IMPLEMENTING PATIENT CENTERED MULTIDISCIPLINARY BEDSIDE ROUNDS



IUNC SCHOOL OF MEDICINE





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BACKGROUND

Communication between daily rounding teams and patients on the medicine wards is ineffective. This is a result of numerous issues including: redundancy in the discussion of clinical data, paucity of meaningful face time with patients, inadequate patient engagement in their plan of care, and deficiency in a multidisciplinary presence during daily rounds.¹ These factors propagate patients' sense of vulnerability and a decreased sense of satisfaction with our work. Rounding with presentations made at the patient's bedside, rather than in the hallway or a remote conference room, has been shown to improve patient and medical team satisfaction without sacrificing efficiency.²⁻⁹ Despite this, residents prefer not to present at the bedside during rounds with concerns that it will increase patient anxiety, compromise teaching, and be inefficient.¹⁰⁻¹² Surveys of UNC internal medicine residents, attending physicians, and nurses showed that patient engagement, teaching and nursing involvement on rounds was inadequate (Figure 1):



Watch the Video Introduction: Multidisciplinary Bedside Rounding



• **Figure 1:** Survey Results – Perceptions of Patient Engagement, Teaching, and Nursing on Rounds



GOALS

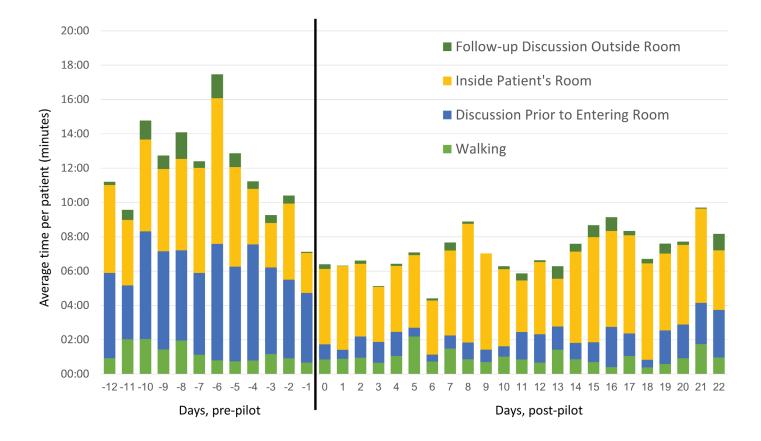
This project was developed to target these problems by restructuring rounds with a consistent multidisciplinary team presence at the patients' bedside to have a clinical discussion with the most important team member: the patient. This new structure aims to maximize meaningful time spent with the patient by eliminating outside the room discussions about patient care when appropriate. The medical team will find more meaning in this valuable time spent at the bedside, learning from the patient and involving them in their own plan of care, as this is critical for sustainability of the bedside rounding technique.¹³⁻¹⁷ It is important to clarify that the objective of bedside presentations is not to shorten overall rounding time, but to allow the medical team to have more meaningful time with patients. The implementation of multidisciplinary bedside rounds will result in improved communication between all members of the team. We also hope this rounds format results in timely placement consults and orders, earlier discharges and expedited documentation.

PROJECT COMMENCEMENT AND SUSTAINABILITY

To kick-off the project, resident, attending, nurse, and social work representatives participated in a flow-map exercise to identify major areas of inefficiencies and dissatisfaction with current rounding methods. Discussions were held with a patient focus group to gain a first-person perspective on sources of vulnerability. These findings were incorporated in the re-structuring of the team rounding processes to better interface with patients.

Consistent buy-in from residents and attending physicians on rounds is paramount for sustainability. In a prepilot survey of the UNC internal medicine residency, 31 out of 63 responses cited that their principal concern with implementation of bedside rounding was that rounding time would increase. To prospectively analyze this concern, a time-motion study was performed to analyze the impact of bedside rounding on overall rounding duration as well as the amount of time medical teams spent face-to-face with patients. Implementation of a bedside rounding strategy decreased average per-patient rounding duration from 11'45'' to 9'22'' (p < 0.0001), and increased average time spent with patients from 4'43'' to 6'31'' (p < 0.0001) (Figure 2). When combined, this led to a significant increase in the fraction of time spent with patients, a term referred to as the "FaceTime Fraction," from 40.2% pre-intervention to 69.6% post-intervention.

