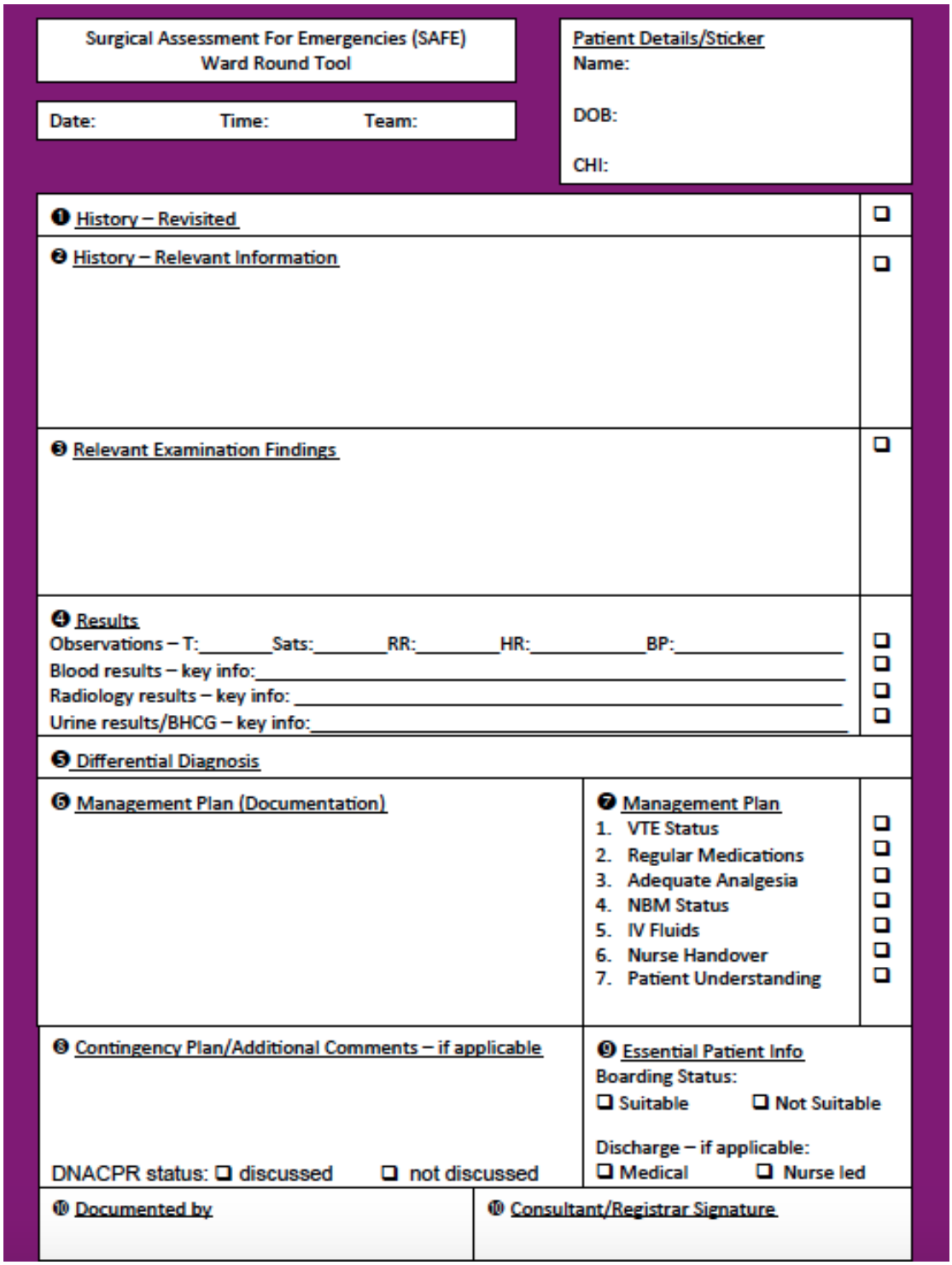
Surgical Ward Round Tool



Surgical Assessment For Emergencies (SAFE)
Ward Round Tool

Date: Time: Team:

Patient Details/Sticker
Name:

