WARD ROUND CHECKLIST

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SaTH Improvement Hub

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REASON WHY?

Effective ward round documentation is vital for ensuring patient safety, continuity of care, and adherence to clinical governance standards. This quality improvement review was conducted at the Royal Shrewsbury Hospital across Wards 22, 26 and 28 to assess and enhance the standard of medical progress notes. in line with RCP and RCN guidance on modern, multidisciplinary ward round documentation

SMART AIM

S SPECIFIC M MEASUREABLE A ACHIEVABLE R RELEVANT T TIME-BOUND

Improve adherence with Royal College of Physicians and Royal College of Nursing (RCP/RCN) documentation guidelines on Wards 26 and 35 ,where the checklist was piloted - from an average baseline of 44% to 60%, supporting safer, more consistent patient care during ward rounds, as evidenced by re audit ion 30/06/2026.

PLAN

A baseline review of 35 ward round enteries, measured against Royal College of Physicians and Royal College of Nursing (RCP/RCN) guidelines, revealed high documentation rates for vital signs (97% and blood tests (82.8%). However, significant gaps were found in imaging (51.4%), antibiotic reviews (60%) ,escalation planning (28.5%), criteria for discharge (25.7% and follow-up arrangements (11 4%)
To address these gaps, a structured ward round checklist aligned with RCP/RCN standards was developed with input from resident doctors, nursing staff ward clerks and physiotherapy and pharmacy and introduced as aide memoire in the notes. Feedback surveys form resident doctors and wider MDT were built into plan from the outset to assess its acceptability.

DO

The checklist was piloted on Wards 26 and 35 added to the notes as a bookmark refined from an initial full page format into a compact 'bookmark' style for ease of use during busy ward rounds.
In parallel, a feedback survey was distributed to resident doctors during the pilot period to explore their views on whether a ward round checklist would be beneficial. It showed that 74% did not currently use a structured approach ,while 80% believed that a checklist would improve documentation and patient safety.

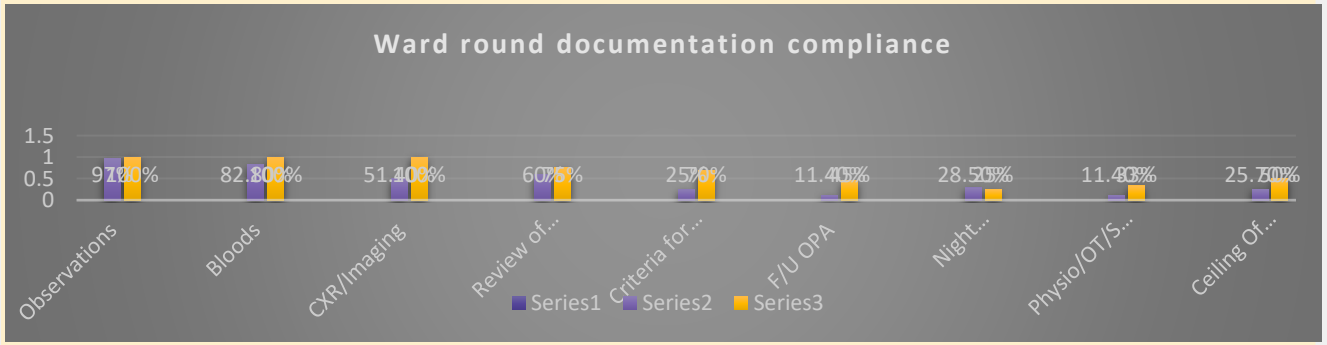
STUDY

Resident doctor survey

1.100% agreed they are aware of aide-memoire is present in the patients folder.
2.100% agreed it is easy to locate
3.100% agreed it has improved patient care

Challenges faced by resident doctors

1.Time pressure during busy ward rounds and checklist can be difficult to review quickly
2.Care-planning section most frequently missed.



Following introduction of the bookmark ,documentation compliance increased on average by 22% (from 44% to 66%).see graph, left. The largest gains were in the areas identified as weakest at baseline. escalation planning, discharge criteria and follow-up arrangements.
FY1 doctors were the most frequent users of the aide-memoire and showed the greatest improvement in documentation.

MDT Feedback Survey: (Nursing staff, Ward clerk , Physiotherapy)

100%found folder mark very helpful in organising patient documentation plus documentation and communication has improved.

Conclusion :Feedback from across the MDT showed a clear improvement in communication ,with FY1 doctors showing the greatest improvement in documentation quality that supported the idea of embedding the aide memoire within FY1 simulation and induction training

ACT

ADOPT

The bookmark aide memoire has been adopted on wards 26 and 35 where it was piloted

ADAPT

Consider how the aide memoire is transferred into notes daily before roll out to further wards, as this is currently relies on ward clerks.

NEXT STEPS

Introduce aide memoire within FY1 simulation and induction training as a dedicated slide on ward documentation ,to promote good documentation habits early in practice and drive further improvement in team communication and patient care.

ACKNOWLEDGEMENTS & REFERENCES | Thanks to Dr Kevin Sean Eardley for all his help and support .Royal collage of Physicians and Royal Collage of Nursing 2021.Modern ward round .Good practice for multidisciplinary documentation. RCP London. UK