Multidisciplinary patient review in COVID-19 cohort wards

This guidance has been produced to support teams caring for people with COVID-19.

As this is a rapidly evolving area of adapted clinical practice, feedback and examples of good practice to inform future updates are welcome.

Multidisciplinary assessment is the hallmark of modern inpatient care. This includes:

- board round discussions for an overview, prioritisation and identification of key actions
- detailed multidisciplinary discussions of individual patients as part of a ward round, or other prioritised review, eg deteriorating patient, new admission
- bedside review of the patient which includes assessment, information sharing and shared decision-making
- case review with external agencies, eg nursing homes, community carers, primary care
- review from specialists outside the immediate care team
- information sharing with the patient's agreed family members, carers or others important to them.

Patients with COVID-19 or with potential COVID-19 may need to receive these elements of care in an adapted way to meet their needs and protect other patients, staff and the public.[1]

Staff caring for patients with COVID-19 or with potential COVID-19 must protect themselves and patients while still providing care that meets the individual patient's needs and minimise the risks of cross-contamination between patients. National and local infection prevention and control (IPC) guidance including the use of personal protective equipment (PPE) enables this.

Board rounds or huddles should be held with one member of each appropriate discipline, respecting the social distancing measures provided by current guidelines, or as distant as possible for effective discussions in the available environment. Doors to patient bays and rooms should be closed, and visiting is restricted to patients with specific needs. This will ensure confidentiality. If this can be done by video conferencing or phone access for some team members, this should be encouraged to facilitate social distancing and full team participation. A team member should update the ward overview board. Tasks should be allocated at the board round to team members for review and to review and progress each patient's care. Board rounds are of added importance for coordination when ward teams are divided into smaller teams for patient review.

Ward rounds including bedside review should include individual members of the multidisciplinary team that are relevant to each patient: eg senior decision-maker (consultant/registrar), nurse, and pharmacist. A safe distance between team members should be maintained during the ward round in accordance with local guidelines and appropriate IPC guidance followed.

Patients' charts and records should be reviewed at a safe distance from the bedside while receiving input from the team members. Where centres are using paper charts and records, they should remain outside the patient room or bay, or a safe distance from the patient.

The ward round lead (normally the consultant) should attend the patient at the bedside using appropriate PPE, other team members, eg lead nurse or patient's own nurse should support this clinical assessment and communication at the bedside dependent of each patient's needs. Normal IPC policies for bedside review should be followed with vigilance. PPE buddies who ensure compliance are helpful.[2]

Other team members should remain at a safe distance from the bedside, eg outside the room or patient bay during this review. Following bedside review, further multidisciplinary discussion and documentation should take place.

A single multidisciplinary patient record should be used whenever possible. Standardised documentation proformas for ward round assessments, checklists and treatment escalation plans should be used. They may benefit from additional elements for patients with COVID-19, eg proning, probability of COVID-19 diagnosis or risk of nosocomial spread.

Other prioritised multi-professional bedside reviews should take place in the same manner as individual reviews on the ward round.

Case discussions with external agencies should take place by phone or video consultation whenever possible, or in a room with appropriate social distancing measures.

Individual patient reviews by team members or other specialists should take place at the bedside (following initial patient record review away from the bedside) using appropriate PPE. Reducing duplication of patient contact and assessment using the SPACES principles should be applied.[3] Case discussion with other specialists can occur over the phone if all relevant clinical details can be obtained but should not replace bedside review if that will add to patient assessment and management. Documentation should note whether patient assessment has happened away from the bedside or remotely when that is the case.

Teaching and training is an integral part of professional practice, and is of particular importance in care for people with COVID-19 as this is a new clinical area. This can happen through all aspects of clinical care. When there is particular value in individual cases for this to be at the bedside then that should happen with individual learners using the precautions outlined for care and with the patients consent. Staff in training performing clinical assessments, and these then being ratified by more senior staff is also appropriate.

Communicating with families, carers and those important to the patient

As hospital visiting is restricted except for specific, often compassionate circumstances such as end of life, proactive daily communication with the patient's preferred family member or next of kin should be the routine standard of care. Clarification of the family member to be contacted should be made with the patient and their verbal consent obtained. Mechanisms for the patient to communicate with their family remotely should be provided such as bedside phone that can be cleaned, or tablet computers for video links.[4] At the end of a ward round or patient review an update to the patient's preferred family member should be made by the relevant member of the multidisciplinary team or the patient.

This guidance is based on the principles of *Modern ward rounds – good practice for multidisciplinary inpatient review*, which is being developed by the Royal College of Physicians and Royal College of Nursing in collaboration with the Chartered Society of Physiotherapists, Royal Pharmaceutical Society and NHS England & Improvement Emergency Care Improvement Support Team. This guidance has been developed by the same cross-professional group.

References

1 SPI-B and the Environmental Working Group. Managing infection risk in high contact occupations. June 2020. www.gov.uk/government/publications/managing-infection-risk-in-high-contact-occupations-11-june-2020

2 PHE guidance. COVID-19: personal protective equipment use for aerosol generating procedures. Updated June 2020. www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

3 British Thoracic Society. SPACES information document. www.brit-thoracic.org.uk/document-library/quality-improvement/covid-19/spaces-information-document/

4 Intensive Care Society. Guidance on the use of video communication for patients and relatives in ICU. www.ics.ac.uk/ICS/COVID-19/COVID19.aspx?hkey=d176e2cf-d3ba-4bc7-8435-49bc618c345a