Patient Flow Toolkit

Module 1: Interdisciplinary Rounding

Reference guide for acute care inpatient units in Saskatchewan

September 2015
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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 under the Releasing Time to Care program, Rapid Process Improvement Workshops and other improvement efforts. A future module will include information and resources on enhancing interdisciplinary teamwork and communication.

Interdisciplinary rounds are necessary not only to meet our system needs for communication but also to ensure that patients and families have similar experiences on medical and surgical wards 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.

What are interdisciplinary rounds?

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 once, twice, or even three times a week, depending on the patient’s need 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
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decision-making process, including setting long-term and short-term goals. Individuals from different disciplines, as well as the patient 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 utilize 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) Because Saskatchewan is committed to patient- and family-centered care, we use the term interdisciplinary as it reflects inclusion of the patient and family as part of the care team and supports the breaking down of discipline silos.

Why do interdisciplinary rounds?

Evidence shows 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: Factor analysis of satisfaction surveys completed by 21 providers of interdisciplinary rounds and 19 providers of traditional rounds showed that providers of interdisciplinary rounds had a greater understanding of patient care, more effective communication, and better teamwork than providers of traditional rounds. (Note: Traditional rounds refers to physicians rounding with no other disciplines.) (Curly, McEachern, Speroff, 1998 and Gausvik C. et al, 2015)
Teams may also choose to add extra items of focus to the rounds discussion to support the patients they serve. You may wish to work with your team or region to capture similar data. Teams that have done so have seen reductions in:

- ICU mortality;
- Ventilator-acquired pneumonia (VAP) rate;
- Catheter-related bloodstream infection (CR BSI) rate; and,
- Urinary tract infection (UTI) rate.

(IHI, 2013)

**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 attributes chart (p.7). A self-assessment tool (p. 6) 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 (i.e., 30, 60, 90, and 180 days) 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 as 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. Patients and families should be equal participants and therefore participate in the discussion, decision-making, and implementation of the plan. Each is defined below.
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.

The Spectrum helps to define the public’s role in any public participation process. It emphasizes the need for balanced and objective information, consultation, engagement, collaboration, and empowerment.

**PUBLIC PARTICIPATION GOAL**

- **Inform**: To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities, and/or solutions.
- **Consult**: To obtain public feedback on analysis, alternatives, and/or decisions.
- **Involve**: To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.
- **Collaborate**: To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.
- **Empower**: To place final decision-making in the hands of the public.

**PROMISE TO THE PUBLIC**

- **Inform**: We will keep you informed.
- **Consult**: 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.
- **Involve**: 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.
- **Collaborate**: We will work together with you to formulate solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.
- **Empower**: We will implement what you decide.

**INCREASING IMPACT ON THE DECISION**
Interdisciplinary rounds 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 2 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: Row C requires reference to Interdisciplinary Rounds Required Attributes Table (p. 9).

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Patients and families do not participate or contribute to rounds. They are informed by the nurse afterwards what decisions were made.</td>
<td>Patients and families do not participate in rounds. They contribute by putting forward questions to their nurse.</td>
<td>Patients and families are informed about rounds and have the opportunity to contribute their questions via their nurse.</td>
<td>Patients and families fully participate by adding information and insights, and asking questions.</td>
<td>Patients and families participate fully by adding information, insight, asking questions, and making decisions regarding their care.</td>
<td>Target ≥4</td>
</tr>
<tr>
<td>B</td>
<td>Disciplines round independently. Rounds do not occur at the bedside.</td>
<td>Interdisciplinary team rounds occur. Rounds do not occur at the bedside.</td>
<td>Inter-disciplinary teams round together (attending physician is not present). Rounds occur at the bedside.</td>
<td>Inter-disciplinary teams round together (attending physician is present). Rounds occur at the bedside.</td>
<td>Target ≥4</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Standard Work is not in place for rounds. Not all required attributes are included.</td>
<td>Standard Work is in place for rounds, including role of each member. Training has not been completed on standard work.</td>
<td>Standard Work is in place for rounds, including role of each member. Training has been completed on standard work.</td>
<td>Standard Work is in place for rounds, including role of each member. Training has been completed on standard work.</td>
<td>Target ≥4</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>The care plan is not updated to reflect the rounds discussion.</td>
<td>A team worksheet is used to capture the rounds discussion. All staff members have access to the worksheet. The care plan is not updated to reflect the worksheet.</td>
<td>A team worksheet is used to capture the rounds discussion. All staff members have access to the worksheet. The care plan is updated to reflect the worksheet.</td>
<td>Staff directly update the care plan during rounds to reflect the discussion. All staff have access to the care plan following rounds.</td>
<td>Staff update a care plan and whiteboard to reflect rounds discussion. Patients and families are encouraged to contribute to the plan and use the whiteboard for communication. All staff and the patient have access to the care plan following rounds.</td>
<td>Target ≥4</td>
</tr>
</tbody>
</table>

*Telehealth or phone may be used as a platform 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.iap2.org

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Required attributes of interdisciplinary rounds

Successful interdisciplinary rounds include the attributes listed in the table below. Each item should be discussed during rounds. The table provides suggestions on what could be discussed for each attribute.