With the support of the School of Medicine as well as Hospital Operations leadership, this project was developed and piloted on one inpatient general medicine teaching service beginning in October 2017. This pilot was successful in achieving our goals and is now being implemented across all rounding teams (with the exception of the ICU) in the Department of Medicine at UNC.



• Figure 2: Time-Motion Study Results

KEY STAKEHOLDERS

The key stakeholders in this project are first and foremost the patients and their families, the residents and medical students, attendings, nurses, care managers, and pharmacists. There is also significant investment from a patient advocacy group, residency and fellow department representatives, and hospital leadership.

DETAILS OF ROUNDING TECHNIQUE

The team implemented a four-phased approach to conducting daily rounds, outlined below.

Pre-8:35 am	 Pre-rounding All members of the medical team computer pre-round on the patients including overnight admissions (refer to <u>Team Member Expectations</u>) Interns and residents physically pre-round on patients, prioritizing sick or decompensating patients, admissions, transfers and, discharges
8:35 am	 Pre-Round Huddle: Upper level resident leading discussion with attending, charge nurse, and care management representative (5- 10 minutes) Determine which patients will be rounded on as a team, and which patients will be seen by the attending and residents separately Decide rounding order (refer to Prioritization of Patients for Bedside Rounds) Update care managers on discharges Interns should use this time to page consults
8:45 - 11:00 am	 Team Rounds Notify nursing staff when in transit to primary regionalized area Charge nurse joins rounds when able Outside patient room team touch base should occur only in certain scenarios (i.e. patient issue that cannot be discussed in front of family members) In the patients' rooms the presenter will: Sit at eye-level with the patient Introduce bedside rounding format and roles of each team member, and give a FaceSheet to new patients (refer to <u>Appendix 1</u>) Present in an assessment/plan format, prioritizing patient's active problems (refer to <u>Appendix 2</u> Example Scripts) Respond to patient and caregiver questions Update white-board with the daily plan discussed (medical student or nurse) Non-presenting intern should input orders for this patient on a computer on wheels and complete an order recap After exiting the patients' rooms the team should when necessary close the loop of communication on the patient care plan
After 11:00 am	 Post-rounds Attending and residents visit patients pre-determined to see separately Rest of team input any additional orders and ensure clear on the care plan for the rest of the day

• It is an expectation that attendings see stable patients outside of team rounds which end no later than 11:00 am.

PRIORITIZATION OF PATIENTS FOR BEDSIDE ROUNDS

In the Pre-round Huddle the resident and attending will strategize the rounding order with prioritization of patients in the following order:

- Sick and decompensating patients
- New admissions and transfers
- Discharges
- Stable patients

On average teams spend about 10 minutes per patient, and 12-14 patients on a 20-patent census is the ideal number to round on together with the multidisciplinary team.



Watch the Video Pre-Round Huddle



INTRODUCTION OF TEAM AND BEDSIDE ROUNDING FORMAT

A patient-centered approach involves discussion of the day's medical plan at eye level with the patient with emphasis on engaging them in their own medical plan. The following is an example of how to introduce the technique to a patient:

"Hello Mrs. Smith, my name is Dr. Jones and I am the supervising resident doctor on your medical team. Here is a sheet with our pictures and names on it so that you can be more familiar with your doctors. I would like to introduce you to [intern], [attending], [medical students], and [pharmacist]. We will all be working closely with you and your nurse [nurse's name] to come up with a medical plan for the day. We prefer to talk about your medical course and plan with you, rather than having these discussions without you present. If there are medical terms that are unclear please let us know and we will help clarify. Please feel free to provide input, and we will likely ask you questions as we discuss your case."



Watch the Video Effective Multidisciplinary Bedside Rounding



TEAM MEMBER EXPECTATIONS

All team members are expected to computer pre-round, arrive to rounds on time, balance speaking in layman's terms versus medical jargon, and allow patients to interject while maintaining the focus of rounds.

Attendings:

Computer pre-round on existing and new patients, provide recommendations at appropriate times during the presentations while trying to minimize presentation interruptions, ensure that full assessment and plan based structure is utilized, and round independently on appropriate patients established in pre-round huddle. Attendings should not schedule themselves or be responsible for other clinical duties while on service such as procedures or clinic. It is an expectation that attendings see stable patients outside of team rounds which end no later than 11:00 am.

