The Importance of Ward Rounds

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The Importance of Ward Rounds

Thank you for asking me to come to talk with you about the Importance of Ward Rounds. I hope to convince you that reliable ward rounds are key to swift, timely, safe and effective clinical care of inpatients. If ward rounds are run reliably you will see a fall in hospital associated harm such as C difficile diarrhoea, deep vein thrombosis, other hospital acquired infections, pressure area damage and more “on time discharges”, fewer readmissions, and an increase in patient and staff satisfaction. Yet ward rounds are underappreciated, undervalued and underdeveloped. Your group may be more interested in macro health economics, but I would argue that unless a business gets the main production line optimised to produce high quality reliable products with a satisfied creative and fulfilled workforce, it will never achieve macro economic success. On the economics of ward rounds, there are about 120,000 acute inpatients in NHS England Hospitals. Each patient takes between 10 and 15 minutes a day for review on a round, equating to 1,200,000 to 1,800,000 minutes of work a day. Rounds cost between £5 and £10 per minute for staff alone, meaning the direct staffing cost is between £6 million and £18 million a day, let’s say £10 million. So, in London your costs might be £1 million a day, or £250 million per annum for weekday rounds. The on costs after the rounds in terms of treatments started, tests and potential additional costs of hospital acquired harm are far greater. Effective, efficient and safe ward rounds could be a major factor in improving productivity, or value for money in the NHS.

I think it will be fairly easy to convince you that ward rounds are underappreciated, but maybe harder work to convince you of their importance. All successful businesses measure what is important to them. If I were a surgeon asking questions of any Hospital Executive team, I could get answers within an hour to questions like

- “How many operations were conducted in your organisation last year?”
- “How many operations were major and how many minor?
- “How many operations were cancelled on the day, the day before etc?
- “What was the mortality rate?”
- “What was the post-operative infection rate?”
- “What was the income associated with the operations?” and maybe even
- “What were the costs associated with the operations?”

Similarly the Executive Team could readily provide answers about outpatient attendances, new to follow up ratios, numbers of procedures in outpatients, did not attend rates, income and again possibly expenditure.

I doubt that any Hospital in the NHS could answer similar questions about ward rounds. How many ward rounds were conducted? How many patients were seen? How many staff were involved? How many rounds were done at weekends? How long did the rounds take? What work was done on the rounds, and what standards were displayed in the work done? Yet as soon as there is a bed crisis, the call goes out “Go and do a ward round, see if there is anyone you can send home!” Or if an inpatient is not seen on a weekday, it constitutes an incident worthy of a Datix report and an investigation. So in some ways Hospitals see the value of ward rounds, but in general rounds are unappreciated, and I hope to show you, also undervalued. I think this lack of appreciation has several causes, including

- Ward Rounds are “Ordinary”, therefore unremarkable
- Doctors are bright people, they know what they are doing, so they must have rounds well organised
- Ward Rounds are private and confidential, therefore managers must stay away
- Clinical care can be frightening and disturbing, so managers may shy away
- Doctors and other clinicians have great difficulty in describing what they are doing on rounds
- Quality, safety, reliability, effectiveness, efficiency, patient and staff satisfaction on ward rounds are very hard to measure
- An inherent belief that the process of diagnosis is easy, and it is treatment that is difficult

What are the Purposes of Ward Rounds?

Ward Rounds are an essential process in the clinical care of acute inpatients. In simple terms the work of acute inpatient care is to take cohorts of patients with major acute clinical conditions, and restore their health as swiftly and safely as possible to the point that they can resume living outside hospital with the risk of readmission minimised as much as possible. For a small number of patients the work is to anticipate end of life and to provide for a calm death. Clinical care is practise and

during all care, we must be striving to continuously improve our own work, as well as training the next generation to better our performance. For the Doctors in the Clinical Team I summarise this work for the cohort of patients as being making the

- Right Diagnoses and providing the
- Right Treatments at the
- Right Time in the
- Right Place and at the
- Right Pace with the
- Right to no Avoidable Harm and
- Better Next Time

Our team strives to meet these objectives on ward rounds.

