SIBR: Interprofessional Rounding

A VCU Health Priority Initiative
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Disclosure of conflict of interest

I have no relevant financial or nonfinancial relationships to disclose.

Disclaimer: When I use the term SIBR during this presentation, I am referring to the concept of Interprofessional Bedside Rounds using a structured communication sequence. We are not using this term to reference the specific model developed at Emory Healthcare.
Overview

• Background
  • VCU Health & the Care Transitions Initiative
• The Case for SIBR
  • Barriers to Effective Teamwork & Collaboration
• Building Interdisciplinary Rounds
  • Quality Improvement Methodology
  • Our Current Model
• Impact of SIBR and Future Directions
Objectives

1. Describe the team based method of bedside rounding
2. Describe how to involve patients and families in the rounding process
3. Identify two strategies that would assist in the formation of bedside team rounding
Background: The Care Transitions Initiative
VCU Health
BY THE NUMBERS

- 1125+ Licensed Beds
- 800+ Physicians
- 200+ Specialties
- 14000+ Employees
- 5000+ Learners

VCU Health:
- MCV Hospitals
- Children’s Hospital of Richmond
- VCU Community Memorial Hospital
- MCV Physicians
- Virginia Premier Health Plan
- Massey Cancer Center

Health Science Schools include Allied Health, Dentistry, Medicine, Public Health, Nursing, Pharmacy

More than 15 affiliated centers and institutes, including the VCU Massey Cancer Center, Virginia’s first NCI-designated cancer center.
VCU Health: Care Transitions Initiative

Driving forces:
- Safety First
- STEEEP principles
- Journey towards High Reliability
  - Conceptual shift:
    "Readmission Reduction" ➔ "Improving Care Transitions"

• Quality by design, rather than quality by accident
• Building reliable processes & resilient teams
VCU Health: Care Transitions Initiative

- Identifying High Risk Patients
- Early Discharge Planning Assessment
- Posting Anticipated Discharge Date
- Early Referrals to Post-Acute Services
- Plan for Discharge Transport
- Medication Reconciliation
- Discharge Meds to Bedside
- Follow-up Appointment in Best Practice Time Frame
- Post-discharge phone call or SW visit

Early Admission | During Admission | Discharge | Post-Discharge
Effective Teams

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VCU Health: Care Transitions Initiative
The Case for Building Better Teams
Traditional Rounds

“The medical attending, two interns, a resident, two medical students, and a pharmacist stand outside their patient’s door. One intern faces the attending with his back to the other members of the group, and recounts in excessive detail the patient’s long list of symptoms and past medical illnesses. As the attending begins grilling the presenting intern on diagnostic criteria, and beautifully dissects the pathophysiology of the patient’s illness, the medical students consult their pocket manuals. The resident checks his smart phone, and the other intern returns a page. The two-way conversation between the intern and attending is finally completed, and those remaining in the group enter the patient’s room. The floor nurse is nowhere to be found, and the pharmacist is noticeably silent…

*Is this a highly functional interprofessional team?*”

Characteristics of an Effective Healthcare Team

Working Groups

- Parallel Interdependence
  - Providers working in parallel and assuming their work will be coordinated
- Hierarchical structure
- High degree of variability

Working Teams

- Reciprocal Interdependence
  - Providers working together and actively coordinating their work
- Interprofessional
- Shared goals and mental model
- Communication
  - Structured
  - Both Horizontal and vertical

Rounds #1: Morning Patient Rounds
- Physician rounds on 16 patients with 16 different nurses on 10 individual nursing units. Nurses are caring for patients from multiple medical services.
- Occasionally included: Nurse, Family
- Not Included: Care coordinator, social worker, or pharmacist

Rounds #2: Discharge Planning Rounds
- Physician meets with primary Care Coordinator & Social Worker
- May have different team members depending on the patient type or location
- Not Included: Patient, family, nurse, pharmacist

Rounds #3: Pharmacy Rounds
- Physician meets with Clinical Pharmacist
- Not available every day
- Not Included: Patient, family, nurse, CC, SW

Rounds #4: Ancillary Services
- Physician contacts ancillary services by phone
- These providers are often different for each unit
- Not Included: Patient, family, nurse, CC, SW, pharmacist
Non-Geographic Distribution of Patients

The way a team plays as a whole determines its success. You may have the greatest bunch of individual stars in the world, but if they don't play together, the club won't be worth a dime.