Residents:

Computer and physical pre-round on new and sick patients, determine order of rounds and patients to be rounded on as a team versus attending only, lead the pre-round huddle, introduce bedside rounding format to patients, give new patients a FaceSheet (refer to <u>Appendix 3</u>), and provide input and recommendations after the presenter has finished.

Interns:

Computer and physical pre-round on patients, assessment and plan based bedside presentations while sitting at eye-level with the patient, engage team for input when needed during presentations, utilize computer on wheels for orders, consults, discharges and documentation when co-intern is presenting their patients, and perform order recap after co-intern's presentations.

Factors Critical to Success

- Resident and attending buy-in
- Nurse and care management participation
- Hand out FaceSheets (refer to <u>Appendix 3</u>)
- Pre-determine of patients to use technique on with team versus have the attending and residents see separately
- Talk to the patient at eye-level
- Use the workstation on wheels and stool which is stored on the workstation

Medical Students:

Computer and physical pre-round on patients, help to locate primary nurses on rounds, assessment and plan based bedside presentations, ask questions when appropriate and engage team for their expertise, and update white-board in room.

Charge Nurses:

Participate in pre-round huddle, notify team of unexpected changes in patient status, and help to locate primary nurses on rounds.

Bedside Nurses:

Make reasonable efforts to be present for bedside rounds, advocate for patients, supplement important information not relayed during the presentation, ask clarifying questions, and update the whiteboard.

Pharmacists:

Contribute expert advice at appropriate times during rounds.

Care manager:

Make contact with primary team in the morning through phone conversation or face-to-face participation in the pre-round huddle to optimize use of time while team is rounding.



Follow hospital infection control regulations: clean the stool if it becomes visibly soiled, after use in the room of a patient on Contact or Enteric Precautions, and daily after rounds.



TESTIMONIALS

I did NOT believe in patientcentered rounding before doing it. Now 100% changed. – Intern

I felt that patients really enjoyed the extra time and rounds were pretty efficient. – Resident

It really works -- can be efficient, save time, better patient engagement." - Attending

I think the patients really engage more when they are part of the conversation. - Attending

[The pre-round huddle] is very effective, the quick 5-10 minutes helps me prioritize my day!

– Care manager

FREQUENTLY ASKED QUESTIONS

Q: How do I politely exit the patient room when the patient or care partner is continuing to ask questions that I may not have the answer to/may not need to be answered at this time?

A: We suggest first reinforcing expectations with the introduction of the team and the FaceSheet, explaining that our goal is to talk about the plan for today and then answer questions that arise from patients and care partners. If answering certain questions would benefit from a more extended conversation, acknowledge the question and state that you would like to discuss this more in-depth after team rounds have finished.

Q: How do I make the patient feel comfortable when surrounded by such a large care team?

A: The best way to make a patient comfortable is to introduce all members of the team and their roles, and to explain the purpose and structure of the presentation. Patients should understand why each person needs to be in the room discussing their sensitive medical information. It is also important to tell the patient that they are a vital member of the team, and encourage the patient to ask questions and make clarifications when appropriate.

Q: What is the best way to educate my department on this technique and implement it sustainably?

A: Initial contacts that are helpful for implementing multidisciplinary bedside rounding on a particular unit is to first meet with that unit's physician service leader and nurse manager. From there, educate the attending and residents teams, primary nurses, and care managers using this multimedia curriculum. It might also be helpful to have attendings and residents "shadow" the service leader or another attending who is experienced with multidisciplinary bedside rounding. Please encourage attendings who are dissatisfied with this format to give feedback and discuss ways for improvement.

Q: How do I ensure there is a place to sit at eye-level with the patient?

A: The medical team was provided with a folding stool that could hang on the side of a mobile workstation on wheels. Our patient advisory panel suggested that sitting on a patient's bedside should be encouraged after asking permission as well.

Q: How do I balance in-depth discussion amongst team members, teaching, and patient-directed conversation?

A: Our patient advisory panel unanimously agreed that listening to their physicians have detailed conversations about their medical care is appreciated. Learning the thought processes behind medical decision making helps foster trustful patient-physician relationships.

Q: How do I incorporate medical students into bedside presentations?

A: Medical students are encouraged to lead bedside rounding presentations just as interns and residents do. Residents and attendings are encouraged to coach the students to present a management plan and ask questions in the room if questions arise.

Q: What strategies help primary nurses attend bedside rounds with the remainder of the medical team?

