

Improving Palliative Care Interdisciplinary Team Rounding

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Abstract

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Interdisciplinary team (IDT) rounding is integral in providing patient-centered, high quality, safe, and efficient care. The University of Washington Medical Center – Montlake campus (UWMC-ML) palliative care team meets daily during rounds to discuss patient cases, address issues and concerns, assign work, remember the lives of those who passed, and attend to the well-being of each other. While all these tasks are valuable, the UWMC-ML palliative care team has had challenges with the current team rounding process due to structure variability, time constraints, and different priorities and expectations across team members. There have been changes to address these problems; however, palliative care team satisfaction continues to be less than ideal. This Doctor of Nursing Practice (DNP) project aimed to improve the IDT rounding process of the UWMC-ML palliative care team by implementing strategies based on the analysis of the current rounding process and review of current best evidence-based practices IDT rounding. This project also assessed the success of implemented changes through a reassessment survey of palliative care team members' satisfaction levels.

Introduction

Interdisciplinary team (IDT) rounding is integral in providing patient-centered, high-quality, safe, and efficient care.^{1,2} The University of Washington Medical Center – Montlake campus (UWMC-ML) palliative care team meets daily during rounds to discuss patient cases, address issues and concerns, assign work, remember the lives of those who passed, and attend to the well-being of each other. While all these tasks are valuable, the UWMC-ML palliative care team has had challenges with the current team rounding process due to structure variability, time constraints, and different priorities and expectations across team members. There have been changes to address these problems; however, palliative care team satisfaction continues to be less than ideal. This Doctorate of Nursing Practice (DNP) project aimed to improve the IDT rounding process of the UWMC-ML palliative care team by implementing strategies based on the analysis of the current rounding process and review of current best evidence-based practices IDT rounding. This project also assessed the success of implemented changes through a reassessment survey of palliative care team members' satisfaction levels.

Objectives

1. Perform a literature review on evidence-based practice (EBP) on IDT rounding that has shown team effectiveness and staff satisfaction.
2. Analyze the dynamics and structure of rounds and assess variability through observation to identify the barriers and facilitators of the rounding process.
3. Develop strategies/tools for implementation based on team members' needs and priorities and current best evidence-based practices on IDT rounding.
4. Implement recommendations through "Plan, Do, Study, Act" (PDSA) cycles and perform a reassessment survey to measure the success of the interventions and guide the tailoring of future interventions.

Background/Significance

Team rounding is especially vital in palliative care because it allows each team member to offer their clinical expertise in coordinating patient care and discussing complex patient cases.³ Successful and effective IDT rounding promotes collaboration and teamwork, resulting in improved patient safety and higher staff and patient satisfaction.^{1,2} On the other hand, ineffective communication among team members leads to poor quality of care and adverse patient outcomes.⁴

Improving team rounding starts in recognizing the variation in the team member's understanding of the goal of the rounds, their perceptions about their attendance compared to that of their colleagues, and their views on the quality of collaboration and communication between team members.^{5,6,7} Aligning goals, expectations, and perceptions with each member to achieve a shared understanding of the rounding process allows for better collaboration and teamwork.⁴ Utilizing interventions focusing on creating structure in the communication and rounding process as well as employing tools and training to promote cooperation and collaboration have shown to increase team effectiveness.^{2,4,6-10} Structure can be achieved through communication tools, scripts, or meeting agendas.^{4,7-10} Furthermore, Registered Nurse-led or shared-led meetings result in a higher level of cooperation than MD/NP-led meetings.¹⁰ (Evidence tables provided in Appendix A)

A quality improvement (QI) project by Brennan et al.⁷ specifically aimed to improve the efficiency of IDT palliative care team meetings yielded significant improvement in structure, inclusion, and team care as evidenced by the increase in mean team satisfaction levels from 2.4 to 4.5 on a 5-point Likert-type scale. The authors conducted a stakeholder presurvey to analyze the challenges and issues of the current rounding process and proposed a plan for intervention to address the problems; however, this study did not explore the relationship between improved team satisfaction and patient outcomes. Multiple PDSA cycles were conducted to test interventions and do rapid evaluations of their efficacy to achieve the right balance of structure and flexibility. Interventions tested during the PDSA included adopting a shortened version of the 7-step meeting process and using templates to guide the discussion. Other interventions are using a timer, limiting the opening statement for each patient to 1 minute, putting topics/ideas in the parking lot, and setting aside time for morning reflection, remembrance, staff meeting, and continuing education. Refinement in the structure using the 7-step meeting process improved inclusion and collaboration among the palliative care members.⁷

UWMC-ML palliative care team pre-intervention survey results are similar to the findings from the QI project by Brennan et al.⁷ Coincidentally, this DNP project's objectives align closely with what Brennan et al. and his team achieved. Therefore, the results and recommendations from Brennan's QI project on improving team effectiveness set the groundwork for this DNP project's EBP implementation. While there are differences in the team dynamics, rounding structure, and frequency of rounding between the UWMC-ML palliative care team and the specific palliative care team in Brennan's QI project, parts of the recommendations can still be applicable to particular challenges faced by the UWMC-ML palliative care team.

Implementation Process

The Ottawa Model for Research Use (OMRU) (Appendix B) guided this DNP project's design and implementation plan. The OMRU is a planned action model that facilitates the translation of research into practice.¹¹ It has excellent utility in an organizational and team-based transformation due to its descriptive and prescriptive nature. To effectively utilize the OMRU model, the six-step approach¹² was highlighted and followed in an organized fashion, as explained below.

1. Set the Stage

The UWMC-ML palliative care team is an interdisciplinary team comprised of doctors, advanced practice providers, social workers, spiritual counselors, pharmacists, and learners (medical students, fellows, residents, nurse practitioner students, social work students). In August 2021, a baseline satisfaction survey (Appendix C) was conducted and showed a baseline satisfaction level of 5.9/10 (Appendix D). The results were shared with the UWMC-ML palliative care team in November 2021 during a team workshop to bring awareness to the problem. Concurrently, the DNP student conducted a literature review on EBP in palliative care rounding to guide the innovation. The literature review was performed by searching online databases; CINAHL, Embase, and PubMed using the keywords "interdisciplinary team rounding," "team meeting," "team rounding," and "palliative care rounds." A total of 6 publications written in English and published within the past fifteen years were selected and appraised.

2. Specify the Innovation

The innovation chosen for this project was to standardize the rounding process; with the intent to increase efficiency, promote structure, and increase learner's participation. The first set of interventions implemented through the PDSA cycle was: reinstituting "key patients" into daily rounds, discussing only new patients, new consults from the day prior, key patients on Wednesdays, and allotting time for learner's didactics on Wednesdays.