How can they work as a team if they don't know who is on the team?
Simulation: Non-Geographic Distribution of Patient

**Source:** Division of General Internal Medicine POWER Team (Program in Operations and Workflow Effectiveness Research)
Geographic Distribution of Patients (Ideal State)

- Devotes one nursing unit to an entire interdisciplinary team and their shared group of patients
- Organizes staff based on the needs of the patient, family
  - Clusters all providers responsible for their care on the same unit.
  - Consistent, predictable team members

Benefits:
- Builds relationships between providers
- Facilitates timely communication
- Promotes face-to-face problem solving
- Improved patient satisfaction
- Decreased length of stay
- Reductions in morbidity and mortality

Communication in the Modern Era of Healthcare

“The single biggest problem in communication is the illusion that it has taken place.”
Communicating with the Patient and Family

Structure & processes organized around providers

Decreased provider & patient satisfaction

Increased provider & patient satisfaction

Structure & processes organized around patient and family

PATIENT-CENTERED CARE

Concept by Soo-Hyeon Kim. Art by Matthew Hayward © 2014 All Rights Reserved

VCU Health
Building Interprofessional Rounds
Large or Complex Projects

Use robust QI methods such as Lean Six Sigma

Cross functional team efforts lasting several weeks to months, designed to attack a selected problem/opportunity or to eliminate a selected, major process problem through significant process improvements or a new process implementation.

Basic Projects

Use basic QI methods such as IHI-PDSA or FADE

Basic QI model guides improvement work that includes setting aims, establishing measures, selecting changes, testing changes through PDSA, spreading changes.

Alternative approach is Kaizen, a management approved, local team effort lasting 1-5 days to improve a process.

Quick Win

It is very common for projects to also include ‘Quick Wins’

Obvious ‘just do it’ solution. Must meet ALL 3 criteria: (1) virtually no risk (2) can be implemented with little effort (hours) and (3) is easily reversible.
Building SIBR Rounds

July 2014
Established Care Transitions Oversight Team

December 2014
Kickoff for SIBR Work Group

February 2015
Pilot on first unit

February 2016
Continuing to monitor daily

March 2015
Pilot on second unit

Let me know if you want to know why I am here.
Structured Interdisciplinary Bedside Rounds

Developed at Emory Healthcare
(Jason Stein, MD)

• Geographic units
• Includes entire care team
• Shared values and goals
• Use of a structured communication sequence
• Embedded quality and safety elements
• Predictable rounding times

… What follows is the modified SIBR Model developed at VCU
Selecting Pilot Groups

• Engaged physician and nursing leaders
  – Invest resources, support time, and see value in quality improvement efforts
  – Support from associated training programs

• Staff (all disciplines) invested in outcome, see relative advantage of new process

• Ease of testing, especially with rotating team members: physicians and clinical pharmacists
  – Demonstrated interest/experience in patient safety and process improvement
  – Some training in strategies to improve team performance

SIBR Pilot Groups

**Women’s Care Unit, 1 Hospitalist Medicine Team**
- 24 bed women’s health medical-surgical unit
- Partially geographic SIBR team
  - Patients admitted first to the Hospitalist SIBR Team
  - Then, attempt to cluster patients these patients on the pilot unit
- General/Acute care
- Combination of private and semi-private rooms

**Acute Care Medicine Unit, 2 Teaching Medicine Services**
- 24 bed medical unit, adult cystic fibrosis patients
- Fully geographic SIBR teams
  - Patients admitted first to the pilot unit
  - All patients on the unit assigned to the two Teaching SIBR Teams
- General/Acute care initially
  - Currently adding progressive care beds
- Private rooms only
## SIBR Team Training

### SIBR Elements

- **Patient-centered**
  - Use patient values to create care plan
  - Updates are addressed to the patient

- **Team Leadership (RN & MD)**
  - Facilitate problem solving
  - Monitor team performance and interactions
  - Feedback on performance

- **Active listeners**

- **Closed-loop communication**

### SIBR Outcomes

- **Mutual Trust**
- **Situational Awareness**
- **Shared Mental Model**
- **Adaptability**
- **Team Performance**
- **Patient Safety**

* Borrowed elements from TeamSTEPPS Curriculum

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SIBR Preparation

**Day prior to SIBR:**
- Selection of patients

**Morning before SIBR:**
- SIBR schedule and nursing assignments
- Primary data collection
- Patient preparation
  - Elicit concerns and questions
  - Schedule and expectations
  - Family involvement
- Room preparation

