Leadership Analysis: Rounding

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Abstract

This paper will discuss the improvements of patient satisfaction, length of stay, and decreased sentinel events due to the implementation of multidisciplinary rounds. A quality improvement team will be utilized to gather data before and after initiation of multidisciplinary rounds. The data will include patient length of stay, quality indicators, and patient satisfaction. A literature review was performed to analyze current evidence-based practice. Current research on multidisciplinary rounds indicates that improved communication shows an increased standard of care related to patient safety and satisfaction. The implementation and success of multidisciplinary rounds depends greatly on the leadership abilities of those involved.

Key words: Multidisciplinary rounds, interdisciplinary team, patient satisfaction, length of stay, quality indicators.
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The use of multidisciplinary rounds (MDR) can have a profound impact on patient outcomes and length of stay (LOS). Collaboration between physicians, nurses, social workers, discharge planning case managers, physical therapists, occupational therapists, pharmacists, and most importantly families can increase effectiveness and efficiency of proper utilization of the multiple disciplines and resources leading to more favorable overall outcomes (Cowan, Shapiro, Hays, Afifi, Vazirani, Ward, & Etter, 2006). It has also been shown that the increase in communication and teamwork with MDR positively affects patient satisfaction (Ababat, Asis, Bonus, Pham, & DePonte, 2013). The purpose of this paper is to analyze multiple aspects of the MDR approach including: the necessity, the appropriate team, the implementation, and the subsequent effects on patient LOS, satisfaction, and overall patient outcomes.

Clinical Need

The Issue

Effective communication between doctors, nurses, and other healthcare disciplines is essential when taking care of patients. Poor communication can impact patient safety and does not allow for a comprehensive team approach when rounding on a patient. A new strategy needs to be implemented to promote a team approach and improve communication between disciplines. Multidisciplinary rounds enhance communication between different specialties and break down the barriers between healthcare providers, patients, and their family members (Ababat et al., 2013). This type of rounding allows the healthcare team to ensure that best practices are being followed and more easily identifies the patient's daily goals in order to improve patient outcomes and decrease intensive care unit (ICU) length of stay (Wilson, Newman, & Ilari, 2009). Some of the patient needs that can be met by MDRs include
“identifying patient/family problems, defining goals, identifying interventions, discussing progress towards goal, revising goals and plans as needed, generating referrals, reviewing discharge and clarifying responsibilities related to the implementation of the plan” (Ababat et al., 2013, para. 2). Without the structure of the MDR, there may be multiple aspects of the patient care experience that are less than optimal as they may be overlooked without the involvement of vital leaders from all disciplines.

**The Literature**

Current nursing research has shown that many hospitals are striving to change the way they round on their patients in order to improve patient outcomes and better the communication between disciplines. In one article, three nurse leaders, Wilson, Newman, and Ilari (2009) outline the implementation of the MDR approach within an Intensive Care Unit (ICU). There was a noted decrease in LOS and improvement in patient outcomes, including mortality rates after implementation. This also led to subsequently lower pharmacy and overall hospital costs (Wilson, Newman, & Ilari, 2009). “Rounding puts everybody on the same page and makes expectations clear and physicians do not have to be disturbed throughout the day because issues for a patient are done right at the bedside” (Sharp, 2013, p.114).

In a study discussed in *Pediatrics in Review*, regular rounds were compared with MDRs. It was found that MDRs increase staff satisfaction and the family’s ability to participate in care and staff can give input after hearing all of the team members’ thoughts while not missing any changes in a patient’s care due to poor communication. (Rosen, Stenger, Bochkoris, Hannon, Kwoh, 2009). “Family-centered multidisciplinary rounds are a method of conducting inpatient hospital rounds that fosters teamwork and empowers hospital staff. The patient and family are engaged in and are the focal point of the rounds. Staff members are able to hear everyone's
perspective and give input” (Rosen et al., 2009, p.3). This has been noted to have a significant impact on both staff and patient/family satisfaction. In a study discussed on the New South Wales (NSW) government website, two patient groups were analyzed and evaluated: one utilizing an MDR approach and the other staying with the traditional approach. There was a noted decrease in the length of stay by 0.6 days for the group that received care utilizing the MDR approach.

