Patient Centered Rounds: Bridging Gaps in Communication

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“Effective teamwork and communication are critical elements for providing high-quality, safe and patient-centered care.”

(Sehgal & Auerbach, 2011)

Nationwide Children’s Hospital

• 68 facilities throughout Ohio
• 427 beds in our main campus
• 124,370 inpatient days in 2013
• External validation of excellence:
  – U.S. News and World Reports
  – Parents Magazine
  – Magnet Recognized
H4A

- 24 bed inpatient cardiac step-down unit, also with urology, plastic surgery, and ophthalmology patients
- 4,592 inpatient days in 2013
- Average daily census = 14
- Average length of stay = 3.21 days
- Age range = birth to adult

JOURNEY TO BEST OUTCOMES

Providing Quality Care

Through excellence in Patient and Family-Centered Rounding

Why Round?

- Interdisciplinary rounds are only recently being identified as having an impact on patient care
- Assembly of healthcare team in a single location to discuss care
- Associated with lower mortality rates in ICU settings and improved collaboration in others

(O’Mahony et al., 2007)
Bedside Rounds
Putting the puzzle together

✓ Patient
✓ Family
✓ Attending Physician
✓ Resident
✓ Nurse Practitioner
✓ Medical Students
✓ Charge Nurse
✓ Bedside Nurse
✓ Care Coordinator
✓ Pharmacist
✓ Dietitian
✓ Social Worker
Spring 2013, a time for change

- A PDSA took place and KDD updated to help guide progress

![PDSA Diagram]

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Rounding Engagement

<table>
<thead>
<tr>
<th>Key Drivers</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>Implement, inquire, and measure goal sheet utilization.</td>
</tr>
<tr>
<td>Physician and Fellow to prioritize patients before rounds begin.</td>
<td></td>
</tr>
<tr>
<td>Nurse to prioritize Ward to enable participation or have Charge RN participate instead.</td>
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<tr>
<td>Educate nursing and physician teams on rounding objectives.</td>
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<tr>
<td>Leadership to share rounding measures and results with staff.</td>
<td></td>
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<tr>
<td>Broadcast room numbers for nursing staff and families as rounds progress.</td>
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<tr>
<td>Nurses to prioritize tasks to enable participation or have Charge RN participate instead.</td>
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<tr>
<td>RN to review information with most shift during handoff report.</td>
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</tr>
</tbody>
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Percentage of Rounds with 64 Required Participants 2013

<table>
<thead>
<tr>
<th>Month</th>
<th>Compliance</th>
<th>Baseline Percent</th>
<th>Influential Periods</th>
<th>Control Limits</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>70%</td>
<td>62%</td>
</tr>
<tr>
<td>Feb</td>
<td>75%</td>
<td>55%</td>
<td>65%</td>
<td>75%</td>
<td>68%</td>
</tr>
<tr>
<td>Mar</td>
<td>80%</td>
<td>70%</td>
<td>80%</td>
<td>80%</td>
<td>73%</td>
</tr>
<tr>
<td>Apr</td>
<td>85%</td>
<td>75%</td>
<td>90%</td>
<td>85%</td>
<td>78%</td>
</tr>
<tr>
<td>May</td>
<td>90%</td>
<td>80%</td>
<td>100%</td>
<td>90%</td>
<td>83%</td>
</tr>
<tr>
<td>June</td>
<td>95%</td>
<td>90%</td>
<td>95%</td>
<td>95%</td>
<td>88%</td>
</tr>
<tr>
<td>Jul</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>Aug</td>
<td>97%</td>
<td>90%</td>
<td>97%</td>
<td>97%</td>
<td>90%</td>
</tr>
<tr>
<td>Sep</td>
<td>94%</td>
<td>85%</td>
<td>94%</td>
<td>94%</td>
<td>87%</td>
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<tr>
<td>Oct</td>
<td>91%</td>
<td>80%</td>
<td>91%</td>
<td>91%</td>
<td>84%</td>
</tr>
<tr>
<td>Nov</td>
<td>88%</td>
<td>75%</td>
<td>88%</td>
<td>88%</td>
<td>81%</td>
</tr>
<tr>
<td>Dec</td>
<td>85%</td>
<td>70%</td>
<td>85%</td>
<td>85%</td>
<td>78%</td>
</tr>
</tbody>
</table>

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• Proposed process change as a result of PDSA to achieve improved communication
  – Bedside RN presence
  – Educate staff involved
  – Prioritization of patients
  – Focused areas
Bridge the Gap: methods

- Engaging the Patient and Family
- Daily Goal Sheets
- Journey Boards
- Discharge Orders before noon

“Family-centered care encompasses the understanding that patients and their families need open, honest, and unbiased communication with all health care providers.”