DOB:

CHI:

❶ History – Revisited ❑

❷ History – Relevant Information ❑

❸ Relevant Examination Findings ❑

❹ Results
Observations – T:_____Sats:_____RR:_____HR:_____BP:_____ ❑
Blood results – key info:_____ ❑
Radiology results – key info: _____ ❑
Urine results/BHCG – key info:_____ ❑

❺ Differential Diagnosis

❻ Management Plan (Documentation)

❼ Management Plan
1. VTE Status ❑
2. Regular Medications ❑
3. Adequate Analgesia ❑
4. NBM Status ❑
5. IV Fluids ❑
6. Nurse Handover ❑
7. Patient Understanding ❑

❽ Contingency Plan/Additional Comments – if applicable

DNACPR status: ❑ discussed ❑ not discussed

❾ Essential Patient Info
Boarding Status:
❑ Suitable ❑ Not Suitable

Discharge – if applicable:
❑ Medical ❑ Nurse led

❿ Documented by

❿ Consultant/Registrar Signature

Background

This study took place in the department of surgery at the Royal Infirmary of Edinburgh. During July-August 2014 interviews were conducted with nursing and medical staff, highlighting issues with emergency surgical ward rounds. Focus-groups were held with nursing staff, Foundation year 1 and 2 doctors, registrars and consultants between January-February 2015 to discuss the development of an intervention to structure the ward rounds. On the basis of staff recommendations a ward round patient assessment tool was developed.

What is the Surgical Assessment For Emergencies (SAFE) tool?

The SAFE tool is a documentation-based ward round tool which aims to provide:

Structure to emergency surgical ward rounds

Consistency in the tasks performed and information checked on these ward rounds

Instructions for Use:

The SAFE tool in its current format has been used on emergency general surgical ward rounds for the assessment of patients who have recently been admitted to hospital. The tool is used to structure the first ward round encounter between the patient and the emergency surgical team, where a large amount of the information that is covered through the tool is relevant to entire team involved in the patient's care. It is therefore not appropriate for completion by the admitting doctor on their own.

Once completion of the tool has been documented it can be placed in the patient's notes.

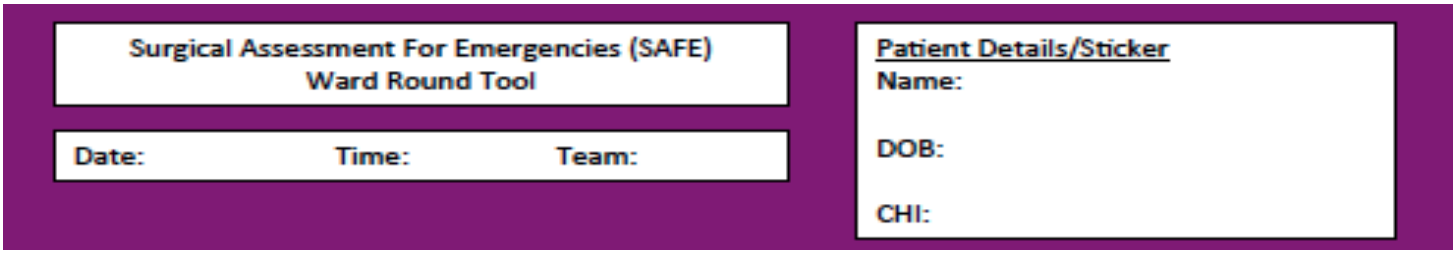
This tool could be adapted for follow-up/review ward rounds and also for electronic ward round documentation.

How can we get the most out if it?

The design of this tool was based on input from medical and nursing staff in the department of general surgery in the Royal Infirmary of Edinburgh. It was therefore specifically developed in the context of the staffing, ward structure, work volume and sub-specialties of that department. The contents of this tool may therefore not be totally applicable to other units and specialties and some adaptation may be required. We would therefore encourage other

departments/specialties to trial the current tool and then make adjustments as appropriate. This type of intervention has the best chance of success when it has been adapted by whichever unit uses it.

How should the SAFE tool be used?