3. Assess the Innovation, Potential Adopters, and the Environment for Barriers and Facilitators

The DNP student reviewed the baseline survey results, summarized the team workshop discussion, and collaborated with the agency mentors (Dr. Katherine Hicks, Dr. James Fausto, and Dr. Kathryn Schlenker) to identify potential barriers and facilitators regarding the innovation, potential adopters, and the environment. Potential barriers noted were the lack of assessment of team members' readiness for change during the initial survey and the potential challenges with coordinating with agency mentors/collaborators as they all have full-time work responsibilities. Facilitators for this project include strong support from the team and administration, the presence of third-party facilitators such as Dr. Katherine Hicks (Director of QI, Cambia Palliative Care Center of Excellence) and this DNP student to reduce the potential tension during the implementation and evaluation, and increased buy-in and participation since strategies and tools to be implemented were based on team members' recommendations.

4. Select and Monitor the Knowledge Translation Strategies

During the team meeting on December 7, 2021, the team workshop discussion summary and the first set of interventions were presented to the team. Given that the interventions chosen to be implemented were from the suggestions and recommendations of the team members, the DNP student expected increased uptake of the innovation. The changes were implemented on December 8, 2021.

5. Monitor Innovation Adoption

The DNP student observed a total of eight daily rounds from mid-January until mid-February on different days of the week to better capture the dynamics between different sets of present team members. The observation tool (Appendix D) was adopted from the Structured Interprofessional Bedside Rounding (SIBR) Toolkit of the University of Washington Center for Health Sciences Interprofessional Education, Research and Practice¹³ to reduce potential bias and increase objectivity during observations. It was revised in consideration of the structure and flow of the UWMC-ML palliative care team care team rounds.

6. Evaluate Outcomes of the Innovation

After incorporating changes into the daily rounds from early December 2021 until mid-January 2022, an assessment was undertaken to understand the intervention's strengths and weaknesses and identify the actual barriers and facilitators. A post-intervention survey (Appendix E) was adopted from the Brennan et al. QI project.⁷ It was revised to be specific to and appropriate for this DNP project, considering the baseline satisfaction survey and implemented interventions. The post-intervention survey hosted on Catalyst was sent electronically via e-mail to 16 palliative care team members on January 14, 2022, and open until

February 4, 2022. The DNP student sent a reminder e-mail and mentioned the survey during one of the daily rounds. Also, Dr. Kathryn Schlenker (Associate Medical Director) sent a follow-up e-mail to the team regarding the survey, which helped increase the response rate. Eleven survey responses out of sixteen were received and analyzed, equating to a 69% response rate. The qualitative data from the survey was evaluated thematically, while the descriptive data were directly exported from the Catalyst.

Outcomes/Deliverables

The stated objectives were all met, and all deliverables (executive summary, summary of literature review with evidence table and references, field notes, implementation plan with tools and strategies, oral/visual presentation of the implementation, and reassessment survey results) were provided to UWMC-ML agency mentors/collaborators by March 15, 2022. The survey results and recommendations were presented to the UWMC-ML palliative care team during their team meeting on March 1, 2022 (Appendix I).

For the first objective, the literature review showed the lack of substantial evidence on daily IDT rounding in the palliative care setting. Many published articles talked about how to effectively perform bedside IDT rounding, which is different from the daily rounds conducted by the UWMC-ML palliative care team. However, the articles had broader concepts, such as communication, collaboration, and structure, which were relatable to the UWMC-ML daily rounds. The literature review affirmed the usefulness of a rounding tool, script, or meeting agenda in promoting structure and efficiency in IDT rounding^{4,7-10} (Appendix A).

For the second objective, the DNP student focused her observation on five key elements of the rounding process: time, the content of discussion, structure, learner's participation, and interdisciplinary collaboration. The rounds generally start and end on time (1-3 minutes before the end time or after the starting time) with two out of eight occasions of going over 5-7 minutes. The content of discussion was centered on the patient's background, current status, and palliative care needs. The timing varies depending on the team members present but typically takes about 1-5 minutes per patient. There was variability in the rounding process depending on who was facilitating. However, the structure had the same format: new patients, key patients, family meetings, all other patients on the list.

On the one Wednesday meeting the DNP student attended, the meeting was shortened, and the team did not go over the whole patient list, but the learner's didactics was not observed as planned. However, there were active efforts to have the learners present patient cases and provide input during discussion. During the discussion of patients, providers typically ask specific team members for their thoughts about the case or if they need assistance. Interdisciplinary collaboration is subtle but present (Appendix J). While efforts were made to accurately capture the dynamics between different team members on different days of the week, the DNP student could have overlooked patterns or variations because of not being present throughout the entire week. Moreover, despite the efforts to be as objective as possible using the observation tool, the DNP student was the only one who performed the observation, increasing the potential for observation bias.

For the third objective, the strategies developed from the literature review and team workshop were implemented for the first PDSA cycle. Unfortunately, it was harder to follow through due to the challenges brought by the Covid-19 Omicron variant surge. The rounds were

switched to virtual format exclusively, creating different dynamics for the team. Additionally, team members experienced increased anxiety and stress due to increased consults/census, short-staffing problems, and other issues affecting how team members adjust and adapt.

For the last objective, the post-intervention survey showed an increase in the team members' mean satisfaction level from 5.9 to 6.3 on a 10-point scale (from 1 = not at all satisfied to 10 = extremely satisfied). The palliative care team staff also noted that there was no change to some improvement in the rounding process in all aspects, as evidenced by the mean score ranging from 3.2 - 3.6 in the Likert-type scale (Appendix H-1). The aspects assessed were timeliness, the content of the discussion, organization/structure, interdisciplinary collaboration/communication, learner's participation, efficiency, and clarification of meeting objectives. The thematic analysis (Appendix H-2) showed that the palliative care team members thought that the following themes worked well: shorter Wednesday rounds were shorter, reinstatement of key patients, having a better structure for running the list, and recognizing the problem with rounds. Conversely, having significant variations due to different facilitator styles, going back to virtual rounds, lack of active listening during the discussion, failure to incorporate learner's didactics are themes that did not work well. The palliative care team members suggested the following areas could be improved: having more consistency with the facilitators, planning the learner didactics and bereavement, being aware of other team members' needs, and keeping the discussion concise and relevant.