- 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.
- Your review should include those issues relevant to your patient population.

The attributes list is based on the review of articles listed in the References (p. 25.) The rounds includes a review of Back to Basics care items, which reduces iatrogenic disability.

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

The following three factors contribute to iatrogenic disability:

- **Pre-existing patient frailty**: Frail patients are more vulnerable to stressors such as illness. This can mean 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)

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.

*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 loss of independence and injury.

*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.

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: The time when patients transition from their acute care stay back to the community or next stage of care is a period of risk. 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. 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 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: 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.

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.
   • Consider identifying a team lead who will help lead the rounds as well as coach staff during the rollout (e.g., Clinical Coordinator, Clinical Nurse Educator or Clinical Nurse Specialist).
   • Patient or family advisors may also be invited to participate, especially if your unit has an advisory council to draw these individuals from.
   • Identify an interdisciplinary rounds champion and develop a communication plan for the implementation.
   • Include not only champions but those who may not be advocates of interdisciplinary rounds.
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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 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 what the rounds process is?
     • Have they participated?
     • Do they know their treatment plan? Discharge plan?
     • Are they comfortable asking questions?

   • Data may include:
     • # of patients
     • # of disciplines involved in care
     • Time that disciplines currently come to unit
     • Average length of stay
     • Baseline from Patient Experience Survey results
     • Critical incidents or patient stories that could have been avoided with improved interdisciplinary team communication.

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. 26 for videos, articles, toolkits).
   • Review existing practices in Saskatchewan (pp. 13-16).
   • 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? (“Just do it” projects)
   • How will patients and families be invited to rounds? (see p. 19 for examples)
   • What standard work or templates will be used? Who will adapt them? (see p. 18 or kaizentracker.ca for examples)
   • How will team members document the rounds discussion? (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?

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?
  • Has there been any changes in patient experience survey results?

ACT

• How do we sustain the gains?
  • 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.

DO

• Implement action plan.
• Engage staff and physician champions to spread enthusiasm about the work.
  • Encourage these individuals to partner with those 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.
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Interdisciplinary rounds planning — team worksheet

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

1. **What patients will be seen each round?**
   - All patients on unit
   - Patients with urgent care issues and newly admitted patients
   - Patients with urgent care issues and patients nearing discharge
   - Other: _______________________________________________________________

2. **Who will attend?**
   - Patients
   - Families
   - Physician
   - Residents
   - Nurse
   - Allied Health (social work, PT, OT, SLP, discharge planner, dietician, ____________)
   - Other: (ie. spiritual care, navigator, educator, ____________)

3. **Who will lead the discussion about each attribute? 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 about rounds?**

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

9. **How will we identify and address patient’s and family’s individual needs for rounds?**
   - (e.g., translators, cultural and spiritual needs, etc.)
Saskatchewan example: Interdisciplinary rounds in an Intensive Care Unit

In 2009, the Intensive Care Unit at St. Paul’s Hospital 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, respiratory therapists, social work, spiritual care, residents, patients, and families. This occurs at 9:15 AM daily at each patient’s bedside.

During 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.

• Residents summarize the patient needs and identify goals for care.
• 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 information on 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. 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 the patients/families and the 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.

For more information, contact:
Manager, Betty Wolfe at betty.wolfe@saskatoonhealthregion.ca

Saskatchewan example: Interdisciplinary rounds in a 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.

Key learnings
• Because there are 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:
Nursing Manager, Lori Keller at lori.keller@shr.sk.ca
Saskatchewan example:
Interdisciplinary rounds in an 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) from the In Safe Hands toolkit from New South Wales, Australia. The SIBR script has 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 off to the Most Responsible Physician to ensure that the plan of care for the patient is updated.

Contact:
Nursing Manager, Erica Pederson,
erica.pederson@rqhealth.ca
Sask. example: Interdisciplinary rounds, urban medical unit

(continued)

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

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 http://www.crepatientsafety.org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonsteinsession2.pdf
Module 1: Interdisciplinary Rounding

Example of Standard Work – Structured Interdisciplinary Team Rounds (SHR Pediatrics)

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

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.creatpatientsafety.org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonstein1session2.pdf](http://www.creatpatientsafety.org.au/seminars/designing_hospital_units/designinghospitalunits-dec11-jasonstein1session2.pdf)
Resources for introducing patients and families to rounds

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 into 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 their 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.
The Five Hills Health Region uses this letter 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.
Examples of transition checklists

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

### Multidisciplinary Discharge Planning

<table>
<thead>
<tr>
<th>Estimated Date of Discharge:</th>
<th>Date written:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>☐ EDD on White board</td>
<td>☐ EDD entered into Bed Management System Initials.</td>
</tr>
<tr>
<td>☐ EDD on Care Plan</td>
<td></td>
</tr>
</tbody>
</table>

**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:** _______________________________
Module 1: Interdisciplinary Rounding

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 are anticipating 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: __________________________

The Saskatoon Health Region uses this discharge planning document to support communication and documentation of transition planning done during rounds.
Saskatoon Health Region’s Dube Centre for Mental Health uses this transition checklist to document discharge readiness.

