Emergency Department Waits and Patient Flow Initiative
putting the Patient First

Patient Flow Toolkit

Module 1:

Interdisciplinary Rounding

Reference guide for acute care inpatient units in Saskatchewan

Updated July 2017

SASKATCHEWAN HEALTH QUALITY COUNCIL

Government of Saskatchewan

Table of Contents

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(Some content from the eHealth Training Guide has been incorporated into this Module. Many descriptions and examples have been updated, or new ones added. Some items that were listed as appendices are now included in the body of this module.)

Module objectives

This module is intended to be a guide for operational leaders, managers, and point of care staff for self-assessment and implementation of a process for interdisciplinary rounds. It was informed by the various types of interdisciplinary rounds that have been piloted in Saskatchewan, Rapid Process Improvement Workshops and other improvement efforts, as well as emerging literature.

Interdisciplinary rounds are necessary not only to meet our system needs for communication, but also to ensure that patients and families have similar patient-centred experiences on all units of our hospitals throughout the province.

The objectives of this module are to:

- provide an assessment tool for measuring progress in implementing rounding;
- provide teams with information that will help them decide how best to adapt and adopt each best practice in a way that meets the needs of the patients and families accessing care and the care team; and,
- provide reference templates for standard work, patient/family information materials, etc.

Interdisciplinary rounding

Definition

Interdisciplinary rounds have been defined as planning and evaluating patient care with health professionals from a variety of other health disciplines. Key activities that can be integrated into interdisciplinary rounds include summarizing patient health data, identifying patient/family problems, defining goals, identifying interventions, discussing progress toward goals, revising goals and plans as needed, generating referrals, reviewing discharge plans, and clarifying responsibilities related to implementation of the plan. Interdisciplinary rounds can occur daily, or between one and three times a week, depending on the patient's needs and average length of stay (Gagner, Goering, Halm, Sabo, Smith, & Zaccagnini, 2003).

There are a variety of different names used to describe interdisciplinary rounds, including multidisciplinary rounds, ward rounds, bullet rounds, and structured interdisciplinary bedside rounds.

What do we mean by 'interdisciplinary'?

"**Interdisciplinary team approaches integrate separate discipline approaches into a single consultation**…."

The patient is intimately involved in any discussions regarding their condition or prognosis and the plans about their care. A common understanding and holistic view of all aspects of the patient's care ensures the patient is empowered in the decision-making process, including setting long-term and

short-term goals, and problem solving.

Individuals from different disciplines, as well as the patients themselves, are encouraged to question each other and explore alternate avenues, stepping out of discipline silos to work toward the best outcome for the patient." (Jessup, 2007)

Why interdisciplinary not multidisciplinary?

Multidisciplinary approaches use the skills and experience of individuals from different disciplines, with each discipline approaching the patient from its own perspective.

Multidisciplinary rounds often do not include the patient and take the form of case conferences. (Jessup, 2007) These tend to be each discipline reporting on their work rather than collaboratively providing their professional insight into a shared plan. Because Saskatchewan is committed to patient- and family-centered care, interdisciplinary care must ensure the inclusion of the patient and family at the centre of the care team.

Multidisciplinary implies multiple professions are working with a patient in parallel, or independently, in a coordinated fashion. Interdisciplinary implies a greater degree of collaboration, with common goals and shared decision making. (D'Amour, D, et al, 2005). It supports the breaking down of discipline silos.

Why do interdisciplinary rounds?

Units that have successfully implemented interdisciplinary rounds have achieved improvements in quality of care, communication between clinical teams and patients and families, and patient flow (through better transitions). Evidence suggests that interdisciplinary rounds have many benefits:

- Decreased patient length of stay: This has been demonstrated in medical and critical care units. Two separate studies show decreases of between 8% and 11%. (Curly, McEachern, Speroff, 1998) Use of a Back to Basics Checklist reduces iatrogenic disability, and the use of a Transitions Checklist helps teams ensure safe and timely transitions to appropriate settings in the community.
- Increased patient safety: Increased communication between providers and the inclusion of safety conversations in rounds lead to a significant reduction in adverse events. (O'Leary KJ, et al, 2011)
- Improved patient care, teamwork, and staff satisfaction: Satisfaction surveys completed by 21 providers of interdisciplinary rounds and 19 providers of traditional rounds found the former had a greater understanding of patient care, more effective communication, and better teamwork. (**Note:** Traditional rounds refers to physicians rounding with no other disciplines.) (Curly, McEachern, Speroff, 1998,Gausvik C. et al, 2015 and O'Leary KJ, et al, 2010)

Interdisciplinary rounds can serve as a platform for quality improvement efforts on the unit. For example, teams may choose to add items of emerging concern to the rounds discussion to improve care and outcomes for the patients they serve. Teams that have done so have seen reductions in:

- Intensive Care Unit mortality;
- Ventilator-acquired pneumonia (VAP) rate;
- Catheter-related bloodstream infection
- (CR BSI) rate; and,
- Urinary tract infection (UTI) rate. (IHI, 2013)

Interdisciplinary rounds can also provide a collaborative opportunity for collecting information on patients who are ready for care elsewhere, also known as alternate level of care (ALC). Barriers to transitions can be identified with the team and patients and family members, and collaborative problem solving can occur.

How to determine if a team has implemented interdisciplinary rounds

The goal is to have patients, families, staff, and physicians meet regularly to review all of the items listed on the 'required attributes' chart (p. 6). A self-assessment tool (p. 5) has been created to support teams in assessing their strengths and opportunities for improvement. This assessment tool should be completed as a baseline measurement and again at regularly scheduled intervals to identify areas of success and opportunities for improvement.

The Saskatchewan health care system seeks to be patient and family centered. The core principles of patient- and family-centered care are respect/dignity, information sharing, collaboration, and participation. Implementing interdisciplinary rounds aligns with these principles because it creates a scheduled, consistent forum for patients, families, staff, and physicians to respectfully share information and collaboratively make care decisions.

