ON THE CUSP PRESSURE INJURY SAFETY TOOLKIT

Observing Patient Care Rounds Tool

Problem statement

Interdisciplinary rounds are in the best interest of patients. Poor communication among staff can be a root cause of patient adverse and sentinel events. Communication among disciplines can be improved if viewed through the eyes of an objective observer.

What are observational rounds?

Observational rounds are a teamwork and communication tool to objectively assess and improve teamwork dynamics across and between disciplines, identify areas where communication can be more concise and relevant in setting daily patient goals, and provide a method to continually improve communication skills.

Purpose of tool

This tool provides a structured approach for improving teamwork and communication behaviors that would otherwise bring down staff morale and patient care delivery across and between disciplines.

Who should use this tool?

Administrators, physicians, nurses, pharmacists, therapists, and medical and nursing students, to better understand the dynamics of multidisciplinary rounds, identify defects in communication, foster collaboration among disciplines or practice domains, and target areas where communication can be improved in the rounding process and in setting patient daily goals.

How to use this tool

Complete the form while observing patient care rounds. Discuss your findings with the multidisciplinary team at the end of rounds. You may use this form for one patient or the entire unit. Leading questions and prompts encourage teamwork and communication assessment from a broad perspective.

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Observation process: Questions to consider

I. Identify communication that was explicit (clearly stated and measurable) versus implicit (suggested but not clearly expressed).

- Who was explicit or implicit in their communication?
- Were care directives ever implied but not clearly expressed?
  If yes, by whom? Within which practice domain (medicine, nursing, pharmacy, dietary, respiratory)?
- Did anyone ask for clarification?
  If yes, which team members spoke up?

II. Were rounds conducted in an open forum (all team members could participate and make suggestions) or closed (led by the attending who dealt with the resident caring for the patient)?

- If rounds were in an open forum, were team members encouraged to offer opinions and suggestions?
- If the rounds were in a closed forum, would input from other team members benefit the patient or improve the care plan?
- Was there something missing in the patient care goals? If so, list it below:

Patient Room and Bed Number	**Patient System, Goal Not Addressed**

III. Were conflicts identified in the patient's care plan?
- How were the conflicts resolved?
- Was hierarchy (attending physician over resident) an issue?
- Was any change in the care plan supported by evidence-based medicine (literature)?
- Did the interaction style or communication change between providers?

IV. Did you witness assertive behavior or communication?
- Was it appropriate for the situation?

V. Were team members able to maintain situational awareness (awareness of activities going on in the unit)?
- Were changes in the day clearly identified?
- How were these changes resolved? Were the resolutions effective or ineffective?

VI. At the end of rounds, what do you wish you would have said? What would you have said differently?

Below is a framework to help review your findings with members of the team.

Based on your observations and the preceding questions, list any teamwork and communication problems you identified during the course of patient rounds.

Problem	Team Members Affected	Patient Care Not Addressed	Suggestions for Improvement