**Transition Checklist** (Discharge Readiness)

<table>
<thead>
<tr>
<th>Date &amp; Time of Admission Round:</th>
<th>Admission Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis:</td>
<td></td>
</tr>
<tr>
<td>Predicted Discharge/Transition Date:</td>
<td>☐ Involuntary ☐ Voluntary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Worker:</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ Financial:</td>
<td>☐ ☐ Rx Coverage:</td>
</tr>
<tr>
<td>☐ ☐ Housing:</td>
<td>☐ ☐ EDS</td>
</tr>
<tr>
<td>☐ ☐ Home Care:</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Family Support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>☐ ☐ Forward orders to CMHN</td>
</tr>
<tr>
<td></td>
<td>☐ ☐ Fax Rx to Pharmacy</td>
</tr>
<tr>
<td></td>
<td>☐ ☐ Bloodwork to Clozapine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupational Therapy:</th>
<th>Dietitian:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ Capacity Assessment</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Cognitive Assessment</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Driving Screening</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Coping Skills &amp; Sensory Strategies</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ADL/Equipment/Functional Assess</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatrist:</td>
</tr>
<tr>
<td></td>
<td>☐ ☐ Discharge Summary</td>
</tr>
<tr>
<td></td>
<td>☐ ☐ Discharge Orders/Rx</td>
</tr>
<tr>
<td></td>
<td>☐ ☐ CTO name:</td>
</tr>
<tr>
<td></td>
<td>☐ ☐ Next Cert Due:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapeutic Recreation:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ Leisure Assessment</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Group Referral</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ CMHN:</td>
</tr>
<tr>
<td>☐ ☐ Out-pt Psychiatrist:</td>
</tr>
<tr>
<td>☐ ☐ G.P.:</td>
</tr>
<tr>
<td>☐ ☐ Concurrent Disorders</td>
</tr>
<tr>
<td>☐ ☐ Addictions Counselling</td>
</tr>
<tr>
<td>☐ ☐ Adult Outreach</td>
</tr>
<tr>
<td>☐ ☐ Other:</td>
</tr>
<tr>
<td>☐ ☐ Other:</td>
</tr>
<tr>
<td>☐ ☐ EPIP</td>
</tr>
<tr>
<td>☐ ☐ Transition Team (incl. Counselling)</td>
</tr>
<tr>
<td>☐ ☐ Bridges</td>
</tr>
<tr>
<td>☐ ☐ McKerracher</td>
</tr>
<tr>
<td>☐ ☐ In-patient Consult</td>
</tr>
<tr>
<td>☐ ☐ Out-pt RT</td>
</tr>
<tr>
<td>☐ ☐ Out-pt OT</td>
</tr>
<tr>
<td>☐ ☐ Out-pt Dietitian</td>
</tr>
</tbody>
</table>
Module 1: Interdisciplinary Rounding

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

<table>
<thead>
<tr>
<th>Areas of Concentration</th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Goal of the day/Concerns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2 Status Update</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overnight events</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital Signs and Pain control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluid and food intake</td>
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<td></td>
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<tr>
<td>Urine and Bowel Movements</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mental Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADLs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3 Quality and Safety</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foley Catheter</td>
<td></td>
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<tr>
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<td>VTE Prophylaxis</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Glycemic Control</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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.

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. Units should establish a process for explaining the rounds process to patients and families on admission and obtaining consent if privacy will be of concern. If patients do not consent, alternative arrangements should be made to accommodate the needs of patients and families.

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 or if the patient is not participating but the family is, have the round in another space.

Do you need to round at the bedside for patients who are not alert?

The most patient and family centered approach would be to round at the bedside if the family wishes. Speak about patients as if they are present.

How do you share clinical information?

Clinical jargon can be confusing to patients and families, however using the clinical terms is often necessary. Share the clinical terms and then provide an explanation in laymans terms. Avoid using acronyms. When sharing information such as vital signs you may give some explanation to help inform the patient/family. i.e., “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.”

How do you share information of a sensitive nature?

If there is information you must share which 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.
Module 1: Interdisciplinary Rounding

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, a teleconference 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.

Helpful Resources

1. The University of Michigan recently released a seven-minute video which explains what multidisciplinary rounds are 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. www.youtube.com/watch?v=--oOcJ1-6Fq4&feature=youtu.be

2. The Clinical Excellence Center has a three-minute video showing structured rounds. www.youtube.com/watch?v=fExlkV5jUI

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

4. 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 in learning about the roles, types, and need for interdisciplinary rounds. www.rcplondon.ac.uk/sites/default/files/documents/ward-rounds-in-medicine-web.pdf
References


Jessup, Rebecca L., Interdisciplinary versus multidisciplinary care teams: do we understand the difference? *Australian Health Review* August 2007 Vol 31 No. 3.


International Association for Public Participation, Spectrum for Public Participation. www.iap2.org