The Acute Illness and Process of Clinical Care

When a patient comes to hospital as a potential acute admission, he or someone else believes there has been an abrupt deterioration in his usual level of health, that he may be seriously ill and need hospital care to improve his health. Imagine a graph and the Y axis goes down from “As good as it gets” down to “Death”. So each patient’s health abruptly drops from “As good as it gets”, some by a little, some by a lot. To fix this sick patient, the clinicians must establish a “working diagnosis”, take into account all the other co-morbidities, decide on treatments, anticipate the patient’s health trajectory and decide on the time of next review. For example a patient comes in with symptoms of fever and cough, the doctor takes a history, does an examination, orders some blood tests and a chest X ray. He reviews the old notes, referral letters and last summary and makes a “Working Diagnosis” of Community Acquired Pneumonia with co-morbidities of COPD, type 2 diabetes, chronic kidney disease stage 4, atrial fibrillation, and warfarin treatment. He decides on treatment with intravenous antibiotics, modified because of the patient’s allergy to penicillins. He anticipates that the patient will be much improved by 9 am the following morning, the time of the “Post take” ward round. On the post take round the evidence for the diagnosis is reviewed and the Consultant sees signs of a possible lung cancer on the chest X ray. He is also worried that the antibiotic will disturb the

warfarin control, and finds that the patient's blood glucose has gone up and the patient needs insulin treatment. The diagnoses and comorbidities are refined and a new trajectory anticipated, ready for the next review on the next routine ward round. At the next round the patient's condition is improved, the antibiotics changed to oral, the cannula removed to prevent cannula site infection, and the diabetes nurse contacted to teach the patient self administration of insulin so that his discharge is not delayed. The possibility of lung cancer is raised, but his partner is not there, nor his primary nurse. Although an outpatient CT scan is booked the patient is left frightened and unclear as to how likely it is that he has cancer. The next two days are weekend days, and he has no chance to discuss this until the Monday round, when the doctors are really worried that his blood has become too thin because of the interaction of the antibiotic and warfarin, which was not picked up on the results of the blood tests on a busy Sunday.

Acute care is repeated cycles of

- This is what we believe is going on,
- This is our plan, and what we think will happen,
- Did it happen as anticipated, if not why not, and if it has, was that just good luck or expert clinical care?
- This is what we plan to do next

Those of you trained in improvement will recognise that this is a series of Plan Do Study Act cycles. Isn't it strange that Doctors are so expert at PDSA in patient care, but struggle with PDSA in process management?

What should be done on a ward round?

One Monday in April 2009 I let our Foundation Year One doctor lead the ward round, acting as spokesperson with every patient. She was of course supported by me, the Registrar and the SHO, and made a very good job of the work. We asked her how she felt it had gone and she said "I enjoyed it, but I worried that I might not have done everything." That set us thinking "What would 'Doing it All' for the patients mean on a ward round. I sent the Juniors away to think this through and a day later, we decided on a list of key points, designed our first Checklist, and used it on the Friday. Since then I have used a Checklist Process to improve the reliability of the

rounds that I have led. When you look at the Checklist it is immediately clear what a complex process a ward round is. If we have to see 20 patients, each with a primary diagnosis and several co-morbidities, and work through these active quality and safety checks, we will be considering something in the region of 400 decisions during the round. How easy it must be to overlook important items, if we just rely on memory and good luck. I don't think there is anything magical about our Checklist. What is important, in my opinion, is that team's recognise the complexity, the risks of errors or omissions, and try to develop their own ways of ensuring reliability. I will talk you through the key features of the current version of the Checklist.

Key Features of the Checklist

The Checklist is on paper, and is only stored in my office, not in the notes. One person is assigned the role of Checker, and asked at the end of each review to report on any omissions. Atul Gawande advised us not to do anything that slowed the necessary pace of clinical care. This is why we chose paper, and did not develop a Checklist that went into every set of notes, every day.

Section one deals with preparation before the bedside, of which the most important item is "Clinical Thinking", which is time to review the diagnosis, comorbidities and progress to date. The next section is to do with introductions, and review of the main conditions and treatments, planning tests, and anticipating discharge. There is then a section on active safety checking, before a summing up and sign off.

At all stages we have audited the presence of a nurse in the process.

What we have learned from using the Checklist

In many ways our team feels we are just starting to understand, control and optimise ward rounds, but also that we are innovators, and finding it hard to inspire followers.

