Multidisciplinary Ward Rounds

A Resource

NSW GOVERNMENT | Health

NSW DEPARTMENT OF HEALTH
73 Miller Street
NORTH SYDNEY NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

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For further copies of this document please contact:
Better Health Centre – Publications Warehouse
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Content

SECTION 1

Background

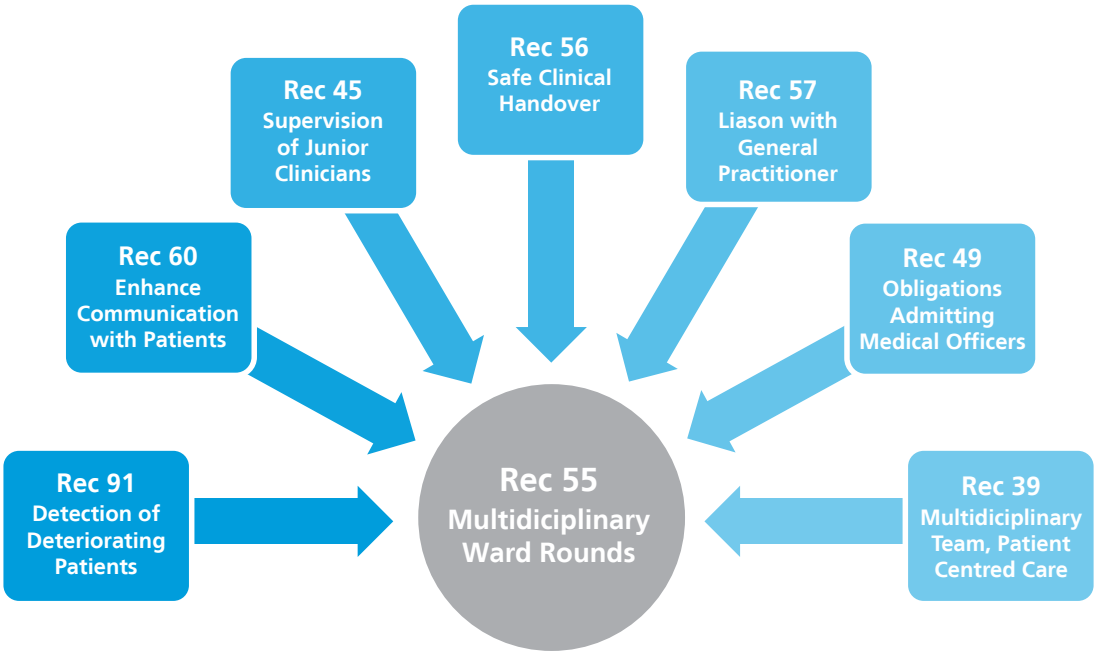
In the report of the Special Commission of Inquiry – Acute Care Services in NSW Public Hospitals (the Garling Report), Peter Garling SC noted that "generally speaking, allied health professionals are not included in ward rounds. This appears to be due, in part, to the hierarchical structure of the health professions, and partly to the fact that allied health professionals are so over-stretched that they are unable to dedicate the required time to a ward round".[1]

Development of this document has been informed by consultation with medical, allied health, nursing, administration, clinical risk and governance and NSW Department of Health staff. In addition, a comprehensive literature search that examined thirty seven articles was undertaken and several Multidisciplinary Ward Rounds (MDWR) in practice were observed.

This document is intended to assist facilities and units to implement Recommendation 55 of the Garling Report, whilst taking into account the specific needs of facilities and units to ensure that implementation reflects local patient profiles and staffing structures, as well as measures already in place in a number of Local Health Networks that are working well to date.

1 Special Commission of Inquiry (2008) *'Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals' (The Garling Report)* p527

Figure 1: The relationship between Recommendation 55 and other recommendations arising from the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (the Garling Report).



1.1 Links with other Garling Report Recommendations

Recommendation 55 is closely linked with a number of other recommendations and the overall intent and purpose of these also provides useful context for local implementation of multidisciplinary ward rounds.

