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Structured Interdisciplinary Bedside Rounds: Reform of Rounds

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Abstract: This paper introduced the relatively mature strategy of structured interdisciplinary bedside rounds (SIBR) in foreign countries, and expounded it from the aspects of its present situations, concrete implementation steps, and abiding principles. SIBR is an organizational optimization strategy, which is beneficial to the tripartite of doctors, nurses and patients, and is worthy of promotion. What is known about the topic? This article introduce SIBR, and it optimizes the entire medical service system, in line with the reform and development direction of modern hospitals in the 21st century. This article aims to inspire hospital managers to learn from the experience of SIBR. If possible, we should go to overseas hospitals that implement SIBR to conduct on-the-spot study to deepen the understanding and application of SIBR. What does this paper add? Multidisciplinary cooperation has become the development direction of the medical service system. But there is lack of systematic and structured guidance. Therefore, a summary method was conducted to expound in detail relatively mature strategy of SIBR, including its implementation steps and principles. What are the implications for practitioners? This paper enables scholars to have a clear idea when applying structured interdisciplinary bedside rounds, grasp the essence of structured interdisciplinary bedside rounds, and is more conducive to the promotion and application of structured interdisciplinary bedside rounds in the world.

Keywords: Physician-Nurse Collaboration, Model of Rounds, Structured Interdisciplinary Bedside Rounds

1. Introduction

Nowadays, with the development of the aging population, diseases are also performing more complex, and multidisciplinary cooperation has become the development direction of the medical service system. In recent years, many scholars have also reported many studies on physician-nurse collaboration [1-4], but a part of scholars are relatively inexperienced compared with foreign development. Therefore, this paper elaborated on the organizational optimization strategy of Structured Interdisciplinary Bedside Rounds (SIBR), aiming to make hospital managers discover shortcomings and learn from the experience of foreign hospitals. Finally, they can develop a systematic and structured multidisciplinary cooperative ward rounds system suitable for themselves.

2. Foreign Structured Interdisciplinary Bedside Rounds (SIBR)

2.1. Status Quo of SIBR

Dr. Jason Stein of Emory University, Atlanta, Georgia, USA, proposed structured interdisciplinary bedside rounds (SIBR) based on the original medical-nursing collaborative research and it has become a registered trademark [5]. SIBR take the patient and the patient's family as the core, based on teamwork, uniting doctors, nurses, and/or other medical staff to communicate at the patient's bedside with a concise and structured checklist, and encouraging patients and their family members participation to finally formulate a clear medical care plan for the patients within a day [5]. Dr. Jason Stein also guided the application of this organization model in other states in the United States, Canada, Australia and other

countries, so he summarized a lot of experience [6]. The term "Structured Interdisciplinary Bedside Rounds" also reflects the three major elements of the organization model: multidisciplinary cooperation; make structured, using structured checklists; bedside rounds [7]. This model has been widely recommended for use in public hospitals in New South Wales, Australia [7]. It can be seen that the benefits of SIBR have been recognized. In particular, SIBR promotes effective communication and solidarity and cooperation between health care providers [7]. It has long been reported in the literature that medical errors caused by poor communication cost between US$17 billion and US$29 billion each year, resulting in 44,000-98,000 preventable patient deaths each year [8]. This shows the importance of effective communication and solidarity between doctors and nurses. The UK has a scholar using the "Weekend Checklist" because the fewer medical staff and more heavy workload on the weekend make incidence of medical adverse events and mortality higher than working days [9]. Therefore, this checklist ensured that some necessary work was completed before Friday. After the use of that list, the patient's security was more guaranteed; simultaneously, the frequency of calling the doctor on the weekend was significantly reduced (because telephone communication was also one of the factors of medical errors [9]). If the checklist can be used in the whole hospital, it was estimated that it will save 317,136 pounds per year [9]. Moreover, the use of structured ward rounds or shift mode has increased the nurses' awareness rate of the daily nursing goals from less than 10% to more than 95% [10], which made nurses more confident when handing over shifts, not worrying about missing information about patients, and improving their "feeling on standby" after get off work [11]. After the implementation of SIBR, patients and their family members also had a better understanding of their physical conditions and treatment plan, which has improved the anxiety, negativity and even depression of the inpatients (Because patients did not know their conditions about health and medical staff had little communication with them before this, which made them feel that no one respected or valued them). Therefore, patients were more actively cooperating with treatment, and nurses also said that patients were better managed than before SIBR, call ringtones were significantly reduced, and they trusted themselves more, reducing unnecessary misunderstandings between each other, which made nurses more proactive in their work [7, 12].

Regarding the outcome of patients after the implementation of SIBR, some studies indicated that the patient's outcome was significantly improved [13], while the other indicated that the changes were not statistically significant [14]. In response to this, some scholars have proposed traditional quality measurement indicators, such as patient hospitalization time, mortality, readmission rate, etc., have no direct feedback on the improvement of the quality of medical care and whether the specific ward rounds meet the standards; and these outcome indicators of patients are affected by many variables; if the nursing process of patients is not deliberately distorted, it will be impossible to find obvious and reliable indicators of the patient outcome in a short time; therefore, the quality of project implementation should be measured by grasping the evidence-based implementation process instead of measuring results [15]. More worth mentioning, the implementation of a new organizational model is often a challenge to the traditional organizational model, which often requires a longer period of adaptation. Secondly, after the implementation of the new organizational model, some scholars found that nurses had limited opportunities for participation and decision-making in this process, yet they doctors only make decisions about patients conditions according to their own wishes, ignoring the role of nurses; so nurses sometimes did not participate in ward rounds because they feel that their observations and recommendations on patients conditions were meaningless to the medical care plan [16]. Other studies indicate that sometimes nurses were busy with their work and did not have time to participate in bedside rounds, which were also the main obstacle to the implementation of SIBR [17].