The date, time and team sections should be filled out for every new patient admission. The 'team' section can be completed by providing the initials of the consultant/senior clinician who is the care provider.

A patient sticker can be applied over the "Patient Details/Sticker" box provided or the correct information can be documented.

Part 1 & 2

Part 1 – "History - Revisited," complete the tick-box for any of the following actions:
History verbally presented by team member
History read-back from an admission sheet
History taken from patient at bedside
There is requirement to document any further history, unless there is any new information. For new information see Part 2.

Part 2 –"History – New Information," for documentation of any new information from the ward round.

❶ History – Revisited	❑
❷ History – Relevant Information	❑

Part 3

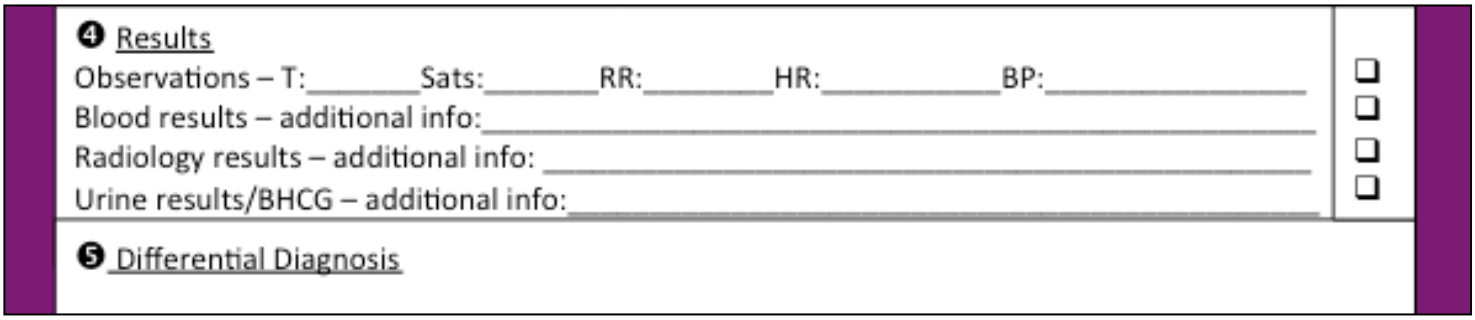
Part 3 – "Relevant Examination Findings," if an examination is performed on the ward round document findings in box provided. Complete the tick-box if relevant examination findings are verbalised.

❸ Relevant Examination Findings	❑

Parts 4,5

Part 4 – "Results," complete the tick-box if relevant results are verbalised by a team member. There is no requirement for documentation of results, however space is provided for this if deemed necessary.

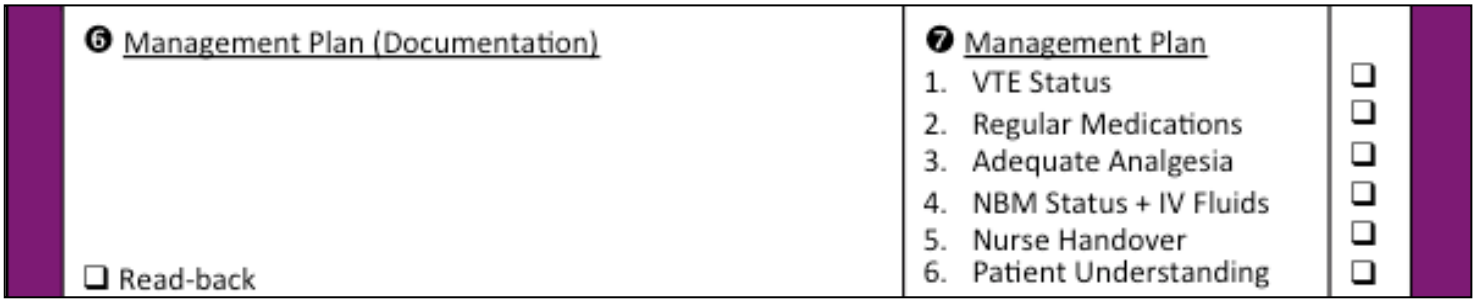
Part 5 – "Differential Diagnosis," completed with documentation of a differential diagnosis.