**During SIBR:**
- Rounds coordinator
  - Follow planned schedule, flow around the unit
  - Deal with unanticipated interruptions, changes
  - Reduce noise on the unit
  - Keep all SIBR members updated about status of rounds
<table>
<thead>
<tr>
<th>Team member</th>
<th>SIBR Elements (Hospitalist Model)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD/NP</strong></td>
<td><strong>Introduction:</strong> (&lt;15 seconds): Team members enter room and greet patient/family, Introduce members of the team and state their role.</td>
</tr>
<tr>
<td><strong>MD/NP</strong></td>
<td><strong>Update Status:</strong> (&lt;45 seconds): Illness script, Significant progress since yesterday, Patient status, Patient’s goal for the day and questions (whiteboard)</td>
</tr>
<tr>
<td><strong>RN</strong></td>
<td><strong>Update Status:</strong> (&lt;30 seconds): Address anything not covered by medical team (Overnight events, Concerns with Vital Signs, Fluid &amp; food intake, Urine &amp; bowel output, Pain/Comfort, Other Critical Information)</td>
</tr>
<tr>
<td><strong>RN</strong></td>
<td><strong>Checklist for Quality-Safety:</strong> (&lt;15 seconds)</td>
</tr>
<tr>
<td></td>
<td>- Foley catheter (Date/Time of Insertion; Plan for Removal)</td>
</tr>
<tr>
<td></td>
<td>- Central line (Date/Time of Insertion; Plan for Removal)</td>
</tr>
<tr>
<td></td>
<td>- VTE prophylaxis (Med or SCDs Any plans to hold?)</td>
</tr>
<tr>
<td></td>
<td>- Pressure ulcer &amp; stage</td>
</tr>
<tr>
<td><strong>Pharm</strong></td>
<td><strong>Pharmacy updates:</strong> (&lt;30 seconds): Missed/Held/Expiring Medications; Antibiotic days and plan for de-escalation, Medication changes</td>
</tr>
<tr>
<td><strong>MD/NP</strong></td>
<td><strong>Synthesize DAILY plan using all inputs:</strong> (&lt;45 seconds): Problem list, Plan for the day, Assign responsibilities as needed</td>
</tr>
<tr>
<td><strong>CC/SW</strong></td>
<td><strong>Synthesize DISCHARGE plan using all inputs:</strong> (&lt;30 seconds): Proposed discharge destination, Other inputs, Other considerations, Any new discharge orders</td>
</tr>
</tbody>
</table>

**VCU SIBR Model**

**Medical Providers**
- Attending, Nurse Practitioner
- Attending, Residents, Interns, Students

**Nursing**
- Bedside Nurse
- SIBR RN Rounds Coordinator

**Clinical Pharmacy**
- Attending, Resident, Students

**Discharge Planning**
- Nurse Care Coordinator
- Social Worker

**SIBR Project Manager**

**Others (as needed)**
- Nutrition
- Chaplain
IHI Model for Improvement

- **Hunches, Theories, Ideas**
  - Very Small Scale Test
  - PDSA Cycles

- **Changes That Result in Improvement**

- **Learning from Data and Tests**
  - Implementation of Change
  - Follow-up Tests
  - Wide-Scale Tests of Change

- **Very Small Scale Test**
  - Try the idea with 1 patient, 1 staff member, or for just 1 day
  - Use measures to predict how much impact that change might have and to modify
  - Learn – adapt the PDSA Cycles

Patient-Centered Care & SIBR

- Care plan incorporates patient goals and perspective from every team member
- Predictable rounding times allows family to be present
- SIBR preparation to encourage patient and family engagement
- Remove the burden of coordinating care from the patient
- Team leaders are responsible for ensuring patient-centeredness
- Ongoing coaching and feedback for team members

Educating the next generation of healthcare
“Perfect” SIBR Day

• Optimal staffing
• Even SIBR patient distribution between nurses
• All members of core team present
• Experienced SIBR participants
• Clinical Coordinator able to act as daily SIBR coordinator

Realistic SIBR Day

• Increased nurse to patient ratio
• Unforeseen emergent situations
• SIBR patients not evenly distributed
• New members to the core team
• Inexperienced SIBR participants
• Clinical Coordinator unable to perform duties of daily SIBR coordinator
• Excessively long SIBR process

Lesson Learned: There is no “perfect day” for SIBR. Instead, we must build resilient teams that can anticipate challenges, adapt to ever-changing circumstances, and maintain high level of performance.
Staff Feedback on SIBR Model

- Encourages patient/family engagement
- Heightened awareness of potential safety issues
- Effective communication between team members
- Improved role clarity
- Improvement in discharge planning
- Less unnecessary duplication of efforts
- Post-rounds workflow more efficient
- Decreased interruptions throughout the day
Patient Feedback on SIBR Model*

Communication with Patient & Family

• Team talks to me, instead of around me
• Communication style is more respectful, and shows you value me as a person
• You always address the big questions

Transparency

• I understand my plan better this way
• I understand the hospitalization process better
• I like learning with the team

Team Communication & Collaboration

• I don’t feel responsible for coordinating the team
• I don’t have to remember things for my family
• I get all my questions answered in one place
• I am more likely to get the right answers with everyone in one place

*Actual patient comments paraphrased for confidentiality
SIBR Metrics

Reduction in LOS (Length of Stay)
- Reduced LOS 1.1 days on Med Unit

Reduction in Falls
- Reduced falls on Med Unit by 25%

Improved communication
- Improvement on nursing surveys of perception of teamwork and communication, mutual respect, etc. on Med-Surg Unit

Decrease in readmissions
- 1% decline in all-cause readmissions on Med Unit

Increased patient satisfaction
- Overall improved HCAHPS scores on Med Unit, but this trend started prior to SIBR
Processes for Sustained Change:

• Project coordinator
• Celebrating and communicating success
• Transition from pilot to part of the daily workflow
• Continuous monitoring of process and outcomes
• Continue to expand team training
• Implementing full Care Transitions Initiative
• Exploring impact of SIBR
  – Opportunities for scholarship
  – Role of learners, educational model
  – Framework for future quality initiatives
“Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.”

(William Foster)
SIBR Video: