Improving Communication on a Medical Floor Through Interdisciplinary Rounding
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Medical errors happen. Increasingly, the medical community, as well as the public, is learning that errors of communication are often at the root of most patient safety issues. This is highlighted by the Joint Commission’s review of over a decade of sentinel events showing that ineffective communication is cited as a root cause in most of the events. Studies at larger hospital settings have demonstrated that interdisciplinary rounding leads to both improved patient, as well as provider satisfaction, though few have been performed within smaller, community based hospitals. Our study endeavored to understand the fragmentation inherent in ineffective communication and work to improve qualitative nursing satisfaction scores regarding our patient care on our adult inpatient medicine service by bedside rounding with physicians, pharmacy and nursing. In October of 2014 our group distributed a basic communication survey designed to evaluate general nursing sentiments around our communications in patient care. We distributed the survey to the two main adult inpatient medicine floors in our hospital. Our survey questions focused on the communication between physician/Family Medicine inpatient team, nursing staff and patient in the areas of: 1) Total (overall) communication, 2) Discharge Planning, 3) Hospital Course and Plan, 4) Imaging and Diagnosis, 5) Family Meetings, 6) Consultations, and, 7) overall Communication between Physician and Patient. We then implemented our bedside rounding format that included Studor AIDET (Acknowledge, Introduce, Duration, Explanation, Thank you) style communication, specific role assignment and integration of patient, patient’s family and nursing. After three months’ implementation, the same qualitative satisfaction survey was distributed and post implementation data assessed. Statistical analysis was performed using the Wilcoxon Signed-Rank Test. We received a total of 18 responses from our nursing colleagues with qualitative improvement across all areas assessed. Our area of greatest improvement was around discharge planning communication which was followed by medication management. Statistical analysis was limited due to low sample size. Using the Wilcoxon Signed-Rank Test, we found a statistically significant improvement in the area of discharge planning (W value =0, p<0.05) While we did increase in every facet that data was collected around, our overall communication score showed little change. One unintended positive outcome of this effort was subjectively fewer pages from nursing in the afternoon. Interdisciplinary bedside rounding can potentially improve communication, especially around transitions of care (discharge planning) and medication management, in smaller, community based hospitals. While our overall communication score showed a slight improvement, further interventions will be required to continue to bridge this gap. Additionally, further study is required to identify ways in which improved communication affects patient safety events and rates of medical errors in hospitals.