Parts 6 & 7

Part 6 – "Management Plan (Documentation),"completed if a management plan for the patient has been verbalised and documented.

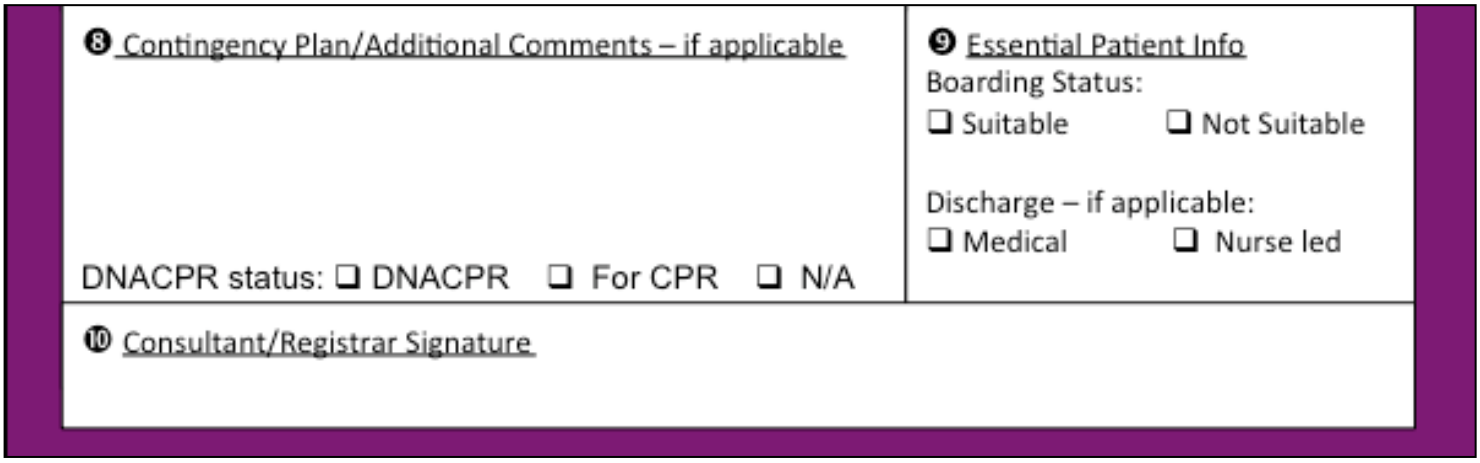
"Read-back", complete tick-box when the staff member documenting has verbalised the management plan written down. This is to ensure all relevant information has been received and taken down.



Part 7 – "Management Plan," complete tick-box when relevant management steps have been verbalised:
VTE Status – checked if patient's VTE prophylaxis prescription has been checked on drug chart and verbalised
Regular Medications – checked if drug chart is assessed for prescription of patient's regular medications (as per clerking sheet)
Adequate Analgesia – checked if team has asked patient whether they are receiving sufficient analgesia

Nil by mouth (NBM) status + IV Fluids – checked if patient's NBM status is verbalised, as well as requirement for IV fluids, if appropriate
Nurse Handover – checked if team has checked with nurse if has any questions/ has conveyed management plan to nurse
Patient understanding – checked if team has checked with patient whether they have any questions.

Parts 8,9 &10



Part 8 – "Contingency Plan/Additional Comments,"
Contingency Plan - in the case where it is anticipated that the patient might deteriorate a contingency plan can be documented here to direct staff. A decision as to the patient's DNACPR status can also be discussed at this time (this however does NOT serve as a replacement for the official "red form" DNACPR documentation which should still be filled in separately)
Additional Comments – for any additional comments relevant to patient assessment on the ward round or patient management

Part 9 – "Essential Patient Info"
Boarding Status – indication as to whether the patient is suitable for boarding to another ward, or not
Discharge – if the patient is due to be discharged, gives an indication whether the discharge can be nurse-led or requires input from medical member of the team

Part 10 – "Consultant/Registrar Signature"
This section should include the signature from the consultant or surgical registrar leading the ward round to indicate that they are satisfied with the information documented on the tool.