The assessment tool is based on the International Spectrum for Participation, which has five categories. It seeks to move the level of engagement from involvement to empowerment. This spectrum is important to consider as the team determines what will be discussed and how.

It is vital to support and educate patients, families, and providers about how to contribute to the conversation in a meaningful way, while ensuring privacy, respect for time, and student learning. In the spirit of 'nothing about me, without me,' patients and families should be equal participants and therefore participate in the discussion, decision-making, and implementation of the plan of care. Each is defined on page 4.

Public Participation Spectrum: International Association for Public Participation

The IAP2 Federation has developed the Spectrum to help groups define the public's role in any public participation process. The IAP2 Spectrum is quickly becoming an international standard.

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision. We will seek your feedback on drafts and proposals.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will work together with you to formulate solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Self-assessment tool

Read each box in row A and score your team as a 1, 2, 3, 4, or 5. Place your score in the far right box. Do the same for each row (A - D). **Note:** You may fall between two boxes; score your team in the box where all of the criteria are met. It is the goal to have all teams in the darker shaded boxes (4 or greater).
Note: For Row C, refer to required attributes of interdisciplinary rounds on following page.

	1	2	3	4	5	Score
A: Patient and Family Engage-ment	Patients and families not invited to participate in or contribute to rounds.	Patients and families not invited to participate in rounds. They are able to put forward questions to the team.	Patients and families are informed about rounds and put forward questions to the team. A team member updates patients/families after rounds discussions.	Patients and families attend rounds and are encouraged to add information, and ask questions.	Patients and families participate fully by adding information, and insights, asking questions, and make all decisions regarding their care.	Target ≥4
B: Team Partici-pation	No form of inter-disciplinary rounds is occurring.	Interdisciplinary rounds occur, with some (not all) team members attending. Rounds occur without patients and families	Interdisciplinary rounds occur. Not all team members attend. Rounds include patients and families.	Interdisciplinary rounds occur. All team members attend, including physicians, and patients and families.	Interdisciplinary rounds occur. All team members attend, including physicians, specialists, patients and families.	Target ≥4
C: Standard Process and Patient and Family Orientation	No standard process in place.	Standard process is developed and orientation is in process. Some 'required attributes'* are included in rounds discussion.	Standard process is in place and training has been completed. A plan is in place to educate new team members. Most 'required attributes'* are included in rounds discussion.	Standard process is in place, All 'required attributes'* are included in rounds discussion. Patient/family materials informing them of rounding process are available.	Standard process is in place. All 'required attributes'* are included in rounds discussion. Patient/family material is available, and patients receive orientation to rounds.	Target ≥4
D: Collab-orative Planning	Rounds discussion is not documented and no updates are made to plan of care.	Rounds discussion is documented by individual disciplines using their own documentation standards, in discipline-specific areas of patient record.	Documentation of rounds discussion is done in a central place that all team members can access. Patient care plan is documented separate from rounds documentation.	Staff directly updates the care plan during rounds to reflect the discussion. All staff have access to the care plan following rounds. Rounds discussions are documented directly into integrated patient care plan, which all team members can access.	Staff updates the care plan and whiteboard to reflect rounds discussion. Rounds discussions are documented directly into integrated patient care plan, which all team members can access. Patients and families are encouraged to use whiteboard.	Target ≥4

- Telehealth or phone may be used to ensure all partners are able to participate.
- Families are defined by the patient. These individuals should only be welcomed based on the patient's preference.
- This model is based on the International Association for Public Participation, Spectrum for Public Participation. www.lap2.org Author: Malori Keller

Required attributes of interdisciplinary rounds

Successful interdisciplinary rounds include the content listed in the table below. Each item should be discussed as a team during rounds. The table provides suggestions on what could be discussed for each category.

- Each team should determine who will lead the discussion and the order of the discussion.
- The items listed in the Quality and Safety Check are suggestions only. These should be tailored to the needs of the patients being served.
- Your review should include those issues relevant to your patient population.

This content is based on the review of articles listed in the References (p. 27.) Rounding includes a review of Back to Basics care items, which can reduce iatrogenic disability.

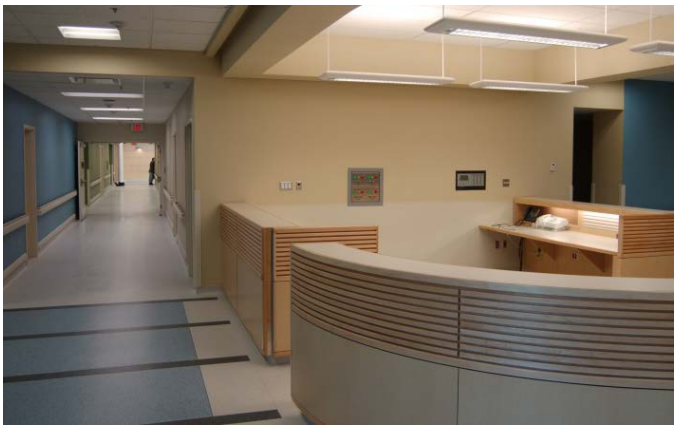
✔		Suggested Lead
	Introduction • Greet patient and family • Team members introduce themselves by name and role	Physician
	Update hospital course • List reason for admission, active problems and response to treatment • Discuss interval test results and consultant notes • Invite input from the patient/family	Nurse
	Update current status • Overnight events and patient goal for the day • Sleep • Back to Basics Care Checklist: • Vital signs or pain • Fluid or food intake • Bladder or bowel output • Mental status • Functional status (as compared to preadmission) • Mobility	Nurse Patient/Family PT/OT
	Quality safety check • **May include such items as:** • Urinary catheter • Canula/central venous catheter • VTE prophylaxis • Pressure ulcer and stage • Hypo or hyperglycemia • Fall risks	Nurse
	Resuscitation plan • Plan is known and documented.	Physician
	Synthesize plan using all inputs • Verbalize and update Patient Communication Board with plan for the day and transition • Transition Checklist: (See p.22 for sample templates) • Choosing best next care setting • Identifying suitable agencies and arranging services • Verifying coverage • Patient and family education needs • Clinical summary (single care plan) • Course in hospital (diagnosis / treatment) • Key data – lab, imaging • Care plan • Medication Reconciliation • Follow-up appointments	Nurse Interdisciplinary team members as appropriate (e.g., physician, social worker, discharge planner, patient navigator, pharmacist, etc.) Patient/Family

What is iatrogenic disability? How will Back to Basics care and safety checks help?