Interdisciplinary Team

In order to make changes to the current state of rounding in the workplace, a Quality Improvement (QI) team needs to be assembled. “QI team members should represent a cross section of workers who are involved with the problem,” according to Folse (2011, pp. 395). This QI team will consist of two staff nurses, the unit nurse manager, an infection control liaison, and two doctors or PA/NPs. These disciplines will be playing an active part in MDR’s so it will benefit this team to have them come together to collect data for this change project. This team will continue to monitor and evaluate progress after implementation.

According to Multidisciplinary rounds (MDR): an implementation system for sustained improvement in the American Heart Association’s Get with the Guidelines Program (2007), “MDR is a patient-focused communication system integrating care delivered by multiple providers using concurrent feedback, redundancy, and rapid cycle improvement.” The MDR team should consist of all types of staff involved in patient care. These team members would include: “The bedside registered nurse who presents the patient; physician on the patient’s case; respiratory therapist; pharmacist; nutritionist; social worker; physical therapist; case management; and trainees who are involved in the patient’s care such as student nurses and medical students” (Ababat et al., 2013, para 3). Each team member will address and discuss the
appropriate aspects of patient care corresponding to his or her specific discipline. This will allow for effective collaboration and increase in communication amongst all members of the healthcare team.

**Data Collection Method**

This study aims to use a data collection method similar to the one used in the 2007 study by O’Mahoney, Mazur, Charney, Wang & Fine in their study about multidisciplinary rounding. Monthly data will be collected from an administrative database to measure the average LOS and nursing quality indicators of patients six months prior to implementing the MDR and monitored continuously following the change. “Nursing quality indicators reflect the structure, process, and outcomes of nursing care,” according to Folse (2011, pg. 399). The pre-MDR measurements and post-MDR measurements will be compared to see if the change shortened the patient’s length of stay, improved nursing quality indicators, and increased patient satisfaction scores. A line graph, or trend graph, can be used to display the monthly data to easily visualize trends and compare data both before and after implementation.

Length of stay (LOS) is the measurement of a single episode in the hospital for a patient. The measurement will provide quantitative data showing if the new implementation of multidisciplinary rounding has shown an average decrease in a patient’s length of stay. This number will be compared to the real length of stay for the patient post MDR implementation. For example, the average LOS for community acquired pneumonia compared to real length of stay for patient after implementation of MDR. This data collection technique can be used for any diagnoses. All diagnosis related groups (DRGs) can be computed for average length of stay (O’Mahoney et. al., 2007).
Quality indicators will be evaluated by measurement of select sentinel events that cause increased LOS or readmissions before implementation of MDR’s. The quality indicators being measured are rates of central line infections, falls, pressure ulcers, urinary tract infections, and ventilator acquired pneumonia. Each quality indicator will be measured in the same way; however, they will be individualized to the patient’s diagnosis. For instance, quality indicators for pneumonia would be different than those for acute myocardial infarction (O’Mahoney et.al, 2007). The data will be collected from the previously mentioned administrative database.

Patient satisfaction scores will also be measured with a five-question survey upon discharge during this year long period. Patient satisfaction surveys will be conducted for patients at time of discharge during the six month period before the new rounding tool and six months following it. The survey will focus on patient satisfaction indicators such as their preparedness for discharge, quality of their care, and how well the medical staff communicated with them. (See Appendix A).