(Sisterhen et al., 2007)
What does ENGAGE mean?
- Patients and Parents = Informed Consumer
- Begins at admission
- Introductions

Leads to…
- Improved patient and family satisfaction
- Efficient resource utilization
- Staff job satisfaction

% of Rounds where Staff Invited Family Step Down Unit
Bridge the Gap: methods

Engaging the Patient and Family
Daily Goal Sheets
Journey Boards
Discharge Orders before noon

"Verbal miscommunication between nurses and physicians is responsible for 37% of all errors"

(Manojilovich, 2009)
Daily Goal Sheets

- Mimics the process utilized in our CTICU to provide consistency
- Filled out on night shift and updated by day shift
- Ensures nursing presence in rounds
- Rounds conclude with a “Read Back” by the RN

% of Rounds Where Nurse Reviewed Goal Sheet Step Down Unit

Goal Sheet Feedback

<table>
<thead>
<tr>
<th>Month of Audit</th>
<th>% of Rounds Where Nurse Reviewed Goal Sheet Step Down Unit</th>
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</thead>
<tbody>
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</table>

Scripted script: % of rounds where nurse reviewed goal sheet step down unit.
Bridge the Gap: methods

- Engaging the Patient and Family
- Daily Goal Sheets
- Journey Boards
- Discharge Orders before noon

“Effective communication between the patient and healthcare professional is essential for successful discharge planning, and is based on open dialogue where a common vision is shared.”

(Olsen & Wagner, 2000)

Journey Boards

- 3 Variations
- Offered in Multiple Languages
- Individualized for each population
  “Journey” to Discharge
We can tell you about my condition and/or surgery.

We know what to expect during this admission.

We know my therapist (PT/OT/speech) and what they do.

We know my social worker and how they can help.

We can tell you what medications I take, why I take it, and the side effects.

We know the date & time of my follow-up appointment.

We know where and when I am doing rehab following discharge.

We know my homecare company and how to use my home equipment.

We know where and when I need to take antibiotics (SBE prophylaxis).

We know when or if I need to take antibiotics.

We have completed teach-back.

We know when and who to call in case of an emergency.

We know any activity restrictions and when I can return to work/school.

We know when to call my primary care physician.

We have completed the necessary classes: ____________________________

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________________

We know when to call my specialized team.

We can tell you what diet or formula I need to follow.

(for infant) We can tell you what calorie formula our child needs and how to prepare it. We have completed teach-back.

We know when or if I need to take antibiotics (SBE prophylaxis).
Bridge the Gap: methods

- Engaging the Patient and Family
- Daily Goal Sheets
- Journey Boards
- Discharge Orders before noon

“...evidence shows that when hospitals focus on the discharge process, patient care and safety improve and costs decline.”

(Clancy, 2009)

Discharge orders

- Hospital initiative to increase orders into EMR by noon
- Allows families to better plan for discharge
- Improves throughput
- Leads to earlier discharge times
Discharge Orders by Noon

Specific Aim
To increase discharge orders by noon for patients with LOS ≥ 36 hrs from 90% in 2013 to 95% in 2014.

Key Drivers
- Information Sharing
- Follow-Through
- Process/Policy
- Rounding Improvement
- Discharge Awareness

Interventions
- Early discharges including LOS ≥ 36 hrs
- Evaluate opportunity for team review of discharge orders written after noon
- Increase use of conditional orders
- Share DC order report with physicians and staff
- Maximize efficiency on rounds
- Make changes to processes during rounds
- High home medication review 48 hours before discharge
- Have evening practitioner complete pended order sets
- Physicians to review discharge orders and not wait on reports
- Discharge awareness rounding order for all patients before rounds begin

Patient Satisfaction Outcomes

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre-PDSA</th>
<th>Post-PDSA</th>
<th>↑</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time DR spent with child</td>
<td>64.7%</td>
<td>70.3%</td>
<td>5.6%</td>
</tr>
<tr>
<td>DR’s concern for questions/worries</td>
<td>70.1%</td>
<td>77.8%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Trust in child’s DR</td>
<td>77.3%</td>
<td>85.7%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Speed of discharge process</td>
<td>58.1%</td>
<td>63.0%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Staff include you in decisions regarding treatment</td>
<td>70.9%</td>
<td>73.3%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>
Additional outcome tracking

- Increase in timely and effective discharge
- Increase in “Good Catch” preventative medication errors

Challenges/Barriers

- Not enough time
- Not enough resources
- Too many other commitments
- Resident availability
- Making mistakes is part of learning
- System redundancy is sufficient to prevent error
- “What I have been doing works fine”
- Lack of physician buy-in

Questions?
The authors would also like to thank the following people:

Ruth Ferroni BSN, RN – Heart Center Educator
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References