Hospitalization can result in a decrease in a patient's independence and ability to perform activities of daily living. This is defined as iatrogenic disability. (Lafont, et al, 2011) Thirty to 60% of seniors experience some functional decline due to their hospitalization. This loss in their ability to perform activities of daily living is partly a result of their acute episode, but also due to their care management while on a unit.

The following three factors contribute to iatrogenic disability:

- **Pre-existing patient frailty:** Frail patients are more vulnerable to stressors such as illness. This can lead to increased rates of hospitalization and longer lengths of stay. (Gill, 2010) Frail patients are more likely to go from having no disability to being mildly disabled following discharge.
- **Severity of the patient's condition that led to their hospitalization:** This can cause functional decline, regardless of how successfully a patient's condition is treated.
- **Hospitalization and post-hospitalization processes:** Admission to hospital results in a sudden interruption in a patient's daily activities that would normally keep them moving (e.g., toileting, meal prep, dressing). Patients are also often confined to a bed during their stay, which results in deconditioning. Hospitalization can also result in inadequate nutrition and a disruption in a patient's regular sleep habits, which can negatively affect his health and strength. (Lafont, et al, 2011)



Take steps to prevent functional decline for patients during hospitalization.

We have the opportunity to prevent or minimize iatrogenic disability by devoting focused attention on "Back to Basics" care and safety and quality checks in the daily care routine.

BACK TO BASICS CARE

Understanding a person's pre-hospital status, basic care needs, and their goals for the future gives the interdisciplinary team a more comprehensive understanding of the patient's needs and desires. The interdisciplinary approach ensures that all care providers support the basics, in addition to a patient's other medical care needs. Back to Basics includes pain management, nutritional intake, bladder and bowel output, mobility, and a patient's ability to perform daily activities. These basic components of care all contribute to a patient's recovery, for example ensuring adequate nutrition for healing and adequate sleep for recovery.

How to include in daily rounds: The team can identify the earliest opportunity at which it is safe for a patient to mobilize. Understanding how the patient mobilized prior to their admission or illness should be taken into consideration as the patient and care team

determine goals, what assistance is needed, the most appropriate time for mobilization, etc. The team is then clear on the patient's status, with all members responsible for ensuring the patient mobilizes safely to prevent injury and loss of independence.

Example: An 80-year-old patient states that she was walking 1 km per day on a walking track without her cane, and used a cane for support on stairs and uneven surfaces. Now, following several days in a hospital bed, the patient is anxious to walk but is very stiff.
She is reluctant to use a cane and unhappy to have to mobilize in this way. This patient may need some encouragement to use the cane, as well as some physical assistance as she begins to mobilize. The team is aware of the patient's abilities before her hospital stay and can work with her to get her back to this baseline. They will also be on alert that she may try to mobilize without the cane and is therefore at risk of a fall.

SAFETY CHECKS

Teams should incorporate safety and quality checks into their daily routines to review and prevent safety risks. Reviews of adverse events in many health care organizations have identified several common themes, including deficiencies in teamwork and communication, and the failure to include patients and their family members as active members of the team. (Pain, et al, 2012)

Identify and incorporate in your team's daily routine those quality and safety checks that are most relevant to your patient population.

How to include in daily rounds: Your unit has a large proportion of patients awaiting long-term care, and many of these patients are immobile. Because these patients are mostly confined to their beds, they are at increased risk of developing pressure ulcers. Your interdisciplinary team should review each patient's risk for pressure ulcers and skin breakdown, and monitor the progress of any existing ulcers. The care team can work with the patient and family to develop integrated prevention and management strategies.

Example: A patient arrives at the hospital with stage 2 pressure ulcers on his heels. Your team should develop an interdisciplinary approach to healing the ulcers and preventing any further breakdown. This could include a plan for repositioning, equipment and surface needs, and nutritional plan. The team will also monitor the ulcers' progress.

TRANSITION CHECKLISTS

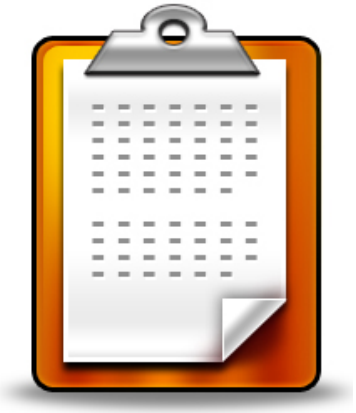
When patients transition from their acute care stay back to the community or next stage of care they are at risk of functional decline.

Transition checklists create standard prompts for discussion that support successful patient and caregiver transitions. Successful transitions require that all care providers and patients and their families are on the same page and working toward a common goal, and that planning can begin early in the patient's stay. The team works together to identify barriers to transition that may need to be addressed several days or even weeks in advance.

How to include in daily rounds: Your surgical unit has many patients from outside your region who receive their surgery then return to their home region hospital for additional care before going home. The team can identify these patients early in their stay and make arrangements for their transition.

Example: Your patient is from rural Saskatchewan and has just had surgery in your tertiary centre. She will eventually be returning to her home hospital to convalesce. This patient has unique equipment needs. The team discusses daily how the patient is progressing, to ensure early preparation occurs, including notifying the receiving hospital so they can prepare for the patient's care needs, such as ensuring medications are available and equipment arrangements are made. This also allows family members to make arrangements so they can be available to help the patient transition to their next care setting.

Including these three key elements (Back to Basics, Safety Checks, Transition Checklists) in your interdisciplinary team's rounding process will ensure an integrated approach to achieving the best possible outcomes for patients.



How do we implement interdisciplinary rounds on our unit or ward?