2.2. Six Steps to Implement SIBR

Dr. Jason Stein authorized the Clinical Excellence Commission (CEC) of New South Wales, Australia to issue six stages of SIBR implementation [18]. Now stated as follows:

First: Identify key people and form a leadership team. The team is jointly led by the head of the department and the head nurse, and includes a representative of each discipline, with special emphasis on including patients or (and) patient caregivers. The team will jointly formulate relevant management arrangements, such as meetings, reports, and communication procedures.

Second: Evaluate the current specific situation of the unit and determine the target. For example, before implementing SIBR, assess the patient's hospitalization experience, medical staff satisfaction, and teamwork.

Third: Prepare resources and tools, implement staff training and education. Give full play to the strength of the team, formulate a structured checklist suitable for the department and some basic rules of the team itself; make an education and training strategy including related implementation procedures and simulation training.

Fourth: Establish an evaluation project and give feedback on the effect of implementing SIBR. For example, assess the patient's hospitalization experience, medical staff satisfaction, and teamwork.

Fifth: Trial SIBR, evaluation in one month. Affirm existing achievements, solve existing problems, and make adjustments in accordance with the team's opinions.

Sixth: Continuously evaluate and improve the project to promote the sustainable development of the project.

The implementation of SIBR needs to follow the following essential principles: (1) must involve doctors and nurses; (2) encourage patients and their families to participate and have the opportunity to ask questions; (3) each team member has clear responsibilities; (4) structured communication without missing important information; the production of the structured checklist can be adjusted according to the needs of

the department, and its content can be updated in real time in accordance with evidence-based medicine; (5) team members, including patients and their families, take the patient as the center, share information and make joint decisions; (6) working out the patient's medical care goals and plans for the day is the end of the bedside rounds, and each team member can understand the medical care goals and plans, with special emphasis on using plain language to make the patients and their families understand; (7) trial on a small scale, discover problems, and continuously evaluate and improve.

3. The Enlightenment of SIBR to Reform of Rounds

Firstly, in terms of the organizational form, there has been a documented complete structure system abroad, from specific implementation steps or stages to basic principles to be followed to clear responsibilities of each person, and even the position of each member during the rounds has clear regulations. Secondly, in terms of the management philosophy followed, SIBR particularly emphasizes that medical care plans should be combined with the wishes of patients or family members, and special attention is paid to communication with patients or family members, to promote patients' health self-management capabilities, and make medical effects more durable; SIBR specially emphasizes that nurses must participate in the rounds to play their unique role; SIBR also emphasizes that it should be updated in real time, and should be adapted to the actual situation and adapted in time to make it localized. Thirdly, in terms of the evaluation system of project, foreign countries advocate no longer using indirect measurement indicators, such as patient hospitalization time, mortality, readmission rate, etc., and do not regard the attitude or satisfaction of the three parties of doctors, nurses, and patients with medical-care cooperation as a measurement indicator; instead, the evidence-based implementation process is used as a direct measurement indicator, so such an evaluation system is more targeted and instructive. Fourthly, in terms of the effects achieved by implementing SIBR, SIBR focuses on combining the wishes of patients or family members to implement the "patient-centered" concept and promote a harmonious doctor-patient relationship; simultaneously, the opinions of nurses have also been adopted to make the medical care plan more perfect, and the cooperation and exchanges between doctors and nurses have also been greatly promoted, so that medical personnel can exist as a truly united medical team; in addition, it has promoted the growth of nurses, and a clear medical care plan makes them work more proactively, be familiar with the patients' condition, and win the respect of the patients, and meanwhile make the doctors more comfortable at work; other countries also use this kind of bedside rounds as a clinical teaching practice. Therefore, SIBR can provide patients with "people-oriented" high-quality and safe services. we should draw lessons from other countries, experience about SIBR and form a bedside rounds system suitable for ourselves; specially, in the future development, they should also expand human resources in hospitals to enable pharmacists, medical technicians, etc. also participate in bedside rounds when necessary to truly achieve multi-disciplinary cooperation rounds.

4. Challenges and Suggestions

As mentioned in previous studies, the problems facing the implementation of SIBR are the actual participation and timing of nurses [16, 17]. In response to such problems, managers should formulate corresponding systems, clarify the responsibilities of each individual, and make rigid requirements from the organizational form to ensure participation. On the other hand, strengthening the management of "soft culture". There are more and more highly educated nursing staff in hospitals, especially in first class hospitals--- undergraduates have accounted for a considerable proportion, and postgraduate students are not a minority. Therefore, the value of highly educated nurses should be reflected as much as possible. It is to say that they can apply unique perspective of nursing disciplines to make advice for patients' health and truly participate in ward rounds instead of being a "listener". Therefore, managers should actively encourage nurses to make them believe in their abilities, intentionally urge them to conduct professional exchanges with doctors, and constantly consolidate their professional knowledge to truly achieve multidisciplinary cooperation.

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