As identified in Figure 1, MDWR should support and complement initiatives that also aim to:

- Identify deteriorating patients early;
- Support and supervise junior clinicians;
- Ensure that there is clear and documented clinical handover between shifts;
- Ensure that there are formal processes in place for liaison between hospital-based clinicians and GPs;
- Ensure appropriate and accurate maintenance of clinical notes;
- Support overarching principles of patient-centred, multidisciplinary care.

1.2 Types of Ward Rounds

The term 'ward round' is used in health facilities to describe a number of different scenarios involving communication between health professionals. The most common are outlined below:

1. **Teaching round** where interns, registrars and specialists go from patient to patient to test the knowledge of the more junior doctors and train them in how to identify particular conditions and determine treatment.
2. **Review of the ward** that is not attended by medical staff, such as a ward round conducted by the nursing/midwifery unit manager (N/MUM) with the nursing staff or by a group of allied health professionals.
3. **Traditional ward round** attended by different health professionals caring for the patient to discuss how the patient is progressing and future plans for care.
4. **Working round** where the medical team visits patients to review their condition and plan their care.

SECTION 2

Defining Multidisciplinary Ward Rounds

For the purpose of this document, a multidisciplinary ward round is defined as:

*a structured round where **key clinicians** involved in the patient's care meet together to discuss the patient's care and the **coordination** of that care. The round is a place where dialogue and feedback occurs in relation to the **needs of the patient** and provides the multidisciplinary team an opportunity to **plan and evaluate** the patient's treatment and transfer of care together. The round is **patient centred** and is based on the needs of the patient and their carers. The frequency of the round is determined by the needs of the patient/carer population.*

An example of an ideal ward round is also provided in the Garling Report:

"I heard evidence about a unit that has a multi-disciplinary ward round every morning....The round usually includes 6 people: the registrar, resident, nurse unit manager, occupational therapist, and physiotherapist and a speech therapist. The round, that takes approximately 15 minutes, provides the opportunity to briefly discuss all of the patients in the ward. I was told that this system decreases the length of stay and greatly improves the quality of care of all of the patients. This is an excellent example of the effective use of a multidisciplinary team and an opportunity for all professionals engaged in the care of the patient to discuss the most appropriate treatment."[2]

The following positive characteristics of effective multidisciplinary ward rounds were also identified in the Report:[3]

- They are structured, efficient and non-hierarchical;
- Accurate, legible notes are made;
- Notes are taken by a member of the team who is able to understand and record complex medical information and instruction. This is not necessarily the most junior medical officer or clinician;
- Those on the ward round introduce themselves to the patient.

2 Special Commission of Inquiry (2008) *'Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals'* p528

3 Special Commission of Inquiry (2008) *'Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals'* pp526-528

SECTION 3

A Case for Change

One of the main themes of the Garling Report was the need for the adoption of an interdisciplinary collaborative model of care. Fundamental to this model is the multidisciplinary ward round.

Whilst multidisciplinary ward rounds do occur for certain patient populations throughout NSW Health there is not consistency or flexible standardised guiding principles for clinicians.

The Garling Report has provided an opportunity to evaluate current approaches and ascertain whether they meet the challenges of providing quality healthcare in today's dynamic and resource limited environment.

3.1 Benefits of the Multidisciplinary Ward Round: themes and learnings from the literature

Literature suggests that interdisciplinary collaboration across the patient's continuum of care improves patient outcomes, capitalises on the strengths of the team, reduces errors, streamlines services and promotes the effective use of available resources.[4,5]

In order to develop and evaluate the patient's integrated plan of care a diverse range of health professionals are required to work closely together. It has been suggested that to provide seamless patient care healthcare teams must move from a mindset of independence to one of interdependence.[6]

An effective multidisciplinary ward round presents a valuable opportunity for both staff and the patient/carer to share information, problem solve and plan treatment as an interdependent team.[7]

Could an effective multidisciplinary ward round have changed Jane's outcome?