A: Giving primary nurses adequate lead time before going into a mutual patient's room is the most important. It is helpful to contact that unit's charge nurse prior to the rest of the team arriving for rounds. Charge nurses can help alert primary nurses in addition to teams contacting primary nurses through Vocera or comparable means of direct communication. It helps to have a dedicated member of the team be responsible for contacting primary nurses for consistency

APPENDICES

PATIENT CENTERED MULTIDISCIPLINARY BEDSIDE ROUNDS

APPENDIX 1: PRESENTATION RUBRIC FOR DISTRIBUTION TO ROUNDING TEAM

8:35- 8:45 am "Pre-round Huddle"

- Create a patient rounding order to prioritize seeing sick/decompensating patients, admissions/transfers, and discharges
- Decide what patients are appropriate for the bedside rounds format and which patients should be seen separately by the attending physician and resident after completion of rounds
- Update care managers on discharges
- Interns should use this time to page consults

8:45-11:00 am Bedside Rounds

- Notify the charge nurse and primary nurse for first patient via Vocera when in transit to primary regionalized area (i.e. 8BT for Med W).
- Arrive to the patient's room
- Presenter sits at eye level with the patient
- Introduce team members (hand out the FaceSheet to new patients) and bedside rounding format
- Present in an assessment/ plan format prioritizing the active problems
- Medical student or nurse will update the white-board with the plan for the day
- Bedside nurse should advocate for the patient and make sure questions are answered
- At the same time of the presentation, the co-intern can enter in orders for the patient on a workstation on wheels
- Perform an "order re-cap"
- - The team will use an "exit strategy" to return to the room for more lengthy discussions with the patient and family members (ie goals of care discussions)



APPENDIX 2: EXAMPLE SCRIPTS

EXAMPLE OF A GOOD CASE: PATIENT ADMITTED OVERNIGHT AND IS SEEN BY THE TEAM FOR THE FIRST TIME

[Resident calls nurse on Vocera using phone to alert them of rounds]

RESIDENT: We are starting rounds in Room 8302.

[Knock on door]

[Medical team enters room, resident gives introduction of the team and bedside rounding technique. Hands and describes FaceSheet to patient. Intern sits on a stool at bedside]

RESIDENT: Hi Ms. Smith, I'm Dr. Williams, the resident on your medical team. You know Dr. Douglas, the intern. This is Dr. Anderson, the attending and Susan is our pharmacist. Here is a FaceSheet with our names, photos and a description of our roles. We're going to be doing our rounds at the bedside, meaning we will go over the events from overnight and the plan for today. We may use words you don't understand, and we will do our best to define them, but please ask if it is still unclear. The purpose of this type of rounds is to include you in your care plan, so please feel free to speak up if anything is incorrect or if you have any questions.

[Ms. Smith nods]

INTERN: Ms. Smith is our 60 year old woman with diabetes, heart failure with reduced ejection fraction and chronic kidney disease who is here for acute kidney injury which resulted from dehydration from fluid pills and a low heart rate.

[RN enters, goes to white-board and updates while team is discussing problems]



Watch the Video Effective Multidisciplinary Bedside Rounding



PROBLEM #1: ACUTE ON CHRONIC KIDNEY DISEASE

Assessment: You received 1 liter of saline in the past day and we have seen an improvement your creatinine, which is a marker of kidney function. The creatinine improved from 2.3 on admission to 1.5 today, which is near your baseline of 1.3. On your exam this morning, I saw the JVP at 2 cm above the clavicle with the head of the bed at 60 degrees, which is a vein in your neck that indicates that you have some extra fluid on your heart. In addition, I also detected some mild fluid accumulation in your legs and your weight is up 0.5 kg. You had urine output of 1500 mL in the past 24 hours.

Plan: I would like to re-start the Lasix medication and plan to give you a dose of 40 mg once this morning. Then I will re-examine you and re-evaluate your urine output this afternoon.

[Resident and Attending nod in agreement]

PROBLEM #2: HYPERTENSION

Assessment: Blood pressure has been in the 160s-170s/80s overnight.

Plan: I am going to discuss with my team here which of your home medications we should re-start since your kidneys are still recovering.

RESIDENT: This is a good question. We do not want to re-start the lisinopril medication while the kidneys are still recovering, especially as we are planning to re-start a small dose of the Lasix today. I propose that we re-start your beta-blocker.