Complexity

We have learned that ward rounds may be routine and ordinary, but are highly complex, and may even be the most complex time limited human activity. There are so many decisions to make, factors to check and communications with the patient and within the team. It is likely that errors will occur. Errors are even more likely

because rounds are generally conducted with no designated quiet space for clinical thinking, frequent interruptions, and inadequate quantities of hardware and frighteningly slow software.

The need for active safety checking

We thought we were good at doing ward rounds, but the first month was eye opening. We had been performing very poorly on tracking co-morbidities, pain relief, hydration and nutrition, pressure area care, inspecting for cannulas and catheters. More recently we have found we were poor on checking who the patient is, and on checking the team's "Shared Mental Model" of the patient's condition and plans.

Having a process helps and releases time

We now know generally what is going to happen next in a patient review. It is easier being organised and able to anticipate. This allows more time to have discussions with the patient and to clarify the "Shared Mental Model".

Proving an effect is difficult

Naturally people want evidence that using the Checklist process "works". We have shown that all the major Checks are evidence based, so should "work". We believe we

- have had fewer cannula site infections because we get cannulas removed as soon as redundant
- have had fewer catheter associated infections, from using fewer catheters
- use far less iv fluids, because of emphasis on drinking backed up by "Intentional Rounding"
- have ordered fewer blood tests and radiology tests, because of active discussion of tests needed
- have better, though far from ideal "Shared Mental Models"
- have patients more confident in our team and with better understanding of their diagnoses and prognosis
- safer, more legible notes keeping and prescribing

Proving effects on length of stay, costs, patient satisfaction etc is difficult, and would be time consuming and costly. We reassure ourselves by reasoning that: “You can only get reliable outcomes from reliable processes.”

Ward Rounds are Costly and there is a lot of Waste

Ward rounds are costly! A consultant costs the NHS about £2 per minute. If I have to wait 5 minutes for someone to find an echocardiogram report, that is £10 of wasted expensive professional resource just for my time! One day five doctors waited for 10 minutes for a PC to reboot then access PACS, only to find the CT scan had not been reported. That was 50 minutes of wasted professional time, over £50 spent achieving nothing. The seconds and minutes spent finding the notes, finding the right page, finding results, finding the patient, finding the vital signs, deciphering the end of bed folder, finding a nurse to talk with, soon mount up so that the “Value added time” on rounds, probably amounts to only about 20 to 30%. If we could release that time, we could improve quality and safety, or use the time in other ways e.g. see extra patients in clinic.

Cutting Waste

We have devised some ways to create more productive ward rounds, by reducing the non productive wasted time. There is so much more waste to cut!

- Bespoke ward round trolley – Vista 90, saves time in finding the notes, improves filing of the notes, holds the team together in a mobile office. With use of a laptop allows significant reduction in walking distance and time on a ward round. (My laptop has failed, so no longer able use on rounds)

- Diagnostic Cockpit – arranged, organised area for “clinical thinking”, Stationery arranged in Perspex holders on the wall, clearly labelled.
- Bookmarks for Better Care – save time finding right place in the notes
- Doctors’ rubber stamps – make it easy for nurse or pharmacist to contact the right doctor
- Ward Arrival Summary – easy to find “overview” of the patient, helps coding

What slows us down?

So many factors slow us down

- Lack of electronic patient record. Too many people need the notes at the same time. The diagnosis and co-morbidities are written in too many places, undermining “Shared Mental Models”. Duplication of same data on readmissions. Slows production of discharge summary.
- Lack of order comms system. We spend a lot of time just finding out if a test has been requested.
- Inadequate results viewer. Results can appear on a number of different systems. Finding an ECG, a CXR and a potassium result takes effort. Often tests get repeated, because it is easier to repeat than find a test result
- Lack of access to the GPs list of patients’ drugs, clinic letters etc
- Lack of access to our own hospitals letters, discharge summaries, results
- Only one PC in the “Diagnostic Cockpit” area

- No “near patient PC” to access all of above, plus e.g. NICE recommendations, British National Formulary, local policies, pathways, evidence based practice
- Repeated conversations because no nurse at bedside, loss of rich communication
- Interruptions, noise
- “Outliers” and safari rounds
- Absent team members – like a five aside football team going against a team of eleven
- We are like a pit stop team, but we have to go back and forward into the pit to fetch our tools (some never there e.g. ophthalmoscope), and fail to co-ordinate the work

How Long Should a Ward Round Take?

April 2009 to August 2014, ward rounds conducted to Checklist reliability

- **377 Routine Rounds**
- 5941 Patient Reviews
- 16 patients per round
- **11.4 minutes per case review** (Start of briefing to end of all patient reviews)

- **247 Post Take rounds**
- 2391 Patient Reviews
- 10 Patients per round
- **15.2 minutes per new patient case review**

Swifter ward rounds are either more efficient or compromising on safety, quality, reliability, documentation and communications.

Team work on General wards is a myth?

We believe that the best model for communications with nursing staff is to get a briefing from a senior nurse before we discuss the patients, then to have a nurse present with the patient during the consultation. In this way the nurse can be an active participant in the consultation, and understand the rich face to face discussions. The team will then have a shared mental model, and the nurse will be able to answer any questions the patient has. The nurse will also understand the need for specific monitoring e.g. respiratory rate and oxygen saturations in an asthmatic, and know what the “Red Flags” for deterioration are.

In the first couple of years we used sometimes to get some briefing from a senior nurse, before our discussions, but in the last 2 years this has deteriorated to almost non existent. On routine Consultant led rounds we now have the nurse at the bedside for well ***under*** half of consultations. Often we then cannot find a nurse to report to at all. This is like a chef trying to co-ordinate a team making a complex 3 course meal with no conversation or contact. We then wonder why the process is slow and frequently goes wrong!

