Safety Rounds: Improving Multidisciplinary Communication

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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

Human Factors	127
Communication	125
Assessment	86
Leadership	66
Information Management	27
Physical Environment	24
Continuum of Care	20

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?