Title:
Safety Rounds: Improving Multidisciplinary Communication

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Session Title:
Enhancing Patient Safety
Slot:
D 10: Sunday, 29 October 2017: 2:45 PM-4:00 PM
Scheduled Time:
3:25 PM

Keywords:
Communication, Plan of Care and Safety and Quality

References:
Heale, P. (2016). Improving multidisciplinary communication through safety rounds. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 45*(3), S2.

Karasin, B & Maund, C. (2015). Multidisciplinary safety rounds to improve patient safety through venous thromboembolism prevention awareness. *Joint Commission Journal for Quality and Safety, 41*(9), 428-431.

Paul, E. (2015). Minimizing patient safety events through a multidisciplinary approach to human milk management. *Childhood Obesity and Nutrition, 7*(5), 258-261.

Abstract Summary:
The Joint Commission describes communication as a key component of sentinel events. Obstetric Safety Rounds provides a forum for the exchange of information between medical providers and nurses thereby improving communication. Obstetric Safety Rounds also allows the opportunity to develop individualized plans of care and share them between specialties.
Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
The learner will be able to identify the barriers to implementation of multidisciplinary Safety Rounds.	Lack of physician participation, Lack of nursing participation, Conflicting priorities, Physician buy-in, Nurse buy-in, "Forgetfulness", Lack of perceived value,
The learner will be able to describe the benefits of implementing multidisciplinary Safety Rounds.	Improved communication, discussion of patient plan of care, physician and nursing understanding/agreement on patient plan of care, identification of points of miscommunication, improved patient safety
The learner will be able to define the steps necessary for implementation of multidisciplinary Safety Rounds.	Space to meet, definition of format, participant identification/selection, communication to involved parties, education of participants as to goals of Safety Rounds

Abstract Text:

Keywords: Purpose for the program:

Ineffective communication among health care providers leads to fragmented care known to be a leading cause of medical errors. The Joint Commission report on communication and sentinel events clearly states that communication is an essential factor in a majority of sentinel events. The Joint Commission compiled data on sentinel events from January 2014 to October 2015. The root causes of those events included 127 failures of communication among 197 total incidents. Within the organization several near misses occurred due to both communication failures and lack of a coordinated plan of care. These near misses also occurred in parallel to an increase in volume and acuity due to the exponential growth of the Maternal Fetal Medicine service.

Proposed change:

The proposal was to develop and implement a standardized process for Multidisciplinary Obstetric Safety Rounds that provides the opportunity to discuss patient care concerns and identifies potential risk(s) through structured communication and development of a coordinated plan of care. Safety Rounds would be led by the Labor & Delivery and Mother-Baby Charge nurses. The plan was for each Antepartum and Labor & Delivery patient to be introduced. As each patient background was discussed the provider of record would describe the plan of care and the opportunity for questions would be provided. The Mother-Baby Unit would be summarized with special consideration given to complex patients and/or patients with unique needs.

Implementation, outcomes and evaluation:

Obstetric Safety Rounds were implemented three times a day, led by the charge nurses. A key component of the implementation plan included staff and physician education regarding the importance of a structured communication process and development of a forum to ensure a comprehensive plan of care for every patient. Barriers to implementation included lack of staff and physician buy-in, OR schedule conflicts and inconsistent attendance.

Pre-implementation, a coordinated plan of care was missing 75-95% of the time. Results to-date demonstrates the presence of a coordinated plan of care greater than 75% of the time; the result of structured communication during OB Safety Rounds.

The initiative has been sustained for four years and is now part of unit culture. Patient issues are regularly identified and communicated leading to positive outcomes for mothers and newborns.

Implications for nursing practice:

Nursing benefitted from Obstetric Safety Rounds in two ways, through the development of a clear individualized plan of care and through the dissemination of that plan. Effective information sharing establishes clear expectations for the team; facilitating communication, teamwork and the development of comprehensive care plans which positively impact nursing practice and patient outcomes.