Jane Smith is an elderly patient in a ward at St Elsewhere Hospital. Jane had emergency surgery a couple of days ago. Jane fell overnight & had hit her head. As it has been an extremely busy night nursing staff have not as yet documented the incident in the patient's notes.

0700 – The team arrives at Jane's bed to do the round – only medical staff attend as nursing staff are currently in handover & allied health staff do not start until 0800.

0715 – The medical team go to visit Jane who is in the toilet. Not wishing to wait or come back later the physician asks the junior medical officer about Jane's condition. The medical team look at the notes and observation charts and ascertain from this that Jane's condition has been stable. They miss reading the entry from the on call resident. The VMO asks the intern to assess the patient later.

0730 – Jane returns from the bathroom disappointed to hear that she had missed the round as she had several questions to ask the VMO and has had a significant headache overnight.

1500 – As Jane has become increasingly confused the Intern is called to review.

2100 – Jane becomes unresponsive nursing staff call a MET call and Jane is resuscitated.

Jane had told her family before coming into hospital that if anything were to 'happen' she did not want to be resuscitated.

2130 – Jane is intubated and transferred to the Intensive Care Unit.

Jane spends 3 months in hospital before being discharged to a nursing home

4 Halm, M., Gagner, S., Goering, M., Sabo, J., Smith, M. and Zaccagnini, M. (2003:133)
5 Special Commission of Inquiry (2008) *'Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals'* p17
6 Halm, M., Gagner, S., Goering, M., Sabo, J., Smith, M. and Zaccagnini, M. (2003:133)
7 Halm, M., Gagner, S., Goering, M., Sabo, J., Smith, M. and Zaccagnini, M. (2003:134)

Multidisciplinary Ward Rounds Improve Patient Care

- Effective communication is key to patient safety.
- Researchers[8] have found significant association between nurse-physician communication and the positive patient outcomes of lower risk-adjusted mortality and higher patient and staff satisfaction. Baggs in a series of studies (cited in Halm et al[9]) demonstrated associated links between the level of interdisciplinary collaboration and the outcomes of ICU patients.
- Studies undertaken in the United Kingdom[10] and America[11] found the presence of a pharmacist on the multidisciplinary ward round reduced prescription costs as well as the rate and duration of drug errors. Outcomes were attributed to the greater knowledge the pharmacist had of the patient's medical problem, history and current goals of care which further enabled them to recognise a potential error and take appropriate action to prevent the error from continuing.
- By providing team members and leaders an opportunity to round on each other and with the patient, the MDWR provides opportunities to ensure that expectations are met and that the care planned is optimal.
- MDWRs play a role in the identification of quality improvement initiatives for specific patient populations.
- Newell[12] reported that an outcome of MDWRs was that fewer patients experienced variances form their clinical pathways.

"In addition to what team members learn about the patient, staff nurses learn about the skills everyone on the team has to offer. They now think to contact social work for certain issues and remember to request a swallow study before orally feeding a long – term intubated patient. They learned that speech therapy can improve cognitive functioning. When they determine that a patient is at risk for falls, they will request physical therapy evaluation. Through rounds everybody learns others strengths."

Halm, Goering and Smith: 2003:140

Multidisciplinary Ward Rounds Promote Interdisciplinary Dialogue

- Interdisciplinary dialogue promotes collaboration between health professionals due to improved communication, role accountability and awareness.
- Dialogue between health professionals enables the knowledge and skills of professionals to synergistically influence the patient care being provided.
- Studies indicate that effective multidisciplinary ward rounds lead to a reduction in costs and improved staff satisfaction and quality of care.[13]
- Through increased communication, reports[14] suggest that multidisciplinary ward rounds result in earlier identification of clinical issues, more timely referrals and implementation of preventative nursing interventions.
- Positive nursing outcomes reported in the literature include increased job satisfaction, enhanced professional relationships and lower staff turnover. For physicians, outcomes included enhanced learning and professional relationships and improved opportunities for research utilisation.[15]
- Staff participation in multidisciplinary ward rounds promotes increased accountability amongst health professionals.

'Enhanced interdisciplinary teaming and learning promotes professional behaviour and satisfaction among the team'.

Halm, Goering and Smith: 2003:140

"Instead of going back and reading notes, we have the entire team together, and we can work together to help the patients progress. We're not making phone calls or paging each other to find out what is going on with the patient we are able to catch up with each other and compare notes …

We are more proactive than reactive. The result is a smoother hospital stay, a shorter length of stay, and happier patients"

Camelio (2009:24) discussing her experience of participating in a multidisciplinary ward round.

8 Boyle, D. and Kochinda, C. (2004) *'Enhancing Collaborative Communication of Nurse Physician Leadership in Two Intensive Care Units'* JONA Vol 34 (2), pp 60 -70
9 Halm, M., Gagner, S., Goering, M., Sabo, J., Smith, M. and Zaccagnini, M. (2003:134)
10 Fertleman, M, Barnett, N and Patel, T. (2005) *'Improving Medication Management for Patients: The Effect of a Pharmacist on Post –Admission ward Rounds'*, Qual Saf Health Care, Vol14, pp 207 -211
11 Scarsi, K, Fotis, M. and Noskin, G. (2002) 'Pharmacist Participation in Medical Rounds Reduces Medication Errors' Am J Health-Syst Pharm, Vol 59, pp 20892092
12 cited in Halm, Goering and Smith (2003: 139)
13 Vazirani, S, Shapiro, M. and Cowan, M. (2005) *' Effect of a Multidisciplinary Intervention on Communication and Collaboration Among Physicians and Nurses'* American Journal of Critical Care, Vol 14 (1), p71-77
14 Halm, M., Gagner, S., Goering, M., Sabo, J., Smith, M. and Zaccagnini, M. (2003:134)
15 Boyle, D. and Kochinda, C. (2004) *'Enhancing Collaborative Communication of Nurse and Physician Leadership in two intensive Care Units'* JONA, Vol 34 (2), pp60-70

Multidisciplinary Ward Rounds Promote the Effective use of Available Resources

- Length of stay (LOS) is a reported outcome measure in the literature for MDWR implementation. When care is improved and barriers to discharge identified and managed, length of stay is reduced.
- In an American study[16] which compared LOS of 2 patient groups, one which experienced MDWR and the other which experienced traditional medical rounds, the mean LOS in the first was 5.46 days, compared with 6.06 days for traditional care and mean total charges were $6,681 and $8,090 respectively for the two groups. In another study[17] the introduction of multidisciplinary ward rounds improved predicted date of discharge by 39% (i.e. from 57% to 96%).
- NSW allied health staff stated that participation in multidisciplinary rounds had:
  1. Impacted on referral patterns – significantly increasing the number of appropriate referrals whilst decreasing the number of inappropriate referrals
  2. Lessened routine interruptions as staff were paged less throughout the day
  3. Enhanced learning and professional relationships.
- Multidisciplinary ward rounds encourage the appropriate use of admission and discharge criteria so that based on review during rounds patients are admitted / transferred according to the needs of the patient.

"A successful ward round requires preparation and commitment from all parties. It should be short and crisp and well informed, decisive but interactive.

The ward round should be characterised by assertive inputs constructive and educative discussion, and agreed firm outcomes"

Sandler (2007:13)

Patient, carer and family involvement in care planning

Patients want and need to be actively involved in the multidisciplinary ward round.

- In a study by Pikielny et al[18] more than 90% of patients and families felt their participation in ward rounds improved their communication with medical staff.
- However, in a study of 2391 observed interactions, only 19% of all the communications in the round were directed at patients, compared with 51% directed at medical staff. On the round patients were only asked their opinion approximately once each.[19]
- In order to improve patient compliance with treatment and prevent patient/carer or family frustration, literature suggests the need to avoid medical terminology, provide explanations in layman's terms and clarify that the patient/carer or family has understood the intended message[20] in the round.