Conclusions/ Recommendations

There was a slight improvement in the satisfaction level of the palliative care team members during the first PDSA cycle. Staff also reported "no change" to "somewhat better" in all aspects of the rounding process. The common themes elicited from the qualitative data suggest that the team members were satisfied with reinstating key patients and having shorter rounds on Wednesdays, but more effort is needed to address variability with flow and structure, incorporating learner's didactics and bereavement, and increasing IDT collaboration. It is essential to find the right balance of structure, flexibility, and consistency that best suits the team's different characteristics and dynamics. This DNP project emphasized the complexity of the rounding process and the uniqueness of the UWMC-ML palliative care team. Results from this project support the earlier findings in prior studies, which point out that there is increased staff satisfaction when structure is incorporated into the process.^{2,4,6-10}

Based on the survey results and field notes, the following recommendations for future PDSA cycles were presented to the UWMC-ML palliative care team:

1. Utilize a rounding guide (Appendix K) to promote structure and consistency. The DNP student provided the team with a rounding guide to modify and iteratively change as they see fit to match their needs and priorities. The rounding guide clearly defines the meeting objectives and ground rules which will be helpful as new members or learners join the daily rounding for the first time.
2. Create a definitive plan for incorporating learner didactics on Wednesday rounds and deciding on a set schedule for bereavement.
3. Have the more consistent participants (e.g., pharmacists & spiritual care) in the daily rounds facilitate increasing consistency and decreasing variability in communication style. The

pharmacist and spiritual care does not rotate as frequently as the other team members and were present most of the day of the week.

4. Use an end cue like “done,” “over,” or “period” to denote that the team member is finished talking to reduce interruptions during virtual rounds. This recommendation will be helpful if the team decides to continue daily rounds via Zoom and can be eliminated once the team goes back to in-person rounding.

Implications for Advanced Practice

This project highlights the fulfillment of the tripartite role expected with a doctorally-prepared advanced practice registered nurse (APRN). The findings of this project suggest the need for more research on improving daily IDT rounding, more specifically in the palliative care setting. Future APRNs should also look into how team member satisfaction level on current team rounding affects patient safety and satisfaction level, which was not addressed in this project. Continued work on improving the rounding process using the PDSA cycle presents leadership opportunities for interprofessional collaboration, communication, and QI project implementation and evaluation.

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Appendix A: Evidence Table Appraisal

Study	Purpose	Design/Sample	Intervention	Outcomes	Results	Clinical Relevance
<p>Adams, Heidi A., and Rose Marie Feudale. Implementation of a structured rounding tool for interprofessional care team rounds to improve communication and collaboration in patient care. <i>Pediatr Nurs.</i> 2018;44 (5):229+. Accessed October 29, 2021.³</p>	<p>Improve team communication and collaboration, and improve team member satisfaction.</p>	<p>Comparative quasi-experimental design method with convenience sampling</p> <p>Setting: eight-bed acute care inpatient pediatric unit in a community-based teaching hospital in the northeastern United States</p> <p>N= 24 (6 males and 18 females), between the ages of 18 and 99 years.</p>	<p>Participants were asked to complete a demographics sheet, a documentation process assessment, and the Collaboration and Satisfaction about Care Decisions (CSACD) tool as a pre- and post-intervention survey.</p> <p>Of those participating, 16 (3 males/13 females) completed the pre-intervention survey, and 16 (3 males/13 females) completed the post-intervention survey.</p>	<ul style="list-style-type: none"> •Satisfaction with the documentation process itself. •Belief of whether the rounding process has the potential to be improved. •Perception of the effect of the documentation process on team collaboration. <p>It is scored using a 7-point Likert-type scale.</p>	<p>Statistical analysis using pooled variance t-tests and post hoc power analysis using G*Power 3.1 demonstrated an improvement in team member satisfaction with the rounding process and team collaboration (p<0.001).</p> <p>Satisfaction with documentation process after implementation of rounding tool - mean increase from 4.44 to 6.25, (p<0.001).</p> <p>Increase in satisfaction score from 3.56 to 5.88.</p> <p>Increase in the perception of improvement in collaboration among the interprofessional team from a neutral response of 4.06 to 6.19.</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Data gathering and analysis were discussed clearly. • All outcomes were statistically significant. <p>Limitations</p> <ul style="list-style-type: none"> • The study is not specific to palliative care team rounding. • Poor response rate of 66%. • Small sample size minimizes generalizability.

Study	Purpose	Design/Sample	Intervention	Outcomes	Results	Clinical Relevance
<p>Walton V, Hogden A, Long JC, Johnson J, Greenfield D. Clinicians' perceptions of rounding processes and effectiveness of clinical communication. <i>Journal of Evaluation in Clinical Practice</i>. 2020;26(3):801-811. doi:10.1111/jep.13248.⁵</p>	<p>Examine how clinicians perceive the nature of rounding processes they undertake within their practice, multidisciplinary team attendance at rounds, and the effectiveness of team communication.</p>	<p>Qualitative study, survey-based method design.</p> <p>Setting: Acute care and rehabilitation units in a 165-bed metropolitan teaching hospital in Sydney, Australia.</p> <p>N=77 (medical officers, nurses, and allied health clinicians)</p>	<p>Frontline professionals in two acute care and two rehabilitation wards were surveyed.</p> <p>Participants selected the type of rounding processes undertaken on their ward from a list of six defined types, then answered questions about who participated in the rounds and their perceptions of the effectiveness of multidisciplinary communication.</p> <p>Survey findings were analyzed using descriptive statistics and comparison</p>	<ul style="list-style-type: none"> •How do clinicians define rounding processes on their wards? •How do clinicians perceive their own and other health professionals' attendance at rounds? •How do clinicians perceive multidisciplinary communication for patient care planning? 	<p>Professionals were inconsistent in the identification of the number and types of rounds.</p> <p>Medical officers identified rounds most consistently, while some nurses were unable to identify any rounding processes undertaken.</p> <p>The perceptions clinicians had of their own attendance at rounds differed from that of their colleagues.</p> <p>Despite variation in perceptions about rounds, professionals reported effective multidisciplinary communication patterns overall.</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Study aligns with other facilities that provide both acute medical and rehabilitation care within a single site. • 93% response rate. <p>Limitations</p> <ul style="list-style-type: none"> • Most of the respondents in the study were nurses. • The study is not specific to palliative care team rounding.

Study	Purpose	Design/Sample	Intervention	Results	Clinical Relevance
<p>Borgstrom E, Cohn S, Driessen A, Martin J, Yardley S. Multidisciplinary team meetings in palliative care: an ethnographic study. <i>BMJ Supportive & Palliative Care</i>. 2021;bmjspcare-2021-. doi:10.1136/bmjspcare-2021-003267.⁶</p>	<p>Describe how hospital and community-based palliative care multidisciplinary team meetings operate to elucidate some of their main values and offer an opportunity to share examples of good practice</p>	<p>Ethnographic observation.</p>	<p>Data were drawn from a larger ethnographic study of palliative and end-of-life care in the UK. Data for this paper were collected between May 2018 and January 2020 and comprise observations of over 70 MDTMs. Fieldnotes were thematically analyzed.</p>	<p>The format followed a standard structure: introductions for any guests, brief discussion of recent deaths, more in-depth discussion of individual complex cases, review of new referrals, an update on staff activities that day including joint visits and 1–1 meetings. The amount of time complex case discussions took varied; occasionally, the teams used discussion frameworks or timers to encourage concise descriptions, mainly when there were many cases to cover. Being cramped into a space and not able to see everyone hampered discussion. Different disciplinary perspectives helped question assumptions and provided complementary expertise. There can be a difference between what staff perceives meeting use, which may be more administrative, and the value of the meetings when considering how they influence patient care, staff well-being, and collaborative working.</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Provided clear recommendations. • Focused on palliative care team IDT. <p>Limitations</p> <ul style="list-style-type: none"> • The study was done in the UK, which represents a different healthcare system.

