, in theory, allow them to organize their work to be available for the round. Patients might also find it helpful to be given a guide as to when they will be seen.

It may make clinical sense to see the sickest patients first but administrative sense to first see those patients who are most likely to be discharged – even though they should be the least unwell. A further consideration is that infectious patients should probably be seen last. There are training and service advantages and disadvantages to both the 'seeing every patient together' and 'divide and conquer' rounds (Reece and Klaber, 2012).

When should the jobs get done?

The ward round will invariably generate a number of tasks. Ward round checklists (Desai et al, 2011) can ensure that important tasks are not overlooked. In their absence it is not always clear who is responsible for each task. Ideally tasks should be performed as soon as possible, but the efficiency dilemma is at play all of the time. Should the whole ward round stop so that one person can rewrite a drug chart, should the drug chart be rewritten at the end of the round or should one person remove him-/herself from the round to write up the drug chart, thereby missing a part of the round. There is no right answer, but the team should decide the most acceptable compromise before the ward round starts.

The complexity, urgency and time required for each task may determine how

and when it should be performed. Hospital departments like X-ray and pharmacy favour receiving requests for services during the course of the morning rather than a large number in one go. The downside to this approach is that the round becomes fragmented and loses educational value.

How tasks are allocated is again usually not actively considered. Often the most junior member of the medical team writes in the notes. Rarely will the entry be checked for accuracy, although the senior doctor will be responsible for the decisions made and how, or if, they are recorded. A further void is that there are no studies measuring how long it takes to write ward round notes to a standard that would satisfy a notes audit, let alone the judiciary. Transcription is yet another task for junior doctors that is just squeezed in.

If ward rounds were really important then interruptions would be kept to a minimum. This can be hard to engineer. One suggestion is that, like nurses on a drug round, the participants wear a lanyard saying 'do not disturb'. A more practical suggestion would be that one individual wears an armband and he/she is the only person that can be disturbed.

Teaching

Teaching and learning are essential components of doctors' lives. For those who believe that 'teaching' and 'service' are somehow mutually exclusive, it may be useful to think of 'explicit' and 'implicit' teaching rounds. In the former the emphasis will be more on the needs of the learners than on the patient. The paradigm example would be a bedside teaching session where the focus is purely on the student with the patient serving as a live simulation aid. In the latter, a ward round might occur with no discussion among the team who merely receive a list of tasks to be carried out, ideally without question.

In reality most ward rounds are somewhere between these extremes. Ensuring that a ward round is maximally educational needs thought and planning (MacLean and Ramos, 2010). A reasonable compromise is to use one or two patients for more protracted learning, e.g. with a medical student presenting, and the rest of the patients receiving a more 'professional' round. Any patients who are going to be used for teaching should agree to this, and consent

should be sought beforehand. If the patient is asked in front of a large team with the student about to speak, this is too intimidating to be considered willing consent.

One excellent way of learning is the supervised round where the trainee leads the round under the supervision of a senior. However, it is important, as with all teaching, to explain the process to the patient and obtain consent from him/her.

Most ward round teaching focuses on training medical staff. In a multidisciplinary round this can have two negative consequences. Other team members may feel excluded and perhaps bored, and the ward round will be prolonged, removing them from other tasks. Not surprisingly they may drift away and be less keen to attend in future.

As the nature of medicine changes, with shorter lengths of stay, more community care and an increase in day-case surgery, training the doctors of tomorrow in the management of chronic conditions is going to involve more work away from the wards than it did for doctors of yesterday.

Finally, the patient remains overlooked by the literature. The patient experience should be considered both as being the vehicle for the education of others but, as importantly, identifying what patients themselves can learn from the ward round.

Conclusions

Ward rounds are a crucial part of hospital life. They form the focus for coordinating care of patients while providing wonderful opportunities for teaching and learning. Historically ward rounds often evolved in a way that may have satisfied some of the participants, most commonly the senior doctors, without paying too much attention to their structure. The last few years have seen a welcome wellspring of interest in this area although there is still much to understand, especially what it is that patients want from the ward round.

There are too many conflicting requirements to envisage a perfect ward round. This does not mean that ward rounds that doctors conduct or participate in cannot improve for the benefit of all the participants, especially patients. There is always much to be gained from looking at practice and asking why things happen as they do, and what changes, often simple ones, could make things better. **BJHM**

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KEY POINTS

- Medical research has largely neglected the ward round.
- The literature pays little or no attention to what patients want or expect from a ward round.
- Multidisciplinary rounds have great advantages but need active management.
- There is no such thing as the perfect ward round, but with some thought all of them could be better than they are.
- Many ward rounds follow a pattern established by habit – think: 'If I was starting from scratch how would I construct a ward round?'

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