"We were very pleased with the reception of the patients and family members who participate… The rounds allow the treatment team to get to know the patient and their family and to learn more about family dynamics and the situation at home"

Camelio (2009:24)

16 Curley, C, McEachern, J and Speroff, T. (1998) *'A Firm Trial of Interdisciplinary Rounds on the Inpatient medical wards, Medical Care*, Vol 36, pp 4-12

17 Moroney, N. and Knowles, C. (2006) *'Innovation and Team Work: Introducing Multidisciplinary Team Ward Rounds'* , Nursing Management, Vol 13, pp 28 -31

18 Pikielny, P., Rabin, B, Amoyal, S. , Mushkat, Y, Zissin, R. and Levy, Y. (2007)

19 Busby, A. and Gilchrist, B. (1991:343)

20 Seo, M., Kazuo, T, Morioka,E and Hiroshi (2000) , Pikielny, P., Rabin, B, Amoyal, S. , Mushkat, Y, Zissin, R. and Levy, Y. (2007), Gurses,A and Xiao, Y. (2006) , O'Hare, J. (2008)

Using and promoting leadership

- MDWRs promote the 'development of leadership potential to achieve a culture of empowerment, continuing modernisation and innovation around the person the service is trying to serve.'[21]
- Effective MDWRs promote shared values and practices, participatory decision making, a common mission, consistency and the involvement of team members fosters interdisciplinary collaboration.
- The purpose of the ward round needs to be clear to all participants, including the patient.
- Rounds develop staff as clinical leaders, as team-initiated dialogue leads to sharing rather than reporting of information.
- The round reflects and promotes personal, team and service effectiveness,[22] the lifelong learning culture and the systems of feedback and evaluation.

21 Manley, K. (2004:2)
22 Manley, K. (2004:2)

SECTION 4

Goals and Outcomes of Effective Multidisciplinary Ward Rounds

The benefits of the use of MDWR are clearly evident. In Table 1 below, the goals and expected outcomes of the use of MDWR are summarised.

Table 1. Goals and Expected Outcomes of Effective MDWR

Goals	Intended Outcomes
■ To facilitate on-the-spot interdisciplinary communication and team work ■ To summarise pertinent health data[23] ■ To define and agree goals for the care of the patient. Discuss progress towards goals, revise goals and plans as necessary ■ To plan and evaluate the patient's treatment and transfer of care ■ To clarify team members responsibilities related to the implementation of the plan ■ To address patients' and families' concerns and problems as well as responses to planned interventions	■ Enhanced quality and safety of patient care[24] ■ Increased patient satisfaction ■ Timely and safe discharge ■ Effective collaborative care delivery ■ Improved documentation ■ Identification of and response to individual and team learning needs ■ Fostering of leadership ■ Increased awareness of the resources needed by specialty patient groups ■ Appropriate and effective use of available resources & a reduction in costs ■ Increased staff satisfaction & enhanced professional relationships

23 Halm, M., Gagner, S., Goering, M., Sabo, J., Smith, M. and Zaccagnini, M. (2003:134)

24 Hodgson, R, Jamal, A. and Gayathri, B. (2005: 171)

SECTION 5

Implementing Multidisciplinary Ward Rounds

The following section of this document provides guidance for services in establishing, developing, implementing and reviewing MDWR in order to achieve the goals and outcomes described in the previous table using the definition of MDWR previously noted:

Definition

*'a structured round where **key clinicians** involved in the patients care meet together to discuss the patient's care and the **coordination** of that care. The round is a place where dialogue and feedback occurs in relation to the **needs of the patient** and provides the multidisciplinary team an opportunity to **plan and evaluate** the patient's treatment and transfer of care together. The round is **patient centred** and is based on the needs of the patient and their carers. The frequency of the round is determined by the needs of the patient/carer population.'*

STEP ONE

Secure high level commitment to supporting the introduction or extension of multidisciplinary ward rounds

In order for MDWRs to be introduced and/or conducted successfully it is important to identify key stakeholders and gain their support early in the process. Identification of a key executive sponsor who will ensure that appropriate support within the organisation's executive team is provided as well as lead clinical sponsors to facilitate the engagement of all clinical groups will assist in achieving success. The identification of an individual or individuals to lead the work supported by local champions will assist in maintaining focus on the key goals and outcomes to be achieved. Overall, the introduction of MDWRs should not be viewed as a 'project' with a specific beginning and end but rather as a change in practice that over time should become embedded within the organisation and be seen as an accepted and standard way of working.

STEP TWO

Gain an understanding of the current situation and practice

The following key questions are provided to assist facilities and units to develop some organisational context before considering how MDWR can best be implemented for their patient populations:

1. How does current multidisciplinary collaboration occur in your facility for your patient population? Is your team a group of professionals all working independently to achieve a common goal, or do you work collaboratively?
2. Do existing ward round processes encourage, support and value the contribution of all team members including that of your patients and their families?
3. Do you currently have a process of multidisciplinary care that meets both the needs of all team members as well as your patients and their family members?
4. Could multidisciplinary collaboration be done differently to achieve a better outcome for your patients, their families and your team?
5. What would your team need to do to make MDWR achieve better outcomes for team members, patients and their families?

As part of this initial work a review of existing resources/ systems that could support the MDWR should be undertaken. The list here provides some areas for consideration:

- Multidisciplinary team meetings
- Clinical rounds
- Case conferences
- Whiteboard meetings
- Redefined role of N/MUM
- Clinical redesign units and work
- Essentials of Care
- Leadership development programs such as the CEC Clinical Leadership Program and *take the lead*
- Garling Report strategies that support MDWR (eg Essentials of Care)

- Existing functioning models in areas such as oncology, rehabilitation, aged care
- Commitment to best practice and improvement
- Clinical champions
- Patient flow systems
- Programs that facilitate multidisciplinary engagement eg Between the Flags.

STEP THREE

Identify challenges and potential barriers

There can be a range of challenges and issues that will be potential barriers to successful implementation of MDWR. Each unit or organisation needs to give consideration to identifying those that will impact in their context. The following list provides some that have been identified but there may be others specific to the local context:

- Diversity and complexity of services
- Change management and change 'fatigue'
- Sustainability
- Time
- Benefit not immediately evident
- Resources available
- Geography
- Attendance, availability, punctuality of participants
- Commitment and engagement of participants
- Allied health and medical staff dispersed across a number of wards/units
- Efficiency versus quality
- Short length of stay
- Competing priorities
- Flexibility of beds used
- No strong case for change identified

Once the relevant challenges and potential barriers have been identified strategies that address these should be included in the implementation plan.

STEP FOUR

Develop an implementation plan

Once the challenges and issues have been identified, an implementation plan that is specific and will support implementation of MDWR should be developed. Plans should include achievable goals and timeframes. The agreement of all stakeholders should be sought regarding:

- Patients to be included eg only those with LOS greater than three days; only patients with complex conditions or significant co-morbidities; those that will need significant care and follow up post transfer of care
- Logistical issues such as frequency, day and time and location of MDWR
- Identification of opportunities to limit duplication and opportunities to streamline processes
- Identification and source of resources that will be required to support the rounds
- Assignment of responsibility for organisational aspects – in many cases this will fall within the role of the N/MUM
- MDWR participants – only those staff relevant to the care of the individual patient are involved
- Documentation requirements and responsibilities – these should be clearly understood by all participants
- A communication strategy for staff and patients
- Strategies to promote attendance of identified participants
- Staff and patient education – develop toolkits as needed
- Ensure that all understand the key goals and outcomes to be achieved
- Identification of strategies to support and foster the active engagement of patients in MDWR
- Strategies to ensure that the language used is understood by clinical staff and patients
- Strategies to ensure that team members roles and input are valued, encouraged and respected
- Discussion of issues with regard to patient safety

STEP FIVE

Implement and evaluate

Once MDWRs have been implemented, evaluation will need to be undertaken. This should be ongoing process so that continuous improvements occur over time. In developing the evaluation strategy, consideration could be given to the following characteristics identified at the workshop held in 2010.