Abbreviations – MDTM: Multidisciplinary team meeting; IDT: Interdisciplinary team

Study	Purpose	Design/ Sample	Intervention	Outcomes	Results	Clinical Relevance
<p>Buljac-Samardzic M, Doekhie KD, Van Wijngaarden JDH. Interventions to improve team effectiveness within health care: a systematic review of the past decade. <i>Human Resources for Health</i>. 2020;18(1). doi:10.1186/s12960-019-0411-3.⁸</p>	<p>Review the literature from the past decade on interventions with the goal of improving team effectiveness within healthcare organizations and identify the "evidence base" levels of the research.</p>	<p>Systematic Review</p> <p>Each article is described using the following structure:</p> <ul style="list-style-type: none"> •Type of intervention •Setting: the setting where the intervention is introduced is described in accordance with the article, without further categorization. •Outcomes: the effect of the intervention. •Quality of evidence: the level of empirical evidence is based in the GRADE scale. 	<p>Seven major databases were systematically searched for relevant articles published between 2008 and July 2018.</p> <p>Keywords: team, health care, interventions, improving team functioning.</p> <p>Of the original search yield of 6025 studies, 297 studies met the inclusion criteria.</p>	<p>The majority of studies evaluated a training.</p> <p>Most of the articles researched an acute hospital setting.</p> <p>Interventions focused on improving non-technical skills such as team working, communication, situational awareness, leadership, decision making and task management.</p> <p>Most studies relied of subjective measures to indicate an improvement in team functioning.</p> <p>Most of the studies have a low level of evidence. A pre- and post-study is a frequently used design.</p>	<p>Studies on improving team functioning focus on four types of interventions:</p> <p>(1) Training is sub-divided into training based on predefined principles (i.e. CRM and TeamSTEPPS) on a specific method or on general team training.</p> <p>(2) Tools covers tools that structure (i.e. SBAR, (de)briefing checklists, and rounds), facilitate or trigger teamwork.</p> <p>(3) Organizational (re)design is about (re)designing structures to stimulate team processes and team functioning.</p> <p>(4) A programme is a combination of the previous types.</p>	<p>Strengths</p> <ul style="list-style-type: none"> • It shed light to the limited high-quality research on team interventions. <p>Limitations</p> <ul style="list-style-type: none"> • Potential publication bias. • Most studies have a low level of evidence based on the GRADE scale.

Abbreviations – CRM: crew resource management; TeamSTEPPS: Team Strategies and Tools to Enhance Performance and Patient Safety; SBAR: Situation, Background, Assessment, and Recommendation; GRADE: Grading of Recommendations Assessment Development, and Evaluation

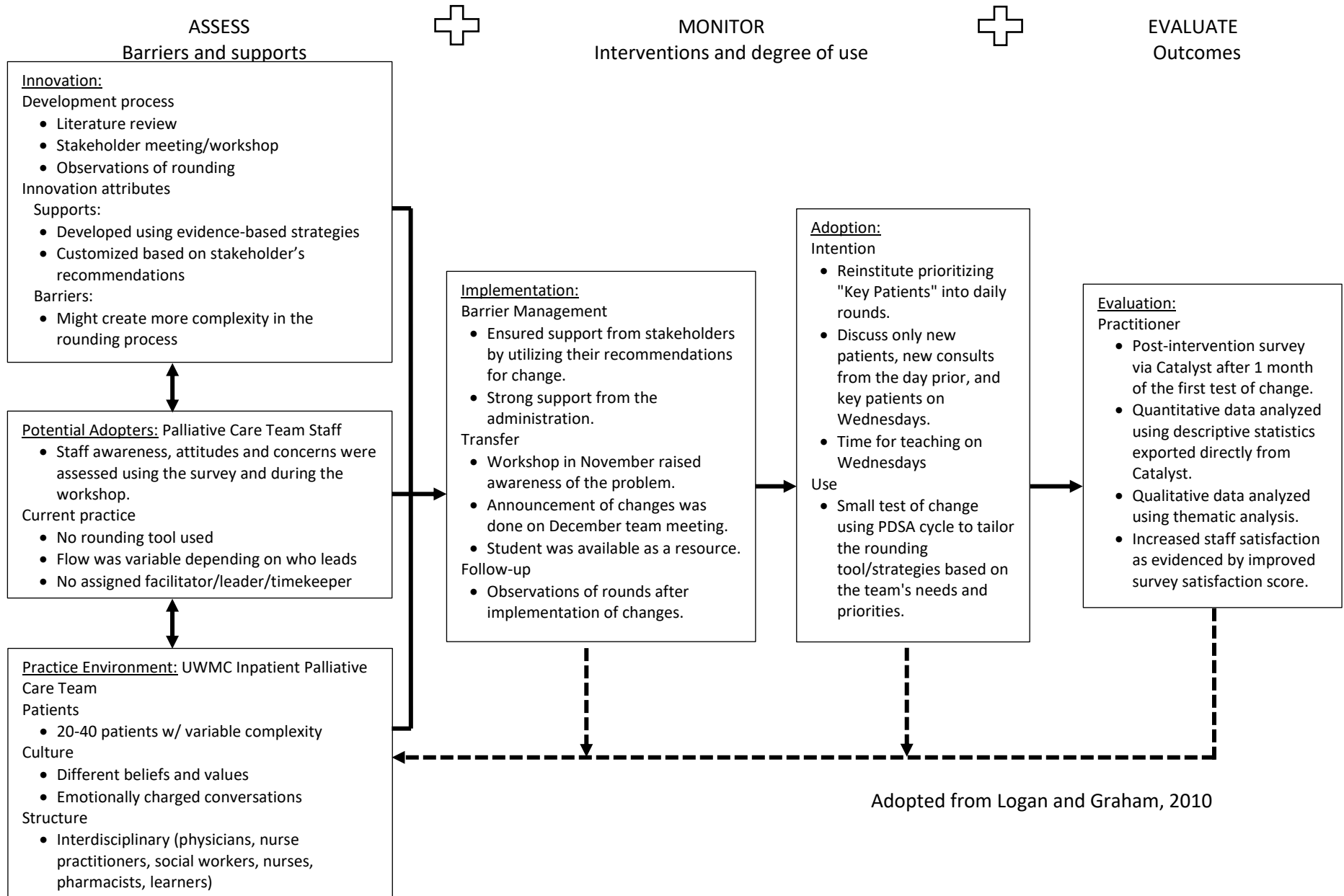
Study	Purpose	Design/Sample	Intervention	Outcomes	Results	Clinical Relevance
O'Leary KJ, Wayne DB, Haviley C, Slade ME, Lee J, Williams MV. Improving Teamwork: Impact of Structured Interdisciplinary Rounds on a Medical Teaching Unit. <i>Journal of General Internal Medicine</i> . 2010;25(8):826-832. doi:10.1007/s11606-010-1345-6. ⁹	To assess the impact of an intervention, SIDR, on hospital care providers' ratings of collaboration and teamwork.	<p>Randomized controlled trial</p> <p>Study was conducted at Northwestern Memorial Hospital (tertiary care teaching hospital)</p> <p>One of two similar teaching service units was randomly selected for the intervention, while the other served as a control unit.</p> <p>One hundred forty-seven of 159 (92%) eligible providers completed the survey.</p>	<p>Control unit: no intervention</p> <p>Intervention unit: SIDR lasted 30–40 minutes, led by the nurse manager and a unit medical director. SIDR was attended by all nurses and resident physicians caring for patients on the unit, as well as the pharmacist, social worker, and case manager assigned to the unit. The structured communication tool was used in SIDR for all patients newly admitted to the unit (admitted in previous 24 hours).</p> <p>The providers on each unit were surveyed asking them to rate the quality of communication and collaboration they had experienced with other disciplines using a five-point ordinal scale. Teamwork and safety climate were also assessed using a validated instrument.</p> <p>All surveys were administered in a web-based format using an internet link delivered via e-mail.</p>	<ul style="list-style-type: none"> •Quality of communication and collaboration provider had experienced with other disciplines •Teamwork and safety climate using the teamwork and safety domains of the SAQ. •Providers' perceptions of whether SIDR improved efficiency of communication, collaboration among team members, and patient care. 	<p>Using a five-point ordinal scale (1=very low, 2=low, 3=adequate, 4=high, 5=very high), a greater percentage of nurses rated the quality of communication and collaboration with physicians as high or very high on the intervention unit than the control unit (74% vs. 44%; p=0.02).</p> <p>Providers on the intervention unit rated the teamwork climate significantly higher than the control unit (82.4±11.7 vs. 77.3±12.3; p=0.01).</p> <p>91% resident physicians and 93% nurses agreed that SIDR improved the efficiency of their workday. 100% of the providers agreed that SIDR improved team collaboration.</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Use of a standard scale and validated instrument to analyze ratings. • Good data collection and intervention implementation. <p>Limitations</p> <ul style="list-style-type: none"> • Not specific to palliative care. • Was done in one hospital setting. • Nurses on the intervention unit had worked at the institution a shorter period of time compared to nurses on the control unit(3.7±3.8vs.6.4±5.2years;p=0.03).

