How to see a ward patient

What are your priorities when you see a patient on a daily basis in the ward?

Each patient is different. But in general, see that the patient is improving, the clinical pathway is heading in the right direction. Look for subtle signs that something may be wrong. Always keep in mind why the patient is there, have they had an operation, are they waiting for their antibiotic course to be completed ect.

How do you start the examination?

Before you get to the patient's bed, observe them while you are walking towards them. Are they in pain, do they look ill, are they sitting up chatting the their neighbor? Is this different from your last ward round, if so how, for better or worse? Greet them, ask how they are, have their symptoms improved from when last you saw them. Ask them about a family visit, how breakfast was if they are allowed to eat. Create a rapport with them, show a genuine interest in them and their well-being.
If you have never seen them before introducing yourself, tell them why you are there, and what you are going to do. Tell them their usual doctor has told you about them, and then proceed to ask them questions about how they are feeling. Always be friendly, even when under time pressure.
While doing this I continue observing the patient, behavior and body language speak volumes. Are they hiccupping? This could be a sign of a subphrenic abscess.

What do you do after you've started a conversation?

I always start by examining the patient. I find that by jumping into the nursing observation file or doctors notes the interaction is broken.
If there are drainage bags, I will start by looking at their content, what is the color and nature of the fluid, is it what you expect or not, is the bag full? (If it is it won't be included in the fluid balance chart).
I usually start by palpating the radial pulse, for two reasons. One is that it's an easy, non-imposing way of initiating a clinical examination, especially with a patient who may be shy or intimidated by the white coat, the second is that I use it to correlate with the vital sign chart, is it regular or is there new onset atrial fibrillation. Is it weak and thready or strong and bounding? I will then move to the area of pathology, by asking the patient if I may have a look at their cellulitic leg, or abdomen as the case may be. If it is something that could be painful, ask if it sore and if it is worse than the day before. Inspect the area, if there was cellulitis is it better, worse or the same as the day before, if there was distension has it changed. Examine gently, always start away from the site of potential pain and move towards it. Auscultate the area if indicated. Always remember why you are examining and what you are looking for with your examination. By the end of your examination you must have answered this question.

Now that you have examined the pathological site, what do you do next?

Once you have completed the pathology specific examination complete a general examination. Auscultate the whole chest, especially the lung bases to exclude atelectasis or the beginnings of a pneumonia. Examine the calf muscles to exclude a deep vein thrombosis, examine drip sites to exclude a cellulitis (this includes central venous catheter sites). If the patient has been bedridden for many days examine the pressure sore sites for early bedsores, roll the patient of required.

Once you have completed your clinical examination what is your next step?

I then go to the file. Look for the vital sign chart and look at the last 24hours. I look for trends as well as gross anomalies. Was the temperature constant, were there spikes? What was the heart rate doing and is it in keeping with the patient's current condition? Does it match my radial pulse count? If not, why not?
Look at the fluid balance chart. What was the drain output? What was the urine output? What did the patient take in orally, how much fluid was given intravenously? Does this fit in with the clinical picture, your expectations? If not, always ask why not? If the patient was supposed to eat, but didn't, why didn't they? Were they feeling ill, or nauseous, or just don't like the food? Never just scan over information, you will miss subtle signs. Know what you are looking for, and you will see it earlier, and maybe prevent a complication. If the patient is on a sliding scale are their blood glucose values controlled, if not, why? Are they becoming septic, or is the dose inadequate?

Check blood results, culture results and other reports.

Stop and think. Assimilate all of the information, is your patient heading in the right direction? If not, why not? Is there something that needs to be done immediately? Does the treatment need to change?

What about the prescription chart?

Lastly, I check the prescription chart. Never assume it is correct. Read each medication. Is it indicated, is it the correct dose? If your patient has developed renal dysfunction then some drugs need their dosages adjusted. Has the course of antibiotics been completed; can the antibiotic be de-escalated following a culture and sensitivity result? Is there deep vein thrombosis prophylaxis? Have the patient's chronic medications been prescribed?

What is the last thing you do at the patient's bedside?

The second last thing is to write clear, concise notes with legible handwriting. Always start with the date and time, and the most current diagnosis, never write 'as above' or 'ISQ' ect. Write down the vital signs, summarize the previous 24hour's happenings, add pertinent results. Document your clinical examination findings, and then write a plan, for the next 24hours as well as in the future. Print your name, add your pager number.

The last thing is to always tell the patient how they are doing and what the plan is going forward. Are they allowed to eat, are they going to radiology for an intervention? Let them ask you questions. Write down in the patient's file what was discussed.

Take home messages?

Always be friendly with the patient, remember they are sick, often scared, very few people intentionally want to be in hospital.
Devise your own system that includes all that we have covered today, and apply it every day, to every patient. It will become second nature to you so that you eventually don't even think about it, but you won't miss a step.
Observe your patient, body language gives a lot of information.
Write adequate notes, never skip this, no matter how busy you are or where you are working.

Ward patient approach algorithm