**Standard of Care Outcome**

As a direct result of the increased collaboration and communication involved with a structured multidisciplinary rounding process, several areas of the overall patient experience will be improved. These improvements will be on multiple levels including: safety, satisfaction, and overall favorable outcomes. The national average LOS in an acute care hospital as of May 2013 was 4.8 days (Centers for Disease Prevention and Control, 2013). With the implementation of an effective and efficient MDR approach, the desired outcome is to decrease the average length of stay by 0.4 days every six months until a desired average four days or less, depending on diagnosis, are reached.
This decrease in LOS will be coupled with an increase in quality indicator scores. In this case, nursing dependent indicators will be measured, monitored, and evaluated. A steady improvement, as evidenced by a decrease in incidence of pressure ulcers, falls, and hospital acquired infections will demonstrate effectiveness of the MDR approach. A rate of decrease of at least 1% per quarter is acceptable until the desired outcome of zero has been reached.

The aforementioned outcomes will ultimately affect the overall patient experience. In ensuring a thorough multidisciplinary approach with open effective communication, the patient and their family members will have a fulfilling experience. This will be evident through the results of patient satisfaction scores. A steady increase in the average score of 0.5% per quarter will occur until a goal of 98% overall patient satisfaction is reached.

**Implementation**

According to the Institute for Healthcare Improvement (IHI), the ideal model for MDRs includes: Daily rounding with all members of the MDR team including a designated team leader, individualized daily goals specific to the patient, at least one key safety concern should be addressed for each patient, a discussion of potential discharge or transfer dates, and verbalizing any barriers and goals. This process will occur on the floor and will attempt to also include the patient families if applicable (IHI, 2010). Effective implementation, facilitation and adherence to the multidisciplinary rounds format require development of a basic functional framework as well as proper education of staff members with respect to their expected involvement and role in participation.

The implementation of the MDR approach will follow the basic change theory of Lewin involving, “Unfreezing, experiencing the change, and refreezing” (Donohue, 2011, p.327). During the unfreezing process, the issue is recognized and the need for change is realized. In
this particular case this phase involves the realization of the breakdown in the collaborative team approach to patient care.

Experiencing the change incorporates the “what is new or different in the ...process to begin to use the change can result in potential integration of the new way of thinking or doing” (Donohue, 2011, p.327). Appendix B provides an example of an MDR tool that may be utilized during a tabletop rounds session. Ideally, information is updated prior to that day’s rounds and adjusted during the session as needs are identified, addressed, or completed. To implement the change managers and leaders also have to “factor in time, information, decision making, and planning,” when contemplating change (Donohue, 2011, p. 325). Refreezing occurs “when the participants in the change situation accept and use the new attitude or behavior” (Donohue, 2011, p.327).

**Evaluation**

In order to determine the effectiveness of the multidisciplinary rounding, data collected from events related to improved patient experiences, nursing quality indicators, and decreased length of stay are examined over a six month period for evaluation. An appropriate sample size of 200 patients would satisfy the goal, provided that at least half of the participants return satisfaction surveys using qualitative data. Each survey will include the measurement of the patient’s experience with a given score of strongly agree, agree, neutral, disagree, and strongly disagree. To determine quantitative data each patient’s length of stay will be recorded and collected by the organization. The nursing quality indicators will also be looked at for a decrease in patient falls, pressure ulcers, central line infections, urinary tract infections, and ventilator acquired pneumonia. Results will be collected and interpreted by the program participants on a continuous basis and evaluated at the end of the six month time period.
Conclusion

After analyzing the various aspects of MDR, it has been shown that all team members must be willing participants in MDRs. A team leader should have all pertinent information such as current labs, any medication changes, possible referrals for physical therapy, and any concerns about possible discharge to keep the rounds on track. Both qualitative and quantitative data will be collected about MDRs to see if LOS is reduced, a reduction in sentinel events has occurred and an increase in patient satisfaction scores. Leaders and managers will be instrumental in implementing MDRs using a basic change theory. The data will be evaluated over a six month period to see if MDRs actually show decreased LOS, reduction in sentinel events, and increase in patient satisfaction.
References


Appendix A

Patient Survey Questions

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<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>I felt well informed about upcoming events/procedures during my stay.</td>
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<td>I felt included in all aspects of my care.</td>
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<td>I felt that I had high quality care.</td>
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<td>I felt that I was treated with respect by the care team.</td>
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<td>I felt that I was prepared for my discharge.</td>
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Appendix B