PATIENT: But I thought yesterday my heart rate was too low for the beta-blocker.

INTERN: This is a good point Ms. Smith and brings me to discuss...

PROBLEM #3: LOW HEART RATES

Assessment: Yes, when you were admitted your heart rate was low. Overnight our heart monitor showed normal sinus rhythm with heart rates in the 80s.

Plan: So, I also think it is a good idea to re-start your home beta-blocker today.

PHARMACIST: Ms. Smith, I saw from your home medications that you take nadolol, is this correct?

MS. SMITH: Yes, I have been on nadolol for years.

PHARMACIST: As this medication is filtered by the kidneys, this medication accumulated in your body and caused your heart rate to be too low. I recommend we stop this medication and start a different medication in the same drug class that is not filtered by the kidneys.

RESIDENT: This was a good teaching point. Let's start a low dose of the beta blocker metoprolol succinate. I think a dose of 12.5 mg is reasonable.

ATTENDING: Ms. Smith, do you have any questions for us?

MS. SMITH: No, this was very helpful.

ATTENDING: Nurse Gigi do you have any questions?

NURSE: Ms. Smith, you told me this morning that you are confused about your home medications. Would you like someone to go over them with you?

MS. SMITH: Yes, this would be extremely helpful.

RESIDENT: A member of our team would be more than happy to come back after rounds sometime in the afternoon to discuss your medications with you. Please let your nurse know if you need anything else.

CO-INTERN AT THE WORKSTATION ON

WHEELS: Order recap- Lasix 40 mg once to continue

removing extra fluid, metoprolol XL 12.5 mg daily for your heart, and a blood draw for a BMP tomorrow morning to monitor your kidney function.

[Team leaves the patient's room]

EXAMPLE OF A BAD CASE: THE TEAM DISCUSSION IN PATIENT ROOM IS TOO BRIEF WHICH HINDERS PATIENT UNDERSTANDING AND DELAYS APPROPRIATE MEDICAL CARE

[Knock on door]

[Medical team enters room, stand in group at bedside, intern sits in a chair. There is no nurse present]

RESIDENT: Hi Ms. Smith, we're going to be doing bedside rounding today, Dr. Douglas here will be discussing the plan for the day. Feel free to interrupt if you have any questions.

INTERN: Ms. Smith is our 60 year old woman with diabetes, heart failure and chronic kidney disease who is

here for an acute kidney injury and bradycardia. Things seem to be getting better, you've been making a good amount of urine and your creatinine, the kidney function number is getting closer to your baseline. We are going to re-start your Lasix and home beta-blocker.

ATTENDING: Ms. Smith, how are you feeling? Do you have any questions for us?

MS. SMITH: I feel much better. I am glad things are going in the right direction.

RESIDENT: Ok, let your nurse know if you need anything. Have a great day.



Watch the Video Innefective Rounds : Discussion too Brief



(CONTINUED) APPENDIX 2: EXAMPLE SCRIPTS

[Team leaves the patient's room and closes door]

Outside the room the team is now discussing the plan of the Lasix dosing and is unclear if the patient was taking nadolol or another type of beta blocker at home. They plan to have the pharmacist come back after rounds to have this discussion with the patient.

EXAMPLE OF A BAD CASE: TOO MUCH MEDICAL JARGON IS USED AND THE ASSESSMENTS AND PLANS ARE NOT ORGANIZED BY PROBLEM. THE PATIENT DOES NOT UNDERSTAND THE PLAN.

[Knocking on door]

[Medical team enters room, patient is eating a meal, stand in group at bedside. Attending moves chair out of the way.]

INTERN: So this is Ms. Smith, a 60 year old woman with Type 2 Diabetes, heart failure with reduced ejection fraction and chronic kidney disease who's here for acute on chronic renal failure from over-diuresis and symptomatic bradycardia.

ASSESSMENT: She had no acute events overnight, vital signs have been stable, urine output was adequate. Physical exam significant for moist mucus membranes, 2/6 systolic ejection murmur heard best over the left upper sternal border, clear lungs, JVP 2 cm above the the clavicle with the head of the bed at 60 degrees, and now 1+ lower extremity edema. Labs on admission were significant for an elevated creatinine to 2.5 and a FeNa of 0.5%. Urine microscopy was bland. For her AKI, creatinine is down-trending from 2.5 yesterday to 1.5 today, with a baseline of 1.3. Her blood pressure has been in the 160s-170s/80s overnight. The bradycardia has resolved per review of telemetry.

Plan: I will re-start Lasix 40 mg daily and re-evaluate her volume status. We will continue to hold her Lisinopril, but I plan to re-start a beta blocker now that her brady-

cardia has resolved. She was on nadolol at home, and as this medication was not dosed for renal impairment I would like to switch her to metoprolol XL 12.5 mg daily.

ATTENDING: That sounds like a good plan. We can continue to monitor urine output and evaluate daily kidney function.

[Team looks at the patient]

ATTENDING: Ms. Smith, how are you feeling? Do you have any questions for us?

MS. SMITH (CONFUSED): I don't think so.

RESIDENT: Ok, let your nurse know if you need anything. Have a great day.

[Team leaves the patient's room and closes door]



EXAMPLE OF A BAD CASE:

(CONTINUED) APPENDIX 2: EXAMPLE SCRIPTS

PATIENT IS MEDICALLY STABLE AND SHOULD BE SEEN AFTER ROUNDS BY THE ATTENDING

[Resident calls nurse on Vocera to alert them of rounds]

[Knock on door]

[Medical team enters room, intern sits at bedside in chair]

INTERN: This is Mrs. Smith, a 42 year old woman with OSSA bacteremia. her vital signs and physical exam are stable. We are getting weekly labs, which are due on Monday. Today is day 10 of her 14 day course of intravenous oxacillin. she will stay here for the duration of her therapy. She is receiving her antibiotics through a PICC line in her right arm which is clean and dressed.

ATTENDING: OK, sounds good. Any questions, Mrs. Smith?

MRS. SMITH: Nope, that pretty much sums it up.

ATTENDING: Nurse GiGi, is there anything you need?

RESIDENT: Ok, let your nurse know if you need anything.

[Team leaves the patient's room and closes door]



Watch the Video Ineffective Rounds: unnecessary full team rounding



EXAMPLE OF A CASE WITH SENSITIVE MEDICAL INFORMATION THAT IS NOT APPROPRIATE FOR BEDSIDE ROUNDS

[Outside patient room]

INTERN: Like we mentioned in the pre-round huddle, Mrs. Smith's care may be best discussed outside the room first given the sensitive nature of her problems. Mrs. Smith is our 42 woman with osteomyelitis, who has been medically stable, but had some events that occurred in the past 24 hours that we need to discuss as a team. Her family is in the room this morning and wanted an update.

[Whole team nods in agreement]

RESIDENT: *[TO OTHER INTERN]*: Will you call Mrs. Smith's nurse to join us outside the room?

[Other intern calls nurse on Vocera]

PROBLEM #1: FEVER AND OSSA BACTEREMIA

Assessment: The patient developed a fever to 38.7 overnight. her other vital signs were stable, and she is now afebrile. Two blood cultures, a urine culture and a chest xray were obtained. The chest xray was unremarkable. The differential includes potential new bacteremia given concerns of tampering with the PICC line or a drug fever. Given her isolated fever and clinical stability, I agree with not starting another antibiotic.

[Nurse joins]

(CONTINUED) APPENDIX 2: EXAMPLE SCRIPTS

Plan: I will follow the results of the blood and urine cultures. For now, I think we should continue the oxacillin which is Day 10 of the planned 14 Day course.

PROBLEM #2: BEHAVIOR AND POSITIVE URINE TOXICOLOGY

Assessment: Yesterday afternoon, the nurse found her lethargic and her PICC line was disconnected. A urine toxicology was sent and has resulted positive for opiates. I am concerned that someone brought her an opiate and now there is a potential line injection.

Plan: I think we should institute a bedside sitter. I would like to return to her room to discuss the positive urine toxicology test once her family has left.

[Team knocks and enter the patient's room]

RESIDENT: Good morning everyone. Mrs. Smith, could you tell us who's with you today?

MS. SMITH: Yes, this is my husband, Roger.

RESIDENT: It's nice to meet you. Ms. Smith, is it okay if we give you an update on the plan of care in front of your family?

PATIENT: Yes, my husband would like to know the plan

for the fever that occurred last night.

INTERN: Mrs. Smith you had a fever to 38.7 degrees Celsius overnight. Fortunately, the fever resolved and the rest of your vital signs are stable. We collected blood and urine cultures and obtained a chest xray. The chest xray showed no source for the fever. We plan to continue the oxacillin now and follow the results of the blood cultures.

HUSBAND: Do you think the antibiotic is not working for the infection?

INTERN: That is a good question. As we saw the bacteria cleared from her bloodstream after the initiation of this antibiotic, I do think it is working. We are doing a thorough evaluation for a possible new source of infection. Mrs. Smith, I would like to come back to your room this afternoon to have a private conversation with you.

PATIENT: Thanks, can we plan to meet sometime this afternoon?

INTERN: Yes, I will see you then.

[Team leaves the patient's room]



APPENDIX 3: FACESHEETS TEMPLATE

Names and Faces of your Doctors



Dr. Sean Gaffney Intern Physician



Dr. Katie Haroldson Resident Physician



Dr. Rimma Osipov Intern Physician



Dr. Seyi Fayanju Attending Physician

OUR ROLES AND ROUNDS STRUCTURE

During your stay, you will have a team of doctors caring for you which includes Residents, Interns and Attending Physicians.

Resident physicians:	are the team leaders that oversee your care and supervise the interns and medical students.
Intern physicians:	will actively participate in all aspects of your care and he/she may start to see you as early as 7:00 am and examine you as they make the plan for the day.
Attending physi- cians:	review treatment plans with the team and will see you every day.

The team meets at **8:35 am** to start the rounds for their entire patient panel (*which can be up to 20 patients in different units*). Between **8:35 am and 11 am** the entire team including the residents, interns and attending physicians will walk to your bedside to update you on test results and engage you in the plan for the day. If there are not major changes in your care plan, then the team members may see you after 11 am.

Other members of your team will include pharmacists, nurses, and care managers.

APPENDIX 4:

BEDSIDE ROUNDING CHEAT SHEET: PHYSICIANS

Communication between daily rounding teams and patients on the medicine wards is ineffective. This is a result of numerous issues including: redundancy in the discussion of clinical data, paucity of meaningful face time with the patients, inadequate patient engagement in their plan of care, and deficiency in a multidisciplinary presence during daily rounds. These factors propagate patients' sense of vulnerability and a decreased sense of meaning in our work. This project was developed to target the aforementioned problems with the current rounding system by reorienting traditional rounding styles to multidisciplinary bedside rounds and including a vital member of the team: the patient.

Pre- 8:35 am

• All team members familiarize themselves with new patients before rounds begin

8:35- 8:45 am Pre-Round Huddle in team work room:

- Determine which patients will be rounded on as a team (usually 10- 12 patients), and which patients will be seen by the attending and residents separately after rounds end at 11 am
- Decide rounding order (new patients, sick or decompensating patients, and discharges should be prioritized to be seen first)
- Discuss discharges with care managers
- Charge nurse updated on approximately what time team will be returning to primary regionalized unit
- Intern calls consultants during this time

8:45-11:00 am Team Rounds

- Notify nursing staff when your team returns to primary unit for rounds (ie if you start rounds in the MPCU)
- Locate Primary RN before entering patient's room (Vocera, call bell, and medical student are all options to help find them)
- In each patient's room:
 - Introduce bedside rounding format and team members, hand out FaceSheet
 - Present clinical data in an assessment and plan format
 - Update white-board (medical student or nurse)
 - Non-presenting intern uses workstation on wheels to enter orders, work on documentation and at the end of the presentation performs "order re-cap"

11:00 am End of Team Rounds

- Return workstation on wheels to primary unit and charge the computer
- It is an expectation that attendings see stable patients outside of team rounds which end no later than 11:00 am.



Watch the Video Multidisciplinary Bedside Rounding (Full Length)



APPENDIX 5:

BEDSIDE ROUNDING CHEAT SHEET: NURSES

Communication between daily rounding teams and patients on the medicine wards is ineffective. This is a result of numerous issues including: redundancy in the discussion of clinical data, paucity of meaningful face time with the patients, inadequate patient engagement in their plan of care, and deficiency in a multidisciplinary presence during daily rounds. These factors propagate patients' sense of vulnerability and a decreased sense of meaning in our work. This project was developed to target the aforementioned problems with the current rounding system by reorienting traditional rounding styles to multidisciplinary bedside rounds and including a vital member of the team: the patient.

Charge Nurses:

we ask that you participate in a 5-10 minute "pre-round huddle" with the physician team at 8:35 am in the team workroom. In this meeting, the upper level resident leads the discussion with you, the attending and the care manager. The goals of this discussion are to orient the team to the big-picture plans for patient care that day which involves the following:

- Determine which patients will be rounded on as a team (usually about 10-12 patients), and which patients will be seen by the attending and residents separately
- Decide rounding order
- Sick or decompensating patients, admissions/transfers and discharges should be prioritized first
- Discuss discharges with care managers
- · Charge nurse updated on approximately what time team will be returning to primary regionalized unit
- Interns will page consultants during this time

Primary Nurses:

The medical team needs your involvement during morning rounds. Most often, you are the one who best knows the patient. Your role in making sure the patients' concerns are being addressed is vital to the success of our project. Your responsibilities on team rounds are as follows:

- Arrive to your patient's room when a member of the physician team alerts you that they will be rounding on your patient soon
- Listen to the problem-based presentation given by the medical student, intern, or upper-level resident
- Contribute pertinent updates or questions at the end of the presentation
- Advocate for the patient when you feel a primary patient concern has not been addressed
- Make sure the whiteboard is updated if not already done by the medical student prior to the completion of bedside rounds



Watch the Video Multidisciplinary Bedside Rounding (Ful Length)



APPENDIX 6:

BEDSIDE ROUNDING CHEAT SHEET: CARE MANAGERS

Communication between daily rounding teams and patients on the medicine wards is ineffective. This is a result of numerous issues including: redundancy in the discussion of clinical data, paucity of meaningful face time with the patients, inadequate patient engagement in their plan of care, and deficiency in a multidisciplinary presence during daily rounds. These factors propagate patients' sense of vulnerability and a decreased sense of meaning in our work. This project was developed to target the aforementioned problems with the current rounding system by reorienting traditional rounding styles to multidisciplinary bedside rounds and including a vital member of the team: the patient.

Care managers play a crucial role in the medical team. Our hope is that care management will be available to participate, either in person or via telephone, in a 5-10 minute "pre-round huddle" at 8:35 am in the team workroom. In this meeting, the upper level resident leads discussion with you, the attending and the care manager. The goals of this discussion are to orient the team to the big-picture plans for patient care that day which involves the following:

- Determine which patients will be rounded on as a team (usually about 10-12 patients), and which patients will be seen by the attending and residents separately
- Decide rounding order
 - Sick or decompensating patients, admissions/ transfers and discharges should be prioritized first
- Discuss discharges with care managers
- · Charge nurse updated on approximately what time team will be returning to primary regionalized unit
- Interns will page consultants during this time

We hope that by standardizing a time that the team touches base in the mornings, care management personnel will be better equipped to use their morning time efficiently.



Watch the Video Multidisciplinary Bedside Rounding (Full Length)



APPENDIX 7:

BEDSIDE ROUNDING CHEAT SHEET: PHARMACISTS

Communication between daily rounding teams and patients on the medicine wards is ineffective. This is a result of numerous issues including: redundancy in the discussion of clinical data, paucity of meaningful face time with the patients, inadequate patient engagement in their plan of care, and deficiency in a multidisciplinary presence during daily rounds. These factors propagate patients' sense of vulnerability and a decreased sense of meaning in our work. This project was developed to target the aforementioned problems with the current rounding system by reorienting traditional rounding styles to multidisciplinary bedside rounds and including a vital member of the team: the patient.

Pharmacists are an essential part of the healthcare teams on rounds and are encouraged to participate in discussion of a patient's care plan with the rest of the healthcare team. At UNC on medicine teams, pharmacists routinely participate in a traditional rounding format. The interventions for this project are as follows:

- Teams will complete a "pre-round huddle" at 8:35am with the team care manager and the primary unit charge nurse to prioritize discharges and determine rounding order for the morning. Pharmacists are encouraged but not required to attend this meeting.
- On rounds and for appropriate patients, teams will forgo a traditional presentation in favor of a bedside problem-based presentation involving the patient more directly in their own plan of care. Pharmacists are encouraged to give suggestions during the discussion of the patient's plan of care.
- A patient's primary nurse will be contacted by the team and invited to join in the team discussion during rounds at the bedside. This will be done in advance of actually entering the room to help give them lead time.



Watch the Video Multidisciplinary Bedside Rounding (Full Length)



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