Safety Rounds: Improving Multidisciplinary Communication

Patricia A. Heale, DNP, RNC-OB
Background

• TJC reports that communication is root cause in 70% of sentinel events
  – Ineffective communication is a leading cause of errors resulting in patient harm
• In 2007, TJC released a NPSG to improve communication among caregivers
## TJC Root Cause – Maternal Events

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Factors</td>
<td>127</td>
</tr>
<tr>
<td>Communication</td>
<td>125</td>
</tr>
<tr>
<td>Assessment</td>
<td>86</td>
</tr>
<tr>
<td>Leadership</td>
<td>66</td>
</tr>
<tr>
<td>Information Management</td>
<td>27</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>24</td>
</tr>
<tr>
<td>Continuum of Care</td>
<td>20</td>
</tr>
</tbody>
</table>

N=131
Our Service

• Academic Medical Center – 800+ beds
• 5,000+ deliveries per year
• Six ICUs including cardiac, neuro, transplant, trauma, surgical and medical
• Level IV NICU
• Prenatal Clinic
• 15 Maternal Fetal Medicine Specialists
Communication Issues

• Communication occurs in silos
• Hierarchy among disciplines
• Perception of lack of value, nurses’ information
• Fragmented patient reporting process
• Varying communication styles
  – Physicians – just the facts
  – Nurses – narrative style
Goals

• Multidisciplinary collaborative model to
  – Effectively communicate plans of care
  – Problem-solve
  – Implement necessary changes based on maternal-fetal status

• Communicate in a “safe” arena

• Foster collegiality
  – Mutual respect and trust
Proposed Change

• Safety Rounds are
  – Multidisciplinary
  – Patient-centered
  – 10AM, 4PM and 10PM

• Opportunity for all clinicians to communicate the patient plan of care
Attendance

• The L&D Charge Nurse would “run” Safety Rounds with the assistance of the Mother Baby Charge Nurse
• Anesthesia, OB/GYNs, MFMs, residents, managers, nurses, CNS, social workers and case managers
Barriers to Implementation

• Hard sell
• Attendance was sporadic at best
• Nurses feelings of inferiority
• Physicians felt that nurses merely needed to follow their orders and that no additional communication was necessary
Barriers to Implementation

- Hierarchy
- Poor understanding of value
- Lack of interest
- Conflicting priorities
Key Steps in Implementation

- Identification of Need
  - Variances
  - Near misses
- Stakeholder Analysis
  - Key stakeholders and what they needed to achieve
- Planning
- Calling physicians
Benefits

- Enhanced clinical decision-making
- Summarize patient updates
- Identify potential safety challenges
- Agree on the Plan of Care
Outcomes

• Standing Room Only!
• Enhanced clinical decision-making
• Improved knowledge acquisition
• Innovative solutions to manage patient care challenges
• Improved collaborations, collegiality and patient safety
Aha Moment!

Patient with a primary C/S and a Pfannensteil skin incision. It was “assumed” that she also had a low transverse uterine incision. Several members of Safety Rounds were concerned that there was no documented uterine scar. After much discussion it was decided to perform a repeat C/S. A small window was noted at the base of the classical scar.
Evaluation

• Safety rounds offers your organization an important opportunity to identify areas for process improvement that will lead to improved patient safety outcomes
Thank You!

Questions?