A SMARTer Way to Round

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SMARTer Rounding: Development of a Rounding Checklist  
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Background

• Poor team communication can lead to adverse safety events, negative patient experience, and delays in patient care coordination.
• Consistent checklist use can develop high reliability units
• Checklists were not routinely used on medical-surgical floors in our hospital.
• Baseline evaluation indicates only 9 - 83% episodes of daily rounds discussed key safety and discharge planning tasks.

Aim Statement

• Develop and implement a daily rounding checklist with at least 80% daily checklist use, sustained over 6 months.
• Team members will report improved multidisciplinary discussion of patient safety and clinical plans.

Interventions

• Multidisciplinary group of nurses, administration, QI specialists, and physicians modified a PICU checklist for use on a medical unit.
• Bedside nurses prompt checklist review during rounds using badge buddies.
• Intervention #1: introduced badge buddies and provider education.
• Intervention #2: simplified the rounding audit tool to improve compliance.

Interventions Cont.

Primary outcome: Use of SMART checklist on daily hospital work rounds.
Secondary outcome: Perceived efficacy of checklist and improved awareness of potential safety issues.
Balancing measure: Acceptability/time spent on checklist.

Conclusions

• Multidisciplinary quality improvement teams are important to rounding process improvement.
• The insertion of a rounding checklist into the workflow of a multidisciplinary care team is both feasible and acceptable to staff.
• Next steps include hospital-wide implementation on all medical-surgical floors.

Post Implementation Survey:
Improves communication: 77% Agree, 2% Disagree. Discuss otherwise unmentioned issues: 67% Agree, 6% Disagree
Improves safety issue awareness: 57% Agree, 12% Disagree. Acceptable use of time: 79% Agree, 2% Disagree