Inpatient Notes: Modernizing Rounds—Why It’s Time to Redesign Our Hospital Practice

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We begin by stating the obvious: Most hospital care as practiced today is fragmented at best and chaotic at worst. Hospitalists often care for patients on multiple units, making it impractical to build the relationships and systems to facilitate teamwork. In the face of this geographic fragmentation, physicians tend to round first on patients who are the sickest or most likely to be discharged. However, that approach does not allow for coordination with the workflow of other hospital professionals, who have valuable information to contribute to daily bedside rounds. When direct communication between hospitalists and other members of the team occurs, it tends to be episodic, unstructured, and inefficient. Hospitalists may share their plans with patients and families, but if nurses or social workers are not present to influence those plans, key data, decisions, and actions can be incomplete, delayed, or absent entirely. For instance, a new bandemia may appear less like an isolated finding if interpreted in the bedside context of a nurse reporting an overnight aspiration event followed by a family member expressing concern that the patient seems altered from baseline. Interprofessional collaboration may represent the best opportunity to recognize and respond to subtle but meaningful changes in patient condition or experience, but there are few models for how to achieve this in the real world.

We believe that reaching this ideal state will require a fundamental redesign of how we organize care for hospitalized patients. Specifically, it will require the creation of “unit-based” models of care. Think about it: If most of a hospitalist's patients were located on a single unit, the primary professionals involved in patient care could exchange information in real time at the bedside. This team could review and reexamine reasons for hospitalization, update interval progress, cross-check quality and safety variables, and coordinate care and discharge plans based on the best possible information. Ideally, these exchanges would also actively involve patients and families, integrate perspectives, generate clarity about priorities, and assign responsibility for specific action items. Using this model, the hospitalist could easily contextualize the new bandemia in the information provided by the family and the nurse, during a single, efficient, bedside encounter. In addition, a model like this reduces reliance on incomplete or 1-directional communication (for example, sending text pages) and eliminates the need to search for a team member for face-to-face communication. Without such a model, a hospitalist may never acquire the information necessary to suspect an evolving aspiration syndrome.

Although desirable, these types of rounds would require radical, disruptive changes in patient assignment and workflow practices for hospitalists, nurses, and others. It would also require participating team members to acquire and master communications skills needed to exchange pertinent information concisely, listen actively, and integrate inputs effectively. Simply put, adopting this approach would change almost everything about how care is delivered in hospital units.

The Accountable Care Unit (ACU) was specifically developed to explore this approach to hospital care delivery (1). The first feature of ACUs—unit-based physician teams—positions hospitalists to dedicate time and attention to the patients, staff, and workflow of a primary unit. The second feature—structured interdisciplinary bedside rounds (SIBR)—outlines an explicit 6-step communication protocol as the basis for information exchange among the physician, nurse, and participating allied health professionals. Accountable Care Units also combine a nurse-physician leadership dyad with unit-level performance reporting so that unit structure and process can be managed toward the best possible outcomes.

Current literature suggests that neither regionalization alone nor unstructured interdisciplinary bedside rounds is sufficient to improve teamwork or unit outcomes (2, 3). These conclusions reinforce our own experience mentoring ACU implementations in the United States, Canada, and Australia. From these experiences, we have learned several lessons that we believe will have important implications for the success of this strategy in the future. First, interdisciplinary rounds require an adequately explicit communication protocol to standardize the content and sequence of contributions from each participant. Second, their effectiveness appears to be a function of the observable skills of each participant within that adequately explicit communication protocol. Finally, these skills can be enumerated, learned, and practiced in vivo, and the skill level of each participant can be assessed objectively to ensure mastery and maintenance.

Firm conclusions about the effectiveness of collaborative care models like ACUs will require well-designed prospective studies. We are encouraged by reports of improvements in a range of metrics (including morbidity, mortality, length of stay, costs, 30-day readmissions, teamwork, and satisfaction) when these models have been piloted (4, 5). Of course, the size of improvements may also be a function of additional variables, such as the effectiveness of the unit leaders and the availability of unit-level performance reports to manage staff, processes, and outcomes.

We close this Inpatient Note by expressing what we anticipate will become increasingly obvious: Optimizing hospital care requires a thoughtful redesign, most
likely combining unit-based teams with adequately explicit communication protocols, and demonstration of the specific skills required for mastery. As progress moves in this direction, we believe hospital medicine will evolve more fully from a revolution in hospital staffing to an innovation in hospital care delivery.

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References