Communications with Nursing Staff in the current year

Routine Rounds

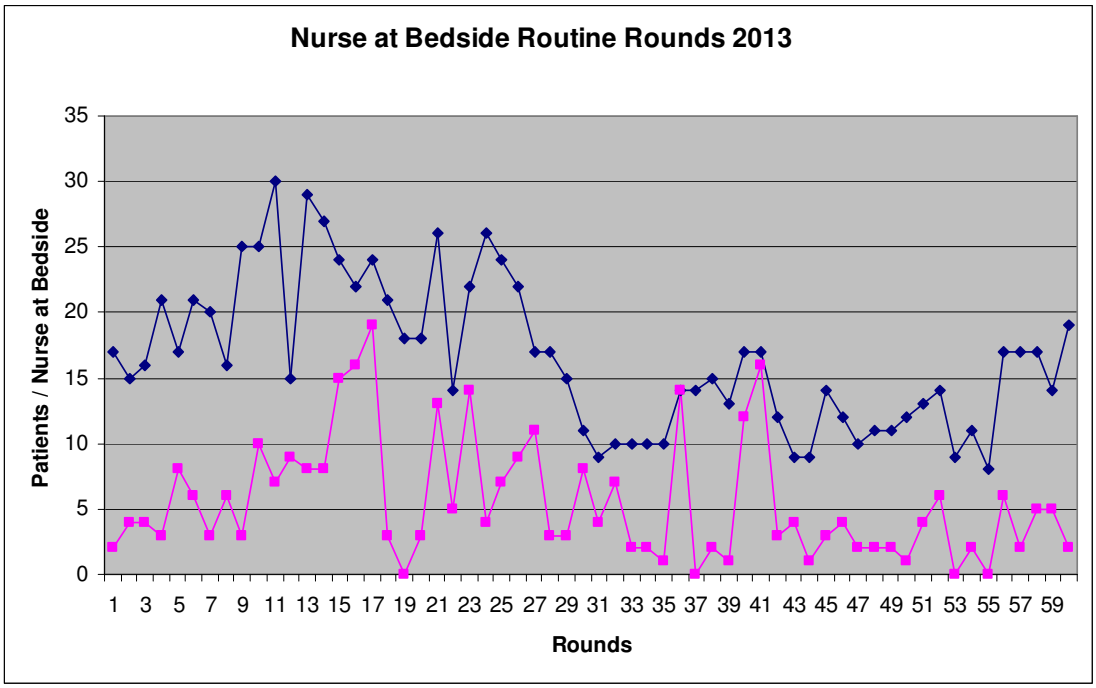
59 rounds

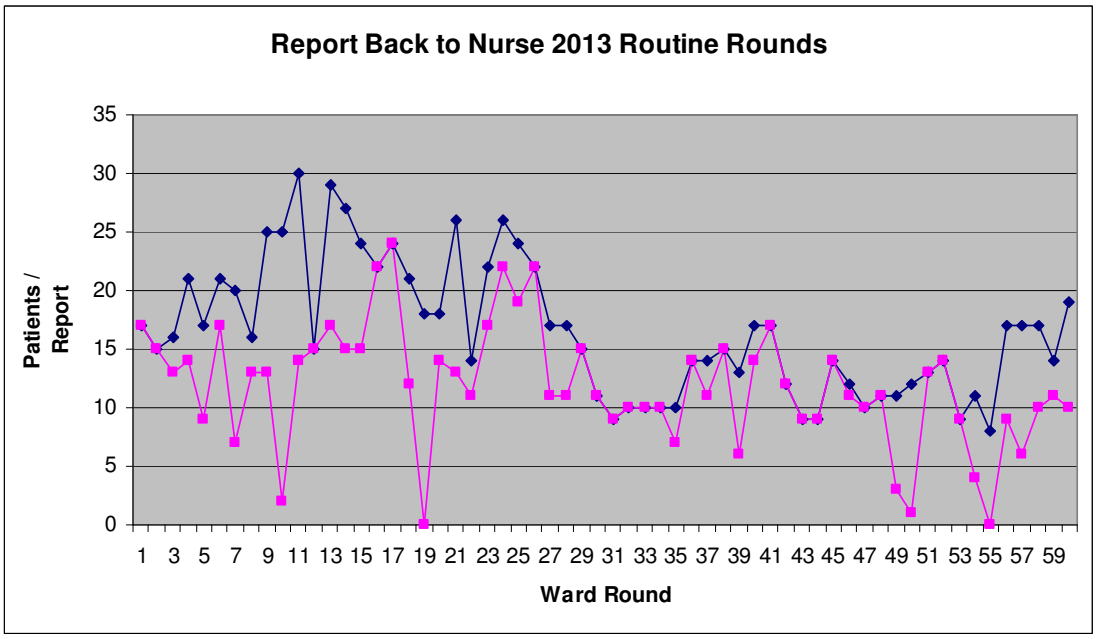
690 patients

Briefing from nurse in 64 (9%) of cases

Nurse at bedside in 246 (36%) of cases

No contact with nurse at all 167 (24%)





Post Take Rounds

50 rounds

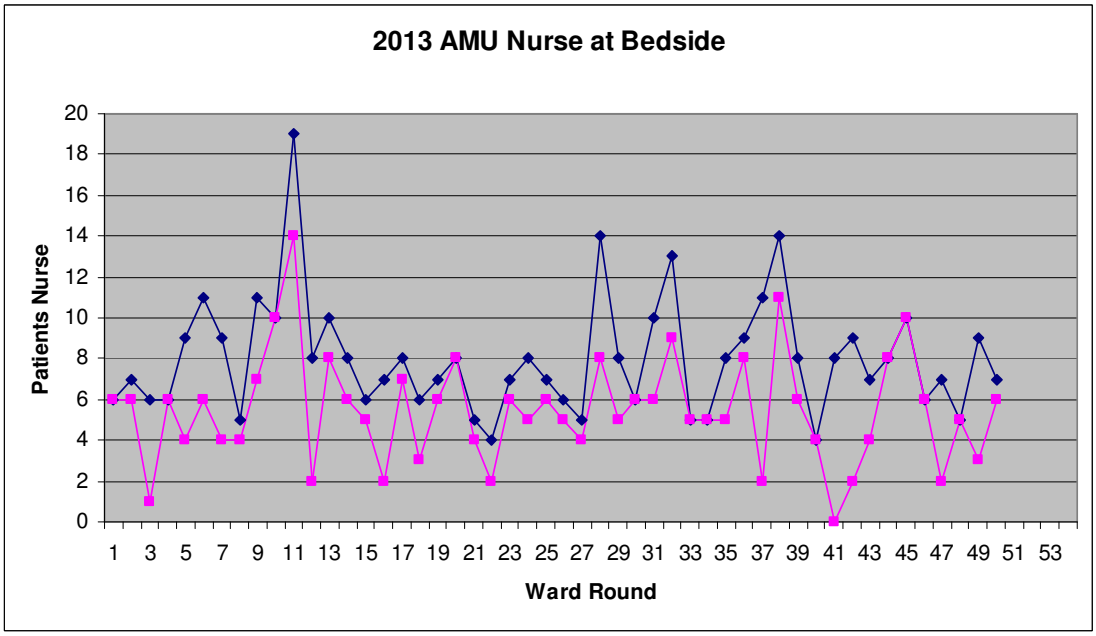
399 patients

Briefing from nurse in 8 (2%) of cases

Nurse at bedside in 274 (69%) of cases

No contact with nurse at all 16 (4%)*

* There is a formal debrief end of round meeting on AMU (very expensive!)