Abbreviations – SIDR: structured inter-disciplinary rounds; SAQ: Safety Attitudes Questionnaire

Study	Purpose	Design/Sample	Intervention	Outcomes	Results	Clinical Relevance
Beard G, Baernholdt M, Byon HD, White KR. Interprofessional rounding design features and associations with collaboration and team effectiveness. <i>Journal of Interprofessional Care.</i> 2021;35(3):343- 351. doi:10.1080/13561 820.2020.1768058. ¹⁰	Examine the association among IPR design features, team collaboration, and team effectiveness.	Cross-sectional design, survey- based method design. Sample: 218 practitioners responded but only 174 had complete responses (from 15 adult hospital units) Female: 87.1% Male:10.7% RNs: 66.9% CM and SW: 7.3% Physicians or NPs: 12.4% Other: 13.4%	A web-link to surveys was e-mailed to practitioners with follow-up e-mails sent at 1 and 2 weeks. The design features were confirmed by observations of IPR before, during, and at completion of the survey period. Team collaboration was measured using two subscales (cooperation and partnership) from the AITCS-II. The 23-item scale measures respondents' level of agreement using a 5-point Likert-style scale ranging from 1=never to 5=always. Team effectiveness was measured by a 5-item subscale from the Primary Care Team Dynamics Survey Patients' perceptions were measured using two HCAHPS survey items: inclusion and working together. Patients rated their experiences on a 5-point Likert-style scale with 1=very poor and 5=very good.	Explanatory variables: IPR design features and team collaboration Outcomes variables: •Practitioners' perceptions of team effectiveness •Patients' perceptions of team effectiveness	Role of the leader and use of a script had a significant positive association with cooperation. Cooperation was measured using the AITCS-II. Rounds that were RN-led or shared-led demonstrated higher levels of cooperation than MD/NP-led rounds. Script was associated with higher levels of cooperation There is no strong evidence to support holding rounds in a specific location; a consistent location is most important.	Strengths • Use of one standard scale (Likert-style scale) to analyze the ratings. • Appropriate statistical analysis tools used. Limitations • Most of the respondents in the study were RNs. • HCAHPS scores are not directly tied to rounding practices. • The study is not specific to palliative care team rounding.

Abbreviations – IPR: interprofessional rounding; AITCS-II: Assessment of Interprofessional Team Collaboration Scale; HCAHPS: Hospital Consumer Assessment of Healthcare Practitioners and System

Appendix B: The Ottawa Model for Research Use



Appendix C: Baseline Satisfaction Survey conducted in August 2021

Daily team rounds are an important part of our work and can be used to address a range of different topics. We are hoping to better understand which of our current practices are going well and which we should change. We would love to hear feedback from every team member to help guide improvements.

Question 1.

How satisfied are you with the current approach to palliative care rounds? (0-10)

Question 2.

What is going well during rounds?

Question 3.

What would you like to change about rounds?

Question 4.

What's most important to you to include in rounds? (list up to 3 components)

Question 5.

During rounds how important is it to you that the team discuss each of the following:

(not at all important, a little, somewhat, very important, most important)

Discussion of challenging symptom management cases

Discussion of patient-related ethical issues

Discussion of psychosocial challenges of cases

Organizing new consults and family meeting schedule

Interdisciplinary team coordination

Bereavement

Addressing discharge related challenges

Bearing witness to colleague's work and experience

Planning your individual day

Learner participation

Question 6.

When considering different approaches to rounds, would you rather talk about all patients briefly or discuss a selection of patients in greater depth?

Question 7.

Do you prefer daily IDT rounding or alternative format (such as MWF team rounding)

Question 8.

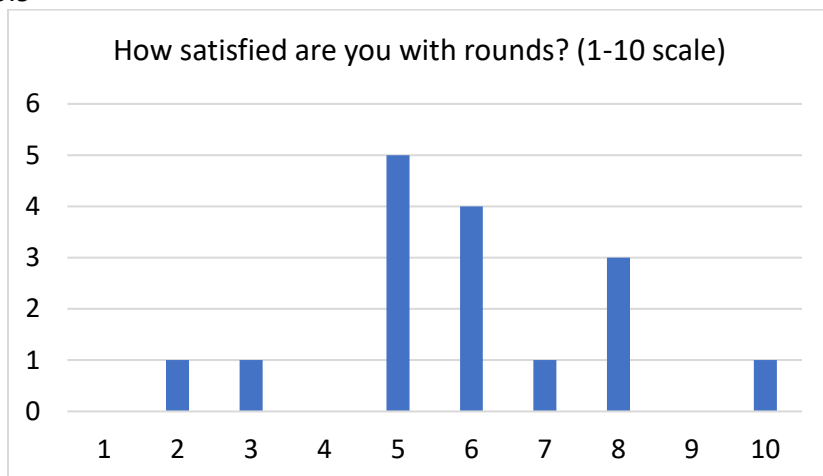
During rounds, would you rather prioritize timeliness or completeness?

Question 9.

Please share any other thoughts or feedback related to rounds that are not addressed above:

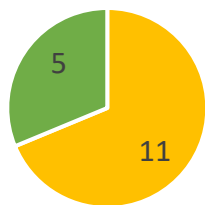
Appendix D: Summary of Baseline Satisfaction Survey Results from Dr. Katherine Hicks

- 16 people completed the survey
- Mean – 5.9



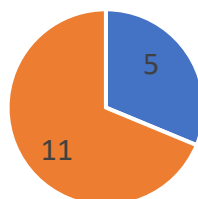
- Rounding Priorities - While numbers are the same for each graph, different individuals make up minority for each topic

Do you prefer daily IDT rounding or alternative format?



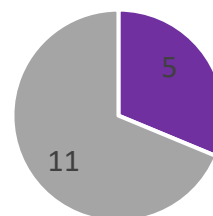
- Daily Rounds
- Alternative Schedule

Would you rather talk about all patients briefly or discuss a selection of patients in greater depth?



- Every Patient
- Selected patients

Would you rather prioritize timeliness or completeness?



- Completeness
- Timeliness

- What's most important to include in rounds?

Most Important
<ul style="list-style-type: none"> • Discussion of challenging symptom management cases • Organizing new consults and family meeting schedule • Discussion of patient related ethical issues • Learner participation

Somewhat Important
<ul style="list-style-type: none"> • Interdisciplinary team coordination • Discussion of psychosocial challenges of cases • Bearing witness to colleague's work and experience • Bereavement • Planning your individual day

Least Important
<ul style="list-style-type: none"> • Addressing discharge related challenges

- What's going well?
 - Team connection and awareness
 - New patient triage
 - Time keeping
 - Space to talk through challenging cases
 - Having pharmacy present
 - Interdisciplinary input

- What would you change?
 - Reduce the amount team members feel rushed or cut off when presenting a challenging case
 - More space for interdisciplinary colleagues to share
 - Simplify and standardize the process of running the list
 - Many patients do not need to be discussed every day
 - Lack of trainee participation and didactics
 - Variation in structure week to week (e.g. change in attendings)

- Opportunities
 - Targeted focus on new and complex patients
 - Balance of efficiency and time to present challenging patients
 - Present only what is relevant rather than all that is happening
 - Present challenging cases in small group discussions
 - Importance of respectful environment and listening to colleagues

Appendix E: Summary of Team Workshop Discussions

- Barriers to changing rounds
 - Different personality and needs (what's energizing for someone can be depleting for someone)
 - Difficulty in creating a space that balance the needs of each team member
 - Dynamic workforce that is constantly changing (different patient complexity and different providers present)
- Something that surprised the group
 - The bell curve of satisfaction (not more skewed towards lower level of satisfaction)
 - Less discordance than expected
 - The struggle with rounds is not unique to the palliative care team
- One thing the is going well in rounds
 - Team connection and opportunity to connect on purpose and with each other
 - The team does a good job in taking care of each other
- Ideas for improvement
 - Once a month meeting specifically to:
 - Discuss ethical issues (complex patients)
 - Allow time to connect with each other
 - Standardize the rounding process
 - Starting the meeting with the agenda and ground rules
 - Different meeting agenda for different days of the week
 - Bereavement on Tues/Thurs or other variation
 - Running the full list of patient only on certain days (Mon/Fri)
 - Different structure for zoom and in-person rounds
 - Be transparent about time commitment at the beginning of rounds to avoid time pressure on other team members
 - Learner's participation
 - Provide learners with more opportunities to discuss their patients more comprehensively
 - Learner didactic every round
 - Prioritize learner's patients
 - Content of discussion
 - Pairing down what is shared for each patient (What is the purpose of sharing the information?)
 - Develop categories to help prioritize patients better
 - Shifting from what the speaker may need to what the audience may need to help
 - Lead patient presentation with specific clinical/ethical questions
 - Interdisciplinary input on patient selection
- Proposed ground rules
 - Self-reflection
 - Setting agenda

Appendix F: Observation Tool (adopted from Structured Interprofessional Bedside Rounding (SIBR) Toolkit of University of Washington Center for Health Sciences Interprofessional Education, Research and Practice)

Date/day: _____

Start Time: _____

End Time: _____

Leader/Timekeeper: _____

Participants: _____ # of healthcare professionals

Attending Physicians	
Advance Practice Providers (APPs)	
Fellows	
Social Worker	
RNs	
Medical Residents	
Pharmacy	
Others (students)	

Interruptions/Rushing others tally:

Census: _____

New consults: _____

Content of discussion: _____

Interdisciplinary discussion: YES NO

Notes: _____

Learner Participation: YES NO

Notes: _____

Structure/Organized: YES NO

Notes: _____

Average time spent per patient: _____

5 TeamSTEPPS Domains
Team Structure: identifies goals, assigns roles and responsibilities, holds members accountable
Leadership: utilizes resources, delegates tasks and balances workload, conducts briefs, huddles, and debriefs, empowers members to speak freely
Situation Monitoring: includes patient/family in communication, cross monitors members and applies the STEP process, fosters communication
Mutual Support: advocates for the patient, resolves conflict using TwoChallenge rule, CUS, and DESC Script, works collaboratively
Communication: provides brief, clear, specific and timely information, seeks and communicates information from all available sources uses SBAR, call-outs, check-backs and handoff techniques

Appendix G: Palliative Care Team Post-Intervention Survey (adopted from Brennan et. al Quality Improvement Project):

Question #1: How satisfied are you with the current approach to palliative care rounds? (0-10)

Question #2: Rate your satisfaction level with the recent changes (minimizing repetition, allowing more time to discuss difficult/challenging patients, and incorporating learners' participation – Wednesday is to discuss new and key patients and learners' didactics) in the palliative care rounds. (10 as extremely satisfied and 0 as not at all satisfied)

Since changes were made with the rounding process in December, what has been better vs worse?

Answer choices 1 - worse; 2 - somewhat worse; 3 - no change; 4 - somewhat better; and 5 – better

Aspects

1. Timeliness
2. Content of discussion
3. Organization/structure of the meeting
4. Interdisciplinary collaboration/communication
5. Learner's participation
6. Efficiency
7. Clarification of meeting objectives

Rapid Evaluation Questions (adopted from Brennan et al. QI Project):

1. What worked well?
2. What did not work well?
3. What could be improved for next cycle of changes?

Appendix H-1: Post-intervention Survey Descriptive Data Analysis

Question #1: How satisfied are you with the current approach to palliative care rounds? (0-10)
(10 as extremely satisfied and 0 as not at all satisfied)

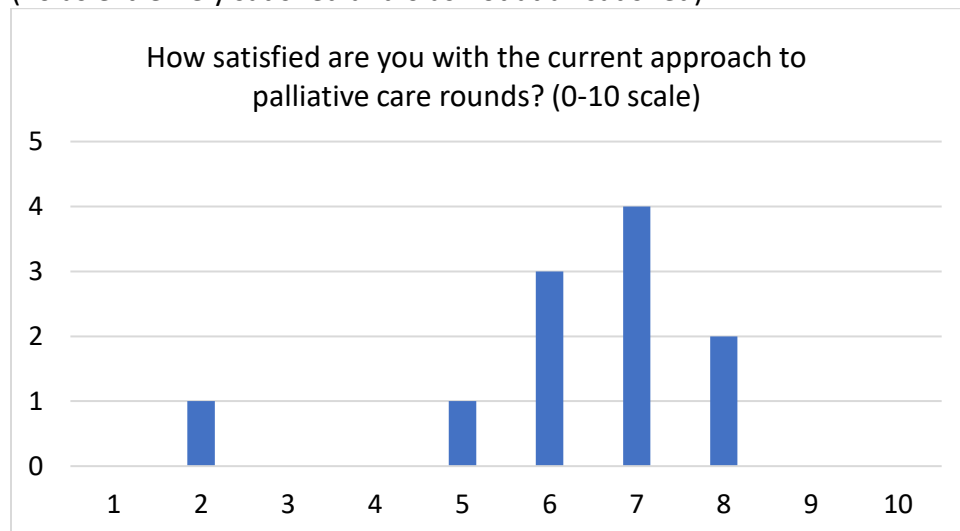


Figure 1: Clustered column chart showing the distribution of team members' rating from 0 to 10. (N= 11, Mean= 6.3)

Question #2: Rate your satisfaction level with the recent changes in the palliative care rounds. Since changes were made with the rounding process in December, what aspects has been better versus worse?

As a reminder, the changes that were instituted following the team meeting on December 7 are the following: -Reinstitute prioritizing "Key Patients" into daily rounds -Discuss only new patients, new consults from the day prior, and key patients on Wednesdays -Time for teaching on Wednesdays (learner didactics, teaching topic identified on rounds)

Timeliness

<i>Numeric value</i>	<i>Answer</i>	<i>Frequency</i>	<i>Percentage</i>		
1	1 - Worse	0	0.00%	<i>Mean</i>	3.64
2	2 - Somewhat worse	0	0.00%	<i>Median</i>	4.00
3	3 - No Change	5	45.45%	<i>Mode</i>	3, 4
4	4 - Somewhat better	5	45.45%	<i>Min/Max</i>	3/5
5	5 - Better	1	9.09%	<i>Standard deviation</i>	0.67

Content of discussion

<i>Numeric value</i>	<i>Answer</i>	<i>Frequency</i>	<i>Percentage</i>		
1	1 - Worse	1	9.09%	<i>Mean</i>	3.27
2	2 - Somewhat worse	0	0.00%	<i>Median</i>	3.00
3	3 - No Change	5	45.45%	<i>Mode</i>	3, 4
4	4 - Somewhat better	5	45.45%	<i>Min/Max</i>	1/4
5	5 - Better	0	0.00%	<i>Standard deviation</i>	0.90

Organization/structure of the meeting

<i>Numeric value</i>	<i>Answer</i>	<i>Frequency</i>	<i>Percentage</i>		
1	1 - Worse	0	0.00%	<i>Mean</i>	3.64
2	2 - Somewhat worse	1	9.09%	<i>Median</i>	4.00
3	3 - No Change	3	27.27%	<i>Mode</i>	4
4	4 - Somewhat better	6	54.55%	<i>Min/Max</i>	2/5
5	5 - Better	1	9.09%	<i>Standard deviation</i>	0.81

Interdisciplinary collaboration/communication

<i>Numeric value</i>	<i>Answer</i>	<i>Frequency</i>	<i>Percentage</i>		
1	1 - Worse	0	0.00%	<i>Mean</i>	3.18
2	2 - Somewhat worse	1	9.09%	<i>Median</i>	3.00
3	3 - No Change	7	63.64%	<i>Mode</i>	3
4	4 - Somewhat better	3	27.27%	<i>Min/Max</i>	2/4
5	5 - Better	0	0.00%	<i>Standard deviation</i>	0.60

Learner's participation

<i>Numeric value</i>	<i>Answer</i>	<i>Frequency</i>	<i>Percentage</i>		
1	1 - Worse	0	0.00%	<i>Mean</i>	3.36
2	2 - Somewhat worse	0	0.00%	<i>Median</i>	3.00
3	3 - No Change	7	63.64%	<i>Mode</i>	3
4	4 - Somewhat better	4	36.36%	<i>Min/Max</i>	3/4
5	5 - Better	0	0.00%	<i>Standard deviation</i>	0.50

Efficiency

<i>Numeric value</i>	<i>Answer</i>	<i>Frequency</i>	<i>Percentage</i>		
1	1 - Worse	0	0.00%	<i>Mean</i>	3.64
2	2 - Somewhat worse	1	9.09%	<i>Median</i>	4.00
3	3 - No Change	4	36.36%	<i>Mode</i>	3, 4
4	4 - Somewhat better	4	36.36%	<i>Min/Max</i>	2/5
5	5 - Better	2	18.18%	<i>Standard deviation</i>	0.92

Clarification of meeting objectives

<i>Numeric value</i>	<i>Answer</i>	<i>Frequency</i>	<i>Percentage</i>		
1	1 - Worse	0	0.00%	<i>Mean</i>	3.45
2	2 - Somewhat worse	0	0.00%	<i>Median</i>	3.00
3	3 - No Change	7	63.64%	<i>Mode</i>	3
4	4 - Somewhat better	3	27.27%	<i>Min/Max</i>	3/5
5	5 - Better	1	9.09%	<i>Standard deviation</i>	0.69

Appendix H-2: Post-intervention Survey Qualitative Data Analysis

Question #3: What worked well?

<i>Theme</i>	<i>Response</i>
Wednesday rounds	<p>"Trying a day (Wednesday) to not talk about all of the patients"</p> <p>"I have like having Wednesdays to have less pressure to get through the list and talk through challenges."</p> <p>"Rounds on Wed were shorter"</p>
Key Patients	<p>"Asking if any key patients after talking about the new patients."</p> <p>"I think having prioritization for key patients is a great idea. I think for the most part this has been hard to achieve, although I have noticed honest effort to streamlining discussions."</p>
Structure	<p>"It has been nice to know what to expect and to have structure."</p> <p>"Structure for each day with variation."</p> <p>"Not reviewing whole list every day."</p> <p>"It is better not discussing stable people too much."</p> <p>"Reminders to be brief and share what is important for the team to know/what you need input on."</p> <p>"I think overall there has been an improvement in efficiency in rounds."</p>
Recognizing the problem	<p>"Just talking about how challenging rounds are helps."</p>

Question #4: What did not work well?

<i>Theme</i>	<i>Response</i>
Facilitator	<p>"It's completely Provider dependent--some go on forever, some are brief, some simply don't know what's going on"</p> <p>"The structure and timeliness of rounds still seems quite varied depending on who is running rounds. So, it's often personality dependent."</p> <p>"I'm still reasonably new to the team, and I really enjoy rounds no matter who is running it, but we are going quite long at times still and there's often a lack of awareness of the amount of time it is taking out of our days, or lack of awareness of our slow pace."</p>
Virtual (Zoom) Rounds	<p>"It has been challenging to follow through on the proposed changes after going back to Zoom rounds."</p> <p>"I hate that we are back to zoom rounds!"</p>
Learners' Participation	<p>"I think we are doing better having learners present their patients."</p> <p>"We still haven't given the learners a chance to talk about any topics other than their patients."</p> <p>"We didn't have the learner didactic component on Wed, so did not achieve the desired effect there."</p>

<p>Content of Discussion</p>	<p>"I think some people still find it challenging to limit discussion on Wednesday's to just 'key patients'."</p> <p>"We have not been doing shorter rounds when I've been on service, we have run the list every day."</p> <p>"At times some team members repeat day after day after the exact info for their patients. It is time consuming and makes me want to zone-out and then I miss something that is actually new info."</p> <p>"On days when it seems we could be done before 10, there is taking of the full hour to share extensive details about a patient that would have been left out if there had been a longer list or other pressing matters."</p> <p>"Conversely, the shorter running of the list, while it was efficient, left me feeling less in touch with what was going on the service as a whole."</p>
<p>Interdisciplinary collaboration</p>	<p>"There are still time where the competing needs on rounds is hard. It is hard to have a challenging patient and not have time/space to get the input of all disciplines or providers who may have a different perspective. This is particularly hard when we are busy and people are stressed."</p> <p>"And it is just easier working with some team members than others given personal quirks and anxieties. Everyone is compassionate toward the patients, often compassionate towards the primary team, and then fails to be compassionate to each other."</p> <p>"Listening to colleagues. Often members continue to zone out when not their patient or not their discipline and expect feedback and support when they are speaking. This makes it hard for collaborative care."</p>
<p>Team Dynamics</p>	<p>"There are still times when one team member will talk about their patients and then tell others to hurry up."</p> <p>"Our every-changing-team-members (even within the same week) extends rounds as, again, info is repeated for those coming on mid-week or who missed rounds the day before. Another layer of the every-changing-team-members is that when a billing provider is fresh off time-off they may be more talkative and as their time on service continues, they may lose some steam."</p> <p>"Also there is often a lot of anxiety about how long the list of new consults is and/or the list itself."</p> <p>"Some of this may reflect that the service is very busy and the list is long and we have way too many learners on - all of which contributes to an overall feeling of being overwhelmed. I just think that's important context for the current environment."</p>

Question #5: What could be improved for next cycle of changes?

<i>Theme</i>	<i>Response</i>
Content of Discussion	<p>“Not running the full list every day.”</p> <p>“Maybe try to not talk about every pt on another day besides Wed.”</p> <p>“Define role of what information is being shared and is there a clinical question? Support need?”</p> <p>“Reminders to be brief and share what is most relevant. When more significant input is needed let's always add those folks to the "key patients" list so that we can appropriately give the attention there.”</p>
Facilitator	<p>“Maybe during the running of the list we can have the leader of running the list just ask the person who is seeing a patient "any new concerns you want to address' to try and guide the running of the list quicker. It can be hard when the person starting the list asks okay now "so and so" then we feel like you need to offer the back story and the challenging things to only say "I am following and support has been good" if that makes sense. Maybe have the person run the list say okay for "so and so" I know X has been following, is there any updates or concerns you have today?”</p>
Learners' participation	<p>“When learners start their rotation let them know that they can choose a topic to talk about (perhaps on their second week) informally at rounds for approx 5-10 minutes.”</p> <p>“Having learners give short presentations.”</p> <p>“I may have missed this - but it would help to have a structure for the learner didactic (who is supposed to figure this out and when?)”</p>
Structure and Flexibility	<p>“Acknowledging there will be some days that go longer than an hour due to long or complex list, but also that there will be days that we are done well before 10.”</p> <p>“An awareness of our personal styles for repeating info. and/or our personal style that is more introverted and then acting upon that awareness.”</p> <p>“Consistent pattern of review for each day of the week.”</p> <p>“Consistency, continuity, accountability”</p>
Team Support	<p>“Finding ways to help everyone stay grounded and not get stressed when we are busy with a lot of new consults. We always get the work done!!”</p> <p>“A reduction of anxiety (individual and team).”</p> <p>“An awareness of the needs for the on-call-attending (i.e. tell them what they need to know for the night or weekend).”</p> <p>“An awareness that some team members talk but then do not listen to others.”</p>
Bereavement	<p>“I'd like to see us review the deaths the very next day. At least Mon-Thurs we have a chance for the team that cared for the patient to still be</p>

	<p>on service. It is painful when the names are left for weeks until a provider returns to work and then that provider says, "Oh I have to look them up because I don't remember." Forgetting is normal and fine. It is still painful when the provider says that, rather than looking at the bereaved list and taking it upon themselves to look up the patient to jog their memory before team meeting."</p> <p>"I think an area for improvement would be more clear times to do bereavement."</p>
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Appendix I: DNP Project Presentation - Palliative Care Team Monthly Meeting (March 1, 2022)

IMPROVING PALLIATIVE CARE INTERDISCIPLINARY TEAM ROUNDING

MIKKA MARUN UEHARA, BSN, RN DNP STUDENT
UNIVERSITY OF WASHINGTON SCHOOL OF NURSING
MARCH 1, 2022

PRESENTATION OVERVIEW

- Background and significance
- Purpose of the project
- Implementation process
- Findings
- Recommendation for future "Plan, Do, Study, Act" (PDSA) cycles
- Conclusion

BACKGROUND

- Challenges on daily rounds is a longstanding problem.
- Frustration due to structure variability, time constraints, and different priorities and expectations.
- Average staff satisfaction level of 5.9/10