Below are suggested steps for implementing interdisciplinary rounds, based on a Plan, Do, Check, Act model.
Note: *Not all of the actions and tools are required for each unit. In consultation with your team, select those actions, tools, and templates that will best support your needs.*

PLAN

1. Establish a core team of individuals who will support interdisciplinary rounds.

- Participants may include physicians, clinical coordinators, nurses, social workers, physiotherapists, translators, patient navigators, pharmacists, etc.
- Identify a team lead who will help lead the rounds as well as coach staff during the rollout (e.g., clinical coordinator, clinical nurse educator, advanced practice nurse, or manager).
- Engage in discussions with patients and families on the unit. Explore how they would like to be communicated with.
- Patient or family advisors may also be invited to participate, especially if your unit has an advisory council to draw these individuals from.
- Identify champions for interdisciplinary rounding and develop a communication plan for the implementation.

Include not only champions but also those who may be skeptical or anxious about the change.

2. Understand the current state.

- Have the core team talk to staff and physicians about the current state.

  Questions may include:
  - Is there a process in place for rounding? If so, when? Where? Who is involved? How is it documented?
  - What processes currently exist for teams to communicate and collaborate?
  - What is working well? What isn't working?
- Have the core team talk to patients and families about the current state. Questions may include:
  - Do they know the rounds process?
  - Have they participated?
  - Do they know their treatment plan? Discharge plan?
  - Are they comfortable asking questions?

3. Gather Patient Quality Analysis (PQA) Data.

- Data may include:
  - Number of patients
  - Number of disciplines involved in care
  - Time that disciplines currently come to unit
  - Average length of stay
  - Critical incidents or negative patient experiences that could have been avoided with improved interdisciplinary team communication
- 30-day readmissions
- Rates of hospital mortality
- Staff engagement, degree of team collaboration, or both
- Patient experience measures

4. Create a visual to depict the current state.

Consider using tools such as:

- Value stream maps
- Spaghetti diagrams
- Time observation forms
- Pictures/videos

5. Complete interdisciplinary rounds assessment. Determine baseline score (p. 5)**.**

6. Engage team in discussion about current state.

- Learn about interdisciplinary rounds (see p. 27 for videos, articles, toolkits).
- Review existing practices in Saskatchewan (pp. 13-20).
- Review interdisciplinary rounds definition and review baseline assessment.
- Review baseline score. Set target for improvement.
- Complete interdisciplinary rounds planning worksheet (p. 12).

7. Create action plan (Consider the following questions)

- What is the purpose of our round?
- What can we improve right now? (i.e., "Just do it" projects)
- How will patients and families be invited to rounds? (see pp. 21-22 for examples)
- What standard work or templates will be used? Who will adapt them? (see p. 18 or the Provincial Improvement SharePoint site for examples)
- How will team members document the rounds discussion and ensure a shared care plan? (see p. 24 for an example.)
- What is the start date?
- Daily visual management board: How will this be communicated on our daily visual management board?
- What other unit processes does the interdisciplinary rounds impact?
- How will we minimize distractions to the interdisciplinary team?
- What training or awareness do staff/ physicians need to feel comfortable adopting interdisciplinary rounds?
- How will we communicate our plan?

DO

- **Implement action plan.**
- **Engage staff and physician champions to spread enthusiasm about the work.**
  - Encourage these individuals to partner with team members who are less eager or are apprehensive about interdisciplinary rounds.
  - Engage these individuals in "just do it" projects and small trials of various tools.
  - Engage these individuals in adapting standard work or training others on standard work.

CHECK

- **Team discussion.**
  - What worked well? What didn't work?
- **Talk to patients and families.**
  - What worked well? What didn't work?
- **Review updated PQA data.**
  - Has length of stay changed?
  - Have there been any changes in patient experience survey results?

ACT

- **How do we sustain the gains?**
  - Measure impact on patients and families and share this feedback with team members.
  - Keep interdisciplinary rounds on daily visual management board: How is it working? What needs improving?
  - Audit using the assessment tool: Are we meeting, maintaining, or exceeding the target? Are we ready for a new target?
  - Train and educate: Are all staff and physicians trained to the new interdisciplinary rounds? How do new staff/physicians get oriented to the process?
  - Recognize staff and physician efforts
  - Share feedback from patients and families.

Planning for interdisciplinary rounds: Team worksheet

There are several different models for interdisciplinary rounds. Consider the following:

1. Who will attend?

- ❑ Patients
- ❑ Families
- ❑ Physician
- ❑ Residents
- ❑ Nurse
- ❑ Allied Health (e.g., social worker, PT, OT, SLP, discharge planner, dietitian, _____)
- ❑ Other: (eg. spiritual care, navigator, educator, _____)

2. Who will lead the discussion about each attribute?

3. What quality and safety checks are relevant to our patients?

4. Do we need a team lead? If so, who is the most appropriate person for this role?

5. What time will we host rounds?

- ❑ AM
- ❑ PM

6. How will rounds discussions be documented?

7. How will patients and families be informed about rounds? Who will inform patients and families? How will we discuss patient consent? (more details on pages 18, 25)

8. How will we accommodate families who cannot physically be present for rounds?
(e.g., families from northern or rural areas)

9. How do we accommodate team members who cannot be present?

10. How will we identify and address patient's and family's individual needs for rounds?
(e.g., translators, cultural and spiritual needs, etc.)

Saskatchewan examples

Interdisciplinary rounds in Intensive Care Unit (ICU)

In 2009, the Intensive Care Unit at **St. Paul's Hospital** in Saskatoon began discussing a transition to patient- and family-centred rounds. At that time, rounds occurred at the nursing station so the patient and family were not able to participate. Through collaboration and the sharing of ideas and stories amongst key members of the health care team, the traditional approach to doing rounds has evolved into a new process where patients and families are active participants in the daily rounds.

The new process

Rounds are an interdisciplinary team meeting of physicians, nurses, physiotherapists, social work, residents, patients, and families. This occurs at 9:15 AM daily at each patient's bedside.