I believe “Nurse at the Bedside” is a powerful simple measure of adequacy of nursing levels, organisation of allocation of Consultants to wards and the culture of inter-disciplinary team working.

What can you do about to improve ward rounds?

Firstly I think you should recognise the central importance of rounds for the progress of clinical care, and secondly recognise that there are major problems with the organisation, content, process and reliability of rounds on acute general wards. The fundamental infrastructure of general acute care needs modernising and radical reform to enable individualised professional patient centred clinical care of the cohorts of complex inpatients coming through our wards. We need process measures that will enhance the care of every patient, not just those that attract special attention like stroke, acute coronary syndrome and community acquired pneumonia.

The simplest step would be to ask Trusts to report real time on

- the numbers of ward rounds conducted
- number of patients seen
- duration of the rounds
- numbers and grades of staff on the round

If commissioners also asked that every inpatient experienced every day (7 days a week) a bedside clinical review attended simultaneously by at least a doctor with a nurse before 1 pm, this alone would require major changes in working arrangements. Achieving compliance with this very simple process measure would take, I think, at least 5 years of transformational change. Obviously I believe these process measures would be only a very low hurdle in comparison with how I believe ward rounds should be conducted. Adding in that one team member should conduct a structured review of the drug chart, and that the Consultant should read and sign off the ward round note, would drive further improvements for all patients.

Ward Rounds are the production line of acute inpatient services. Hardly any of the geography, systems or culture of wards support safe, swift, effective, efficient, easy, enjoyable working on “fixing sick patients”, which is the reason we are all here. Unless we get the micro-environment optimised we will never make important

reductions in avoidable harm, reduce costs of waste, achieve on time discharges, and low readmission rates, with grateful patients and fulfilled staff.

Unless we make changes, everything will remain the same.

The Importance of Ward Rounds has been greatly undervalued and underappreciated, leaving our patients in hospital longer than needed, and frustrating our valuable front line staff. It is going to be long hard work to improve the processes. Are you with me in the struggle?

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Western Sussex Hospitals Standard process for Post Take Ward Round

Considerative Checklist for Complete Patient Review

The purpose of this process is to ensure that the team "does it all" for all the patients during the round

Make one member of the team the "Safety Checker" who uses this checklist before leaving each patient.

The checker must highlight anything omitted, speak up and get it done!

Key = **these sections must be checked in all patients**, tick white boxes only when indicated

Date	Checker's Name	Checker's Status	Signed	Clinical Team	Type of Round
/ /2013					**Post take**
Start time	Finish time	Number of Doctors	Number of patients		

Aspect of Care	**Item done**	√	**Not yet done**	**O**	**Not done**	**x**	
Patient Initials							
Bed number							
Preparatory Discussions	**Preparation Before Going to the Bedside**						
Check Bloods, ECG, CXR							
Report from Nurse?							
DVT prophylaxis form							
Ceiling of care or CPR							
Consultation	**Bedside Patient Consultation**						
Nurse present?							
Leader's hand hygiene							
Introductions							
Wristband check							
Focussed Examination?							
Charts	**Check All Relevant Bedside Charts**						
Write the NEWS score							
Drugs Chart inspected?							
Diabetic? Glucose							
Planning	**Decide on blood tests, radiology, set Estimated Discharge Date, CPR status**						
Agree future tests							
EDD / Ward in notes?							
7 Point Safety Check	**7 Point Patient Active Safety Check to Reduce Avoidable Harm**						
Pain or discomfort							
Eating and Drinking							
Bowel function							
Urine / catheter							
Cannula and iv lines							
Pressure area care							
DVT prophylaxis Rx							
All 7 points checked?							
Documentation	**Consultant confirms problems list and plans as written, signs notes**						
Notes stamped by Consultant							
Scribe Sums Up to Team							
Reported Plan to Nurse?							

Western Sussex Hospitals Standard Process for Routine Ward Round
Considerative Checklist for Complete Patient Review
The purpose of this process is to ensure that the team "does it all" for all the patients during the round

Make one member of the team the "Safety Checker" who uses this checklist before leaving each patient.

The checker must highlight anything omitted, speak up and get it done!

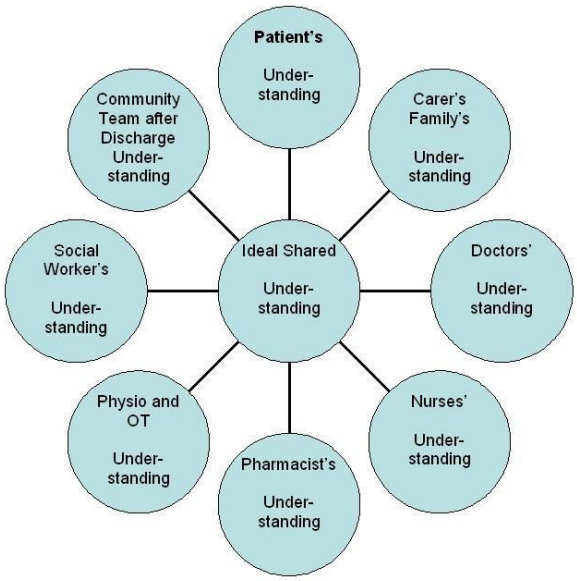
Key = **these sections must be checked in all patients**, tick white boxes only when indicated

Date	Checker's Name	Checker's Status	Signed	Clinical Team	Type of Round
…/…./2013					**Routine**
Start time	Finish time	Number of Doctors	**Total number of patients**		
			New	**Review**	**No of wards**

Aspect of Care	**Item done**		**√**	**Not yet done**		**O**	**Not done**		**x**	
Duration of Admission										
Patient Initials										
Bed number										
Preparatory Discussions	**Preparation Before Going to the Bedside**									
Filed Clerking Notes										
Checked New Results										
Clinical Thinking										
Report from Nurse?										
Consultation	**Bedside Patient Consultation**									
Nurse present?										
Hand hygiene										
Introductions										
Wristband check										
Ask and Listen										
Charts	**Check All Relevant Bedside Charts**									
Write the NEWS Score										
Drugs Chart										
Fluid Rx chart + Balance										
Diabetes / Glucose										
Planning	**Decide on blood tests, radiology, Discuss Discharge Date, Ceiling of Care**									
Agree future tests										
EDD Discussed?										
Confirm Ceiling of Care										
7 Point Safety Check	**7 Point Safety Check to Reduce Avoidable Harm**									
Pain or discomfort										
Eating and Drinking										
Bowel Function										
Urine / catheter?										
Cannula and iv lines										
Pressure area+falls										
Review VTE Rx?										
All 7 points checked?										
Documentation	**Consultant Inspects and Counter Signs Today's Notes**									
Notes signed by Consultant?										
Scribe Sums Up Plans										
Patient progress as expected?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Reported Plan to Nurse?										

Scribe Sums Up on Ward Rounds

At the end of a patient review on a ward round there should be a shared understanding of the patient's problems and the planned actions to improve the situation.



The problem

At the end of the bedside review, what is written in the medical notes by the doctor (the scribe) often does not represent what the ward round leader believes he communicated during the review. This then affects the reliability of any handovers, the assessment of the patient after any sudden deterioration and the discharge summary. The nursing staff may write another account with different words to describe the diagnosis and plans. The nurses then hand on information to patients, relatives, therapists and social workers and the important issues can become fogged with misunderstanding.

The Suggested Solutions

1) Some ward round leaders dictate to the scribe what to write. Obviously this is time consuming and legibility is likely to suffer for the sake of speed
2) Some ward round leaders dictate into a Dictaphone and the secretary later files the report. This always involved delay, but the quality of the information is likely to be high.
3) Some ward round leaders write the note themselves, which may well result in wasted time for the rest of the team. On a post take round, I usually write the diagnoses and problems into the notes before seeing the patient, whilst I listen to the account of the history and examination.
4) I now countersign every ward round note, when I am on rounds. At least the Juniors know that I will cast an eye over their writing. However I rarely have the time to read the note.
5) The Registrar is called the Registrar because his role was to register the account of the ward round. Registrars have expertise and may well write a better and shorter note. In current NHS practice the notes writing is given to the minion in the team, usually the F1 or Student. Maybe this is wrong?
6) Scribe Sums Up. In this process the scribe, or someone other than the ward round leader is asked to "Sum Up" at the end of the consultation. Everyone else should be quiet and the Scribe addresses the patient. The summing up should be brief, perhaps an average of 15 seconds, maximum a minute. I ask that the Scribe says the patient's name, the diagnosis or diagnoses e.g. pneumonia with COPD, or problem "Severe sepsis, source not known", the plans for treatments and tests, and anticipations for the period of time to next review, and eventual discharge. The benefits of this seem to be
    a. The Scribe and team remain attentive throughout the Consultation
    b. All the talking stops, and the patient and team know whom to listen to
    c. The Scribe may well improve the layout of the note, in preparation for summing up
    d. The Ward Round leader, Patient, Nurse or any team member can correct any misunderstandings or ask for clarification

I believe many of the same issues would apply with electronic records.

Evaluation

It would be useful to know if this was prolonging rounds, so it might be of value to measure with a stopwatch, how long each “Summing Up” takes.

Formally measuring “Shared Mental Models” would be very time consuming, so some simple qualitative evaluations from doctors, nurses and patients could be used.

Coders might be able to provide some evaluation, because meaningful clinical notes are easier to code.

Video of consultations with Scribe Sums Up could be powerful evidence of effectiveness?

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Dr Caldwell's Post Take Ward Round Instant Team Feedback

Date		Day of Week		Most senior Dr on round	Consultant

Our Work on this Post Take Ward Round is to provide for our cohort of patients the

Right Diagnoses and the
Right Treatments at the
Right Time in the
Right Place
Right Pace and with the
Right to no Harm, and
Better next Time

and to document all of this clearly and carefully

Your Commitment to Team Working on this Post Take Round

By signing this you agree to participate actively in the team's work throughout the round, supporting each other in every case review e.g. looking up bloods, X rays, completing documentation.

You will speak up if you see omissions in care, errors, substandard work, or if you feel uncomfortable about any aspect of care or any decision. We must strive to get the care for the patient right first time.

Grade	Name	Present	Signed	Comments and Allocated Task
Consultant	Dr G Caldwell			
Night SPR				
Night SHO				
Night F1				

Pre-Round Briefing – ask these 3 questions:

Any patients so ill that they need review before considering any other cases?	**N/Y**
Any patients needing early discussion with radiology or referral to other specialities outside medicine?	**N/Y**
Safety Question – Which patient has caused the team most concern during the take?	

Total number assessed by team in 24 hours		**Number of wards to visit today**	
Less number of DVT patients			
Less number of non DVT discharged before			
Less number died		**High Dependency Admissions**	
Less number already taken over by another team		Admitted to CCU	
Less number transferred out of hospital		Admitted to ITU / HDU	
Remaining patients admitted by day team			
Evening		Number seen by SPR for other specialities	
Remaining patients admitted by night team		**Sent home overnight:**	
Total new patients now to be seen on round			
Number sent home immediately on round			
Did you find any unidentified acutely unwell patients, who should have been prioritised on the round?	**N/Y**		

Feedback on Medical Take Team Performance

This is feedback on the whole team's working. The team should work together to ensure that all care is timely, safe and well documented. One team member's feedback may be brought down by e.g. poor prescribing by another member of the team, or brought up if we all work effectively together and check each other's work.

Complete the feedback for first patient presented by each Junior. Provide feedback considering the doctor's expected performance in relation to seniority.

Please give useful constructive feedback

Grade of Dr	**Night F1**	**Night SHO**	**SPR**
Trainee's name			
Number of Cases			
Type of case – diagnosis and complexity			
Correct assessment: Is patient acutely ill? NEWS score			
Notes legibility, accountability, and content			
Style and pace of oral presentation			
Clinical thinking, judgement, written diagnoses and problems list			
Initial plans: treatment, investigation, need for review			
Safety in prescribing of drugs, O2, fluids			
Too many or too few tests?			
Case discussed with SPR			
Summing up after Bedside Review			
Suggested learning point			
Rapport with patient			

Consultant's Feedback on the Round