What does a Multidisciplinary Ward Round look like, feel like and sound like?

It is also important to evaluate the impact that MDWR have on individual staff and patients as well as the way it is implemented and the process of implementation. Asking the question how does the MDWR "look, feel and sound" can provide clarity in this area of evaluation. Consider the following suggestions put forward at the workshop to assist in determining how the MDWR might look, feel and sound:

Looks like …

- A locally led process where two or more disciplines involved with the patient and/or carer review current care and plan future care
- A process that is defined by the needs of patient/carer population and the local environment
- A well structured and planned process that has clarity of purpose, roles, agreed goals and outcomes
- A process where the provision of care and the experience of care is the same
- A process that promotes interdisciplinary collaboration to ensure that key clinicians are involved in the patient's coordination of care
- A seamless process that interfaces with generic handover and other types of ward rounds so that the round is well documented and communicated

Feels and sounds like...

- Inclusive
- Respectful
- Valued
- Language used is appropriate for both team members and patients/carers
- Opinions are heard, respected and considered
- Communicative – listening, talking and feedback
- Collaborative
- Patient and carer centred
- Has strong leadership
- A place where patients and their carers are encouraged to ask questions and raise concerns
- Confidential – patients, carers and families are treated with privacy and dignity
- Patient, carers and families feel cared for
- Stimulating – a place where learning occurs

How would you evaluate MDWR effectiveness?

It will also be possible to gather objective data through existing systems that will provide an indication of the impact of MDWR. While these are often impacted by a range of factors of which the MDWR is one, carefully worded questions within some of these tools will give more specific feedback.

- Patient satisfaction
- Staff satisfaction
- Readmission rates
- Observation of process
- Estimated date of transfer versus actual transfer date
- Goal attainment / review of decision plan
- Identification of barriers interfering with patient discharge
- Length of stay

SECTION 6

Conclusions

The important role of effective communication is a strong and recurring theme throughout the Garling Report. Good communication assists to identify issues in patient care early and effectively, puts patients at ease, provides leadership and learning opportunities for staff, and maximises use of resources and time.

MDWR are essentially a vector for good communication between clinicians, including medical officers, nurses and allied health professionals, and also between clinicians and the patient. Evidence has shown they are essential to seamless, safe, quality healthcare when they are patient and person centred, have a formal framework and process, and encourage and promote collaboration.

A successful ward round requires preparation and commitment from all parties. It should be short but crisp and well informed; decisive but interactive. The ward round should be characterised by assertive inputs, constructive and educative discussion and agreed firm outcomes

Sandler, 2007

MDWR Templates/Documentation

Some examples of MDWR templates currently in use were presented at a MDWR workshop held in March 2010. These are appended for information.

Appendix 1
Lithgow Hospital MDWR Document

Appendix 2
Blacktown Hospital Multidisciplinary Care Plan

Appendix 3
Blacktown Hospital Case Conference Template.

Appendix 1: Lithgow Hospital MDWR Document
This document was developed by Ms Deb Gaynor, NUM-Inpatient Unit, and Ms Lynn McLennan, Social Worker, Lithgow Hospital, NSW

MULTI-DISCIPLINARY CARE PLAN

Names of attending health staff are to be found in the Monday Meeting ward book.

CURRENT MANAGEMENT/DISCHARGE ISSUES:

Poor mobility	☐	Immobility	☐
Hx of falls	☐	Visual or hearing impairment	☐
Pre-existing wound	☐	Multiple chronic health problems	☐
Polypharmacy	☐	Incontinenence	☐
Chronic pain	☐	Malnutrition	☐
Pressure area	☐	Unable to perform activities of daily living	☐
Cognitive impairment	☐	Behavioural disturbance	☐
Hx of D&A abuse	☐	Multiple admissions over a 6m period	☐
Psychiatric illness	☐	Life limiting illness	☐
Bereavement and loss	☐	Lives alone with limited supports	☐
Loss of a carer	☐	Carer unable to continue caring	☐
Social isolation	☐	Cultural and/or language issues	☐
Single parent	☐	Young carer	☐
Domestic violence	☐	Elder abuse/child abuse/sexual abuse	☐
Guardianship/OPC	☐	Lives in supported accommodation	☐
Homelessness	☐	Poor home/community environment	☐

MULTI-DISCIPLINARY CARE PLAN:

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-

EDD/DESTINATION:

Signature:

VMO Signature:

Appendix 2: Blacktown Hospital (designed to be printed as stickers and included in patient medical records)
Multidisciplinary Care Plan

MULTI-DISCIPLINARY CARE PLAN
Presenting Issues/Problems/Waiting for What?

	No	Yes	N/A	Comments
Medical Test pending				
Ongoing medical needs				
Awaiting Consults				
Mobility below baseline				
Home visit/ mods required				
ADLS below baseline				
Communication Therapy needed				
Insufficient Nutritional intake				
Swallowing & Diet Ed. needed				
Allied Health Review				
Social work issues				

Multi-disciplinary Care Plan
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Referrals Needed
SP PT SW ACAT AARCS ACBT CCCNC OT DIETICIAN

Community Services Others Pulm Rehab Compact Others
EDD
Discharge Destination …………………………….
Signature ……………………………………………….
MO Signature…………………………………………,,

MULTI-DISCIPLINARY CARE PLAN
Presenting Issues/Problems/Waiting for What?

	No	Yes	N/A	Comments
Medical Test pending				
Ongoing medical needs				
Awaiting Consults				
Mobility below baseline				
Home visit/ mods required				
ADLS below baseline				
Communication Therapy needed				
Insufficient Nutritional intake				
Swallowing & Diet Ed. needed				
Allied Health Review				
Social work issues				

Multi-disciplinary Care Plan
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Referrals Needed
SP PT SW ACAT AARCS ACBT CCCNC OT DIETICIAN

Community Services Others Pulm Rehab Compact Others
EDD
Discharge Destination …………………………….
Signature ……………………………………………….
MO Signature…………………………………………,,

MULTI-DISCIPLINARY CARE PLAN
Presenting Issues/Problems/Waiting for What?

	No	Yes	N/A	Comments
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Allied Health Review				
Social work issues				

Multi-disciplinary Care Plan
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Referrals Needed
SP PT SW ACAT AARCS ACBT CCCNC OT DIETICIAN

Community Services Others Pulm Rehab Compact Others
EDD
Discharge Destination …………………………….
Signature ……………………………………………….
MO Signature…………………………………………,,

MULTI-DISCIPLINARY CARE PLAN
Presenting Issues/Problems/Waiting for What?

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Multi-disciplinary Care Plan
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Referrals Needed
SP PT SW ACAT AARCS ACBT CCCNC OT DIETICIAN

Community Services Others Pulm Rehab Compact Others
EDD
Discharge Destination …………………………….
Signature ……………………………………………….
MO Signature…………………………………………,,

Appendix 3: Blacktown Hospital Case Conference Template.

This document is currently being trialled in the subacute rehabilitation and stroke unit at Blacktown Hospital. It is intended for use in comprehensive assessment and care planning. It was developed by the Blacktown/Mt Druitt Rehabilitation Aged Care and Stroke Team, Blacktown Hospital.

Attachment 3
Blacktown Hospital Subacute Rehabilitation and Stroke Unit
ISBAR CASE CONFERENCE PROFORMA

Date **Time:**

Introduction	***Age / Gender of patient***	
Situation	***Presented with …***	
	Medical diagnosis	
	Secondary diagnoses / issues	
Background	***Relevant medical history***	
	Social history	
Assessment	***Medical issues***	
	Mobility	
	Upper-limb	
	Self-care	
	Swallowing	
	Nutrition	
	Communication	
	Cognition	
	Mood / psychological	
	Social situation	
	Home access / environment	
Recommendations	***Management Plan***	
	Referrals to	
	Discharge Plan	
	Estimated Discharge Date	

Signed:

SECTION 8

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