

IMPROVING RESIDENT-NURSE COMMUNICATION

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Aim Statement

Increase nursing participation on bedside rounds from 22% to 70% by March 2017 for general pediatrics patients on one inpatient unit.

Background

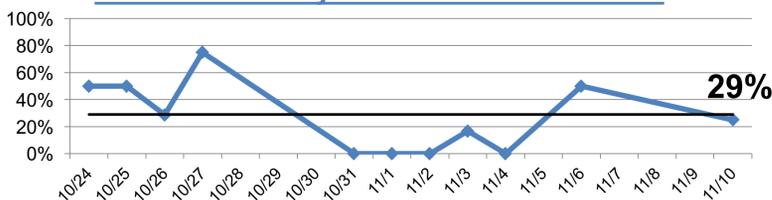
Medical errors occur frequently and miscommunication is the leading cause of inadvertent patient harm. It is a team effort to take care of patients, though sometimes team members do not communicate well with each other. Resident-nurse communication is a crucial interaction that can facilitate safer healthcare delivery. In our institution, nurses and residents inconsistently round together. Our project focuses on resident-nurse communication, specifically targeting rounds- a time when the patients, nurses and physicians come together.

Collaborative meetings between residents, nurses and nurse managers were held to develop a survey which was sent to staff nurses on one patient care unit and pediatric residents. Survey revealed poor impressions of communication

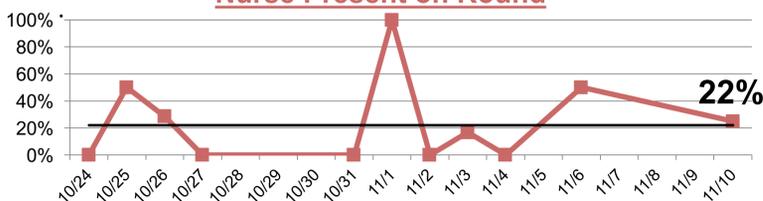
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|---|---|
| <p>Nurses</p> <ul style="list-style-type: none"> Round together 20% of the time 2-4 pages generated per patient within 3 hours of rounds <40% of the time physician communicated with the nurse after rounds | <p>Residents</p> <ul style="list-style-type: none"> Round together 20% of the time 2-4 pages generated per patient within 3 hours of rounds 60-80% of the time physician communicated with the nurse after rounds |
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Baseline Data

Nurse Notified By Resident Prior to Round

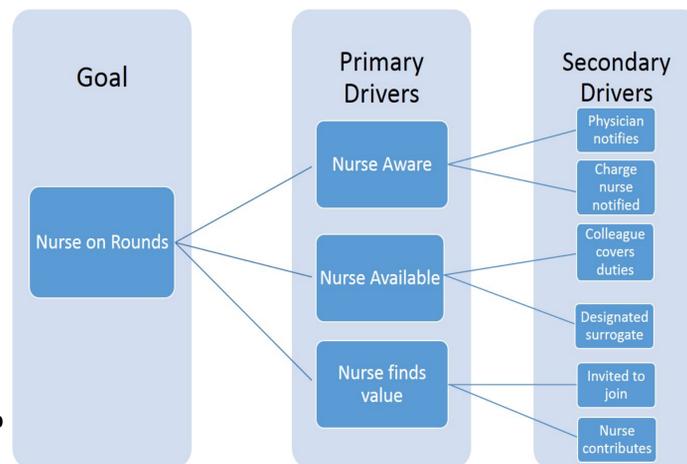
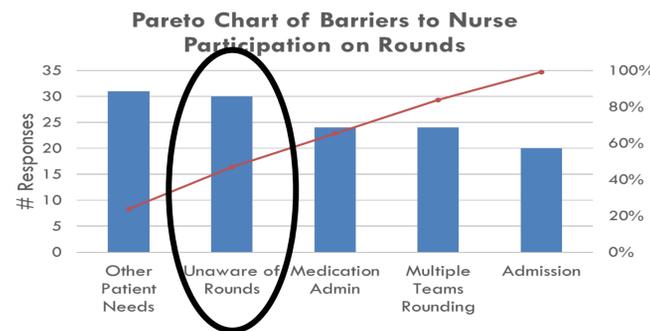


Nurse Present on Round



Analysis

- Reasons for nurses not attending rounds is multifactorial.
- Nurse unaware of rounds was the simplest and most straightforward driver to initiate tests of change.



Measures

- Objective data was collected using RedCap- a web based application for managing surveys and databases
- Residents collected during rounds on each patient on the targeted unit. Answered two questions in the application:
 - Was there an effort to contact the nurse before rounds?
 - Was the nurse present on rounds?

Tests of Change

PDSA Cycle 1

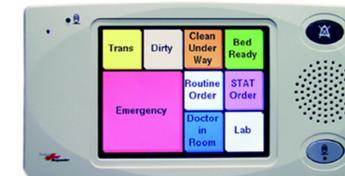
Target: Resident Notification of the Nursing Staff

- Notified all residents of the QI initiative.
- Added nurse name and phone number to the resident patient list on computer.

PDSA Cycle 2

Target: Method Resident Notifies the Nursing Staff

- Utilized establish in-room intercom system
- Trained residents on how to use system.



PDSA Cycle 3

Target: Inviting Nurses to Rounds

- Daily nurse huddle announcement

PDSA Cycle 4

Target: Re-trained Residents on Intercom System

- A resident-nurse team created an in-service video that the residents viewed.

Results

- A special cause event occurred with PDSA cycle 1, leading to a shift in the mean of nursing contact to 79% and nursing presence to 64%.
- Common cause variation was observed in PDSA cycle 2.

- In PDSA cycle 3, contacting nurses improved to 95%.
- In PDSA cycle 4 another special cause event resulted in an increase of nursing presence on rounds to a mean of 81%.