At this time the team will discuss each patient's condition. This can occur in a number of ways, but most often includes the following:

- Resident gives an overview of patient, history, admitting diagnosis, and course in hospital.
- Respiratory therapist reports on oxygenation and ventilation status.
- Nursing staff reports the patient assessment.
- Pharmacist reviews medications, medication interactions, and any history of medication problems.
- Residents summarize the patient needs and identify goals for care.
- The other health disciplines provide input on patient progress.
- The attending physician facilitates a discussion with the team regarding treatment options and next steps.
- The attending physician will summarize the discussion in lay language for the patient/family.
- The patient and family are given an opportunity to ask questions and participate throughout the round.
- Depending on patient/family needs, a family conference may be scheduled.

Key learnings

- Staff found they needed to explain to families what rounds are. They had to encourage families to participate the first time, as families did not want to interfere in the care of the patient. Families are now coached and provided with information about rounds. Staff are mindful that it is a choice for families to participate and that some may choose not to. Thus, nurse updates and family meetings will remain integral to patient/family communication.
- The ICU Patient and Family Advisory Council created a tool to explain the rounds process to patients and families and to invite them to participate in the rounds. This information is found in the Intensive Care Unit Family Guide, which is available in print format and as an iPhone app.
- Patient/family rounds is now standard practice in Saskatoon Health Region's Department of Critical Care. Consistency of practice became important to both patients/families and staff. It was challenging to coordinate and to explain the differences in practice when not all members of the team were engaged in the new style of rounds.

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Saskatchewan example:

Rural Inpatient Unit

At **St. Peter's Hospital** in Melville, interdisciplinary rounds are a long-standing routine. At 7 AM daily, report occurs at the nursing station in a report room. This is a shift-to-shift handover for nursing. Other team members — including pharmacy, social work, unit clerk, pastoral care, and therapies — attend on a daily basis.

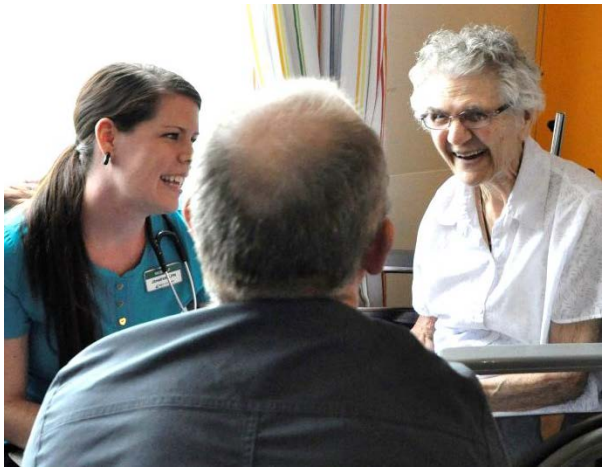
Between 8 AM and 9 AM, the four physicians arrive at the hospital and after seeing any emergent patients, begin bedside patient rounds. A nurse (RN or LPN) rounds with the physician and as appropriate the social worker, physiotherapist, and pastoral care worker join in to see the patients who need these supports.

During the round, the team will discuss each patient's condition. This can occur in a number of ways, but most often includes the following:

- Nursing staff gives an overview of patient, history, admitting diagnosis and course in hospital.
- Nursing staff reports the patient assessment.
- The social worker/discharge planner will communicate discharge planning issues or arrangements, or other patient-specific needs, such as addictions counselling, psychiatric referrals, or required family meetings.
- The physiotherapist updates the physicians on treatment plans or completions.
- The physician facilitates a discussion with the team (including the patient/family) regarding patient needs, goals, treatment options, and next steps. He/she then summarizes the discussion in lay language for the patient/family.
- The patient and family are given an opportunity to ask questions and participate throughout the round.
- Depending on patient/family needs, family conferences and meetings may be arranged.

- Because there is a small number of allied health professional staff on this team, they do not round to see every patient. Rather, they are asked to be present on a case-by-case basis.
- Originally the nurse manager or charge nurse supported the rounds process. However this led to re-work as they then needed to communicate to the bedside nurse. It is now the bedside nurse who rounds with the physician.
- Each discipline plays a role in charting the discussion of rounds.
- White boards are updated on a continuous basis to support ongoing communication throughout the day.
- Pastoral care is an important part of the team. The pastor often communicates things the patient wants or needs from the team, while respecting confidentiality. Pastors do not attend all of the interdisciplinary rounds, but are there to support the patient/family after upsetting news, at points of transition, etc.

For more information, contact: Lori Keller (Nursing Manager) at lori.keller@shr.sk.ca



Interdisciplinary rounds at Unit 4A, Pasqua Hospital.

Saskatchewan example:

Urban Medical Unit

On Unit 4A at **Pasqua Hospital** in Regina, interdisciplinary bedside rounds are a new routine. In January 2015, the team adopted Structured Interdisciplinary Bedside Rounds (SIBR) as part of an 'Accountable Care Unit' pilot. The SIBR rounds have enhanced the accountabilities for safe care, adding components of quality and safety to ensure patients have safe, effective, and timely care.

At 10:30 AM daily, the physician, bedside nurse, and members of the allied health team gather and begin bedside rounds as a team, following the SIBR work standard (p. 17).

Key learnings

- Coaching and mentoring is critical to ensuring that all staff know their role and what information they are required to bring to the round.
- Physician attendance at the bedside round is critical to advancing the care of the patient.
- Documenting rounds has been a challenge as there is no direct entry into the care plan. The rounds manager has a worksheet that is passed on to the Most Responsible Physician to ensure that the plan of care for the patient is updated.

For more information, contact:
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Saskatchewan example, continued:
Urban Medical Unit

	Team Member		Information Needed
A	Attending Physician	1 minute	Presents active problems and current treatments
			Test results / consult info
			Inputs from patient/family and nurse
B	Bedside Nurse	1 minute	***Update Status***
			Overnight events and patient's goal of the day
			Vital signs and pain control
			Fluid and food intake
			Urine and bowel movements
			Mental status
			ADLs
			Quality and Safety
			Foley catheter
			IV or central line
			VTE prophylaxis
			Pressure ulcer/skin
			Glycemic control
C	Allied Care	1 minute	***PT/OT/SLP/SW/Dietitian***
			Mobility status and equipment needs
			Swallowing or nutritional status
			Anticipated D/C needs or next site of care
			Discharge date and transportation
			Follow-up appointment

Adapted for use from Structured Interdisciplinary Bedside Rounds (SIBR), adapted from Improving Hospital Outcomes through Teamwork in an Accountable Care Unit by Jason Stein, Associate Vice Chair for Quality, Department of Medicine, Emory University School of Medicine (accessed December 3, 2014).

See link:
www.crepatientsafety.org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonsteinsession2.pdf

Standard Work: Examples

Interdisciplinary rounds on a Medical Unit

(Dr. F. H. Wigmore Regional Hospital, Moose Jaw)

	Essential Tasks: Responsibilities
1.	**Primary Nurse Role Responsibilities:** • Prior to AM rounds, ask each patient for consent to do plan of care rounds and inform them about the process. "Your care team would like to come in to discuss your care plan with you. The team includes nurses, transition coordinator (who helps to plan your transition from hospital), physiotherapists and occupational therapists, the dietitian, and myself. During these rounds we will discuss the plan for today, your goals for today, and how we can progress to your discharge from hospital. It will be a short visit. We are going to discuss your treatment plans and also leave information on your whiteboard. Is this okay with you?" • Identify ahead of time if any rounds will not be done in patient's room, e.g., end of life.
2.	**Team Lead Role Responsibilities:** • Bring Computer on Wheels (COW) and enter patient's room • Introduce self, ask team members to introduce themselves. • Lead discussion, keep team on task. Tell patient that specific team member will return to answer questions if needed. • Update care plan and confirm it is accurate.
	SCRIPT / ORDER
1.	**Team Lead:** • Lead the team into the room. Explain to the patient that the team is present to do rounds. If there is someone in the room, ask relationship to patient and if they are involved in patient's care. • Ask rest of team to introduce themselves. If patient knows the team from previous rounds, detailed introductions are not necessary.
2.	**Primary Care Nurse:** • Bring Computer on Wheels (COW) and Care Plan Hello _____ (patient name). We are here to discuss your plan of care today. You are here because _____(acute diagnosis in lay terms). You were admitted on _____ (admission date). You come from _____ (living arrangements - home). Your tentative discharge date is _____ and location is _____. Discuss with team what we are doing medically for this patient. Receiving _____to treat _____. Monitoring _____ because _____. **Interventions/Treatments:** What are we doing for you? Receiving _____ to treat _____. Monitoring your _____ because _____. To be ready for discharge, you need _____. **Needs**: What do you need? You are waiting for _____ (tests, consults, services).

	Relay any *ABNORMAL* findings and what is needed to correct/address 1. Overnight events 2. Vital signs/pain 3. Intake/output 4. Mental status 5. Reason if modified early warning score (MEWS) is elevated. **Quality and Safety Checklist:** What can be done to progress care or avoid problems (Can Foley be removed, plan for reddened skin, needs 02 assessment etc.) 1. Foley 2. Central line/IV 3. VTE prevention needs 4. Skin/pressure ulcer concerns 5. Hypo/hyperglycemia 6. 02 requirements 7. Bed alarms 8. Other safety concerns – falls etc.
3.	**Therapies:** • If no involvement, just say that. If not involved and need to be, please ask. • Discuss with patient what we are doing functionally. • PT/OT provide individual responses, converse with the patient and ask any pertinent questions re: Are they safe to mobilize, baseline function, mobility aids used or required, level of assistance required, cognition, balance, strength, bubble packs, etc.
4.	**Transition Coordinator:** • Discuss with team what we are doing socially for this patient. • If no involvements, just say that; otherwise describe plan for the patient. • Active home care client? What services are we providing? What services are currently recommended? • Identify when patient is a complex discharge. • "High risk" patients are identified and maximum supports are offered. • Update whiteboard, transfer lift and repositioning (TLR), and mobility cards.
5.	**Pharmacy** • Will assess drug therapy for concerns and provide information as required. • Will identify any Med Rec concerns. • Will offer suggestions to adjust antibiotics (e.g., move to oral etc.), improve pain management, constipation, etc.
6.	**Dietitian** • Current diet, swallowing assessment required, diet changes (weight reduction, fluid restrictions).
7.	**Team Lead** • Address questions from patient/family. • If patient wants detailed discussion, appropriate discipline will arrange follow-up after interdisciplinary rounds. • Summarize plan of care and ensure a **goal** to reflect discussion is documented on whiteboard before exiting room.

Structured interdisciplinary team rounds (Pediatrics, Royal University Hospital, Saskatoon)

Lead	Topic	Time
Resident or JURSI	**Introduce team** Lead team into room, greet child and family, and introduce team (names and roles) Welcome child and family to participate and confirm wish to have bedside rounds Probe for questions or concerns from child and family **Update status** Active problem list and response to treatment Interval test results and consultant inputs Inputs child/family, nurse or other staff	≤ 15secs ≤ 45 s
Bedside Nurse	**Update status** Overnight events and progress toward milestones Vital signs, pain control Urine output (cc/kg/day) and stools Mental status and ADLs (including mobility status) Specify concerns and suggestions **Checklist for safety** Lines – Shunt, EVD, Central line, Trach, GT, Foley State current precautions and indication – droplet, contact, respiratory, etc	≤ 45 s ≤ 15s
Dietitian	**Update status** Type of diet or formula Fluids (% maintenance) and calories (kcal/kg) Weight (kg), including interpretation Specify concerns and suggestions	≤ 45 s
Other Interprofessional Staff	**Update status** Results of assessment and report recommendations Specify concerns and suggestions	≤ 15 s
Pharmacy	**Update status** Report MAR Specify concerns and suggestions	≤ 30 s
Resident or JURSI	**Promote teamwork and shared decision making** Redirect as needed to stay on time Synthesize inputs into a plan-for-the-day including discharge milestones	≤ 30 s
Senior Resident	**Promote teamwork and shared decision making** Redirect as needed to stay on time Synthesize inputs into a plan-for-the-day including discharge milestones **Teach as able** Patient education Physical findings/pathophysiology	≤ 30 s ≤ 30 s
Attending Physician	**Promote teamwork and shared decision making** Ensure high level of performance at interdisciplinary beside rounding Step in to other medical roles as needed	
Social Work	**Checklist for discharge planning** Seek consensus regarding discharge milestones, anticipated discharge date, needs Clarify outpatient follow-up requirements Probe for questions or concerns from child and family	
Other JURSI or Resident	**Enter orders in real time** Update whiteboard in real time	
Coordinator	**Ensure next bedside nurse ready for team, orient float nurses as required**	

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See link: www.crepatientsafety.org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonsteinsession2.pdf

Resources for introducing patients and families to interdisciplinary rounds

A family guide to rounds (Intensive Care Unit, Saskatoon)

Intensive Care Units in the Saskatoon Health Region include the following information in the patient and family handbook and the iPhone app. This was written by patient and family advisors who serve on their advisory council. Please feel free to adapt this for inclusion in your admission information package, or other patient/family information materials.

A family guide to rounds

Every day, the medical team meets at each patient's bedside to discuss his/her progress. This is called "rounds" and is an opportunity for you to speak with your loved one's doctor. Family can share any additional information with the team.

Rounds begin around 9:00 a.m. and can last until early afternoon. We highly recommend that the decision maker and family spokesperson attend. This is the best opportunity to know what is going on and ask questions.

Team members will review the previous 24 hours of care, then identity goals for the day and current treatment. They will summarize the discussion in terms that are easier for you to understand, and you will be given an opportunity to ask questions. If you do not understand something, or want clarification, make sure to ask. Don't be scared or shy!

If your family requires a more private conversation, or more time to ask questions, let your nurse know. A family conference will be arranged at a time that works for everyone.

Our goal is to help you understand what is happening during this time while your loved one is in this unit.

Poster (Five Hills Health Region)

The Five Hills Health Region uses this poster to invite patient and families to participate in rounds. Please feel free to adapt this to meet the needs of your unit.

Patient Care Rounds
Tuesday Mar 24th
at 10:00 am

We would like to discuss your plan of care with YOU.

Your care team includes:

You
Your family
Your nurse
The nurse in charge of the unit
Transition Coordinator Dietician
Physiotherapist
Occupational Therapist

With you, we would like to discuss:

- Your current care plan
- Your plan for your transition from hospital
- Your health goal for the day which will help you achieve your transition
- Any resources you may need while you are here and after transition

We encourage your family to be present and bring forth any information that would be helpful. Please feel free to write any concerns on the white board in your room in the "Questions/Comments" section .

Please let us know what we can do to help progress your care.

Transition checklist: Examples

Saskatoon Health Region

The Saskatoon Health Region uses this discharge planning document to support communication and documentation of transition planning done during rounds.

Multidisciplinary Discharge Planning

Estimated Date of Discharge: _____ **Date Written:** _____

Comments: ❑ EDD on White board ❑ EDD entered into Bed Management System _____Initials ❑ EDD on Care Plan

Date & Time of Admission Round: _____

Introduce self and team to patient and family. Explain that our main goal is to get them home safely and in a timely fashion so we want to start planning what going home would look like for them.

❑ We would like to find out if you have any concerns about going home (wait for patient's response and note these concerns below).

❑ Is there anyone at home that you care for?

❑ Do you feel you will be able to function safely when you get home?

❑ Will you need help when you go home?

❑ Do you feel you are prepared to go home with your _____ (colostomy, VAC, PICC etc.) If not, what are your concerns?

❑ Will there be any physical barriers when you return home? (stairs, bedroom/bathroom facilities).

❑ Do you know who will follow up with your care (Dr., etc.) once you leave the hospital?

❑ Once you are able to leave hospital, who will drive you? How much notice do they need to be able to pick you up before noon?

❑ Are there any other concerns we have not touched on?

Team member(s) notified:
❑ CPAS ❑ Social Work ❑ Food and Nutrition ❑ OT ❑ PT ❑ ET

Issues Identified: _____

_____

_____

Signature: _____

The Saskatoon Health Region uses this discharge planning document to support communication and documentation of transition planning done during rounds.

Date & Time of Admission Round: _____

Introduce self and team to patient and family. Explain that their health has improved and we anticipate that they will be well enough to go home within the next 48 hours.

- ❑ Do you have transportation home?
  - Who will drive you?
  - Are you able to phone them and let them know you're being discharged or do you need the nurses to do that?
  - How much notice do they need before they pick you up?
- ❑ Do you feel you will be able to function safely when you get home?
- ❑ Will you need more help you when you get home?
- ❑ Is anyone available to help you when you get home?
- ❑ Do you feel you are prepared to go home with your _____ (colostomy, VAC, PICC etc.)
- ❑ Will there be any physical barriers when you return home? (stairs, bedroom/bathroom facilities)
- ❑ Do you know who will follow up with your care (Dr., etc.) once you leave the hospital?
- ❑ Is there anything else you would like to discuss prior to going home?

Team member(s) notified:

❑ CPAS ❑ Social Work ❑ Food and Nutrition ❑ OT ❑ PT ❑ ET

Issues Identified:

_____

_____

_____

_____

_____

_____

Signature: _____

Saskatoon Health Region's **Dubé Centre for Mental Health** uses this transition checklist to document discharge readiness.

Transition Checklist (Discharge Readiness)

Date & Time of Admission Round: _____

Diagnosis: _____ Admission Date: _____

Predicted Discharge/Transition Date: _____ ❑ Involuntary ❑ Voluntary

DONE	NEED	**Social Worker:** _____
❑	❑	Financial: _____
❑	❑	Housing: _____
❑	❑	Home Care: _____
❑	❑	FamilySupport
		Occupational Therapy: _____
❑	❑	Capacity Assessment
❑	❑	Cognitive Assessment
❑	❑	Driving Screening
❑	❑	Coping Skills & Sensory Strategies
❑	❑	ADL/Equipment/Functional Assess
		Therapeutic Recreation: _____
❑	❑	Leisure Assessment
❑	❑	Group Referral
		Referrals:
❑	❑	CMHN: __
❑	❑	Out-pt Psychiatrist: _
❑	❑	G.P.: _
❑	❑	Concurrent Disorders
❑	❑	AddictionsCounselling
❑	❑	Adult Outreach
❑	❑	Other: _
❑	❑	Other: _

DONE	NEED	**Pharmacy**
❑	❑	Rx Coverage: _____
❑	❑	EDS
		Nursing
❑	❑	Forward orders to CMHN
❑	❑	Fax Rx to Pharmacy
❑	❑	Bloodwork to Clozapine
		Dietitian: _____
❑	❑	In-patient Consult
		Psychiatrist: _____
❑	❑	Discharge Summary
❑	❑	Discharge Orders/Rx
❑	❑	CTO name: _____
❑	❑	Next Cert Due: _____
❑	❑	EPIP
❑	❑	Transition Team (incl.Counselling)
❑	❑	Bridges
❑	❑	McKerracher
❑	❑	In-patient Consult
❑	❑	Out-pt RT
❑	❑	Out-pt OT
❑	❑	Out-pt Dietitian

Regina Qu'Appelle Health Region

Regina Qu'Appelle Health Region's Medicine 4A Unit at **Pasqua Hospital** uses this worksheet to support their interdisciplinary rounds. It is used to help nurses collect the information needed for rounds.

Structured Interdisciplinary Bedside Rounds (SIBR)

Bedside Nurse Report

Areas of Concentration	Patient 1	Patient 2	Patient 3
1 **Goal of the Day/Concerns**			
2 **Status Update**			
Overnight events			
Vital signs and pain control			
Fluid and food intake			
Urine and bowel movements			
Mental status			
ADLs			
3 **Quality and Safety**			
Foley catheter			
IV or central line			
VTE prophylaxis			
Pressure ulcer / skin			
Glycemic control			

Adapted for use from Structured Interdisciplinary Bedside Rounds (SIBR), adapted from Improving Hospital Outcomes through Teamwork in an Accountable Care Unit by Jason Stein, Associate Vice Chair for Quality, Department of Medicine, Emory University School of Medicine (accessed December 3, 2014). See link: www.crepatientsafety .org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonsteinsession2.pdf

Commonly asked questions

Do all rounds have to be at the bedside?

All patients and families should be asked if they would like the team to round at the bedside. If there are circumstances which have the team unsure about rounding at the bedside, discuss this with the patient/family. For example, if a patient is agitated she may not be comfortable with everyone coming into the room. If the patient is mobile and would prefer to meet outside the patient room, teams should find a private place for this to occur.

How do we deal with privacy concerns in shared rooms?

Many facilities in Saskatchewan have units with shared rooms. In these cases informed consent will need to be obtained to discuss patient's care needs at the bedside, with privacy risks shared. Units should establish a process for explaining the rounds process to patients and families on admission and obtaining consent. If patients do not consent, alternative arrangements should be made to accommodate the needs of patients and families, such as finding a private space for discussions.

How do you share clinical information?

While clinical jargon can be confusing to patients and families, using the clinical terms is often necessary. Share the clinical terms and then provide an explanation in layman's terms. Avoid using acronyms. When sharing information such as vital signs you may give some explanation to help inform the patient/family (e.g., "Blood pressure is 120/80, this is normal." or "Pulse is high at 130 and we will discuss how to bring that down to normal.").

Do we need to round at the bedside of patients who are not alert?

Yes. Consent should be obtained from the patient's support person. The most patient- and family-centred approach would be to round at the bedside if the family wishes. Speak about patients as if they are able to hear. Avoid using "he" or "she" language; where possible speak *to* the patient, not *about* them.

How do isolation precautions impact rounds?

The most patient-centred approach would be to don the appropriate Personal Protective Equipment and continue to round at the bedside. Options could include having some members remain at the door, but teams will need to ensure they can hear and be heard by the patient. Or if the patient is not participating but the family is, have the round in another space.

How do you share information of a sensitive nature?

If there is information you must share that is sensitive in nature or perhaps is a crucial conversation, tell the patient that this is what you need to discuss. Then ask him if he would like you to discuss this with him personally, and if so, support him in having his family leave the room.

My patient and family have many questions, which we don't have time to address in rounds. What should we do?

If your patient has multiple concerns and questions that require a more in-depth conversation, discuss having the team, or members return following rounds for further discussion. This will allow adequate time to listen and answer questions, or identify that a case conference is required.

How can technology be used to support rounds?

Often computers on wheels have been helpful to support nurses in completing documentation immediately. This may also help with viewing scans or other test results.

For families who are separated by distance, teleconferencing has been used to engage them in their loved one's care. This could also be used in the event that one of the staff team members isn't able to be present due to extenuating circumstances.

Resources

Helpful resources

The University of Michigan recently released a seven-minute video which explains multidisciplinary rounds and how to implement them in a teaching hospital. This video is exemplary, as the rounds depicted also support the use of patient-provider communication whiteboards and nurse shift handover at the bedside.
https://youtu.be/-oOcJ1-6Fq4

The Clinical Excellence Center has a three-minute video showing structured rounds.
www.youtube.com/watch?v=fExlkV5jlUI

The University of Victoria developed a change and transition toolkit entitled Managing Change and Transition: An Overview. It will provide you with strategies for overcoming barriers to culture change.

www.uvic.ca/hr/assets/docs/od/Workbook%20-%20Managing%20Change%20and%20Transition2.pdf

The Royal College of Physicians and **the Royal College of Nursing** have recently developed a guide similar to this module explaining the basics of ward rounds. This is a great tool for supporting physicians and nurses to learn about interdisciplinary rounds, including the roles, types, and benefits of this approach.
www.rcplondon.ac.uk/projects/outputs/ward-rounds-medicine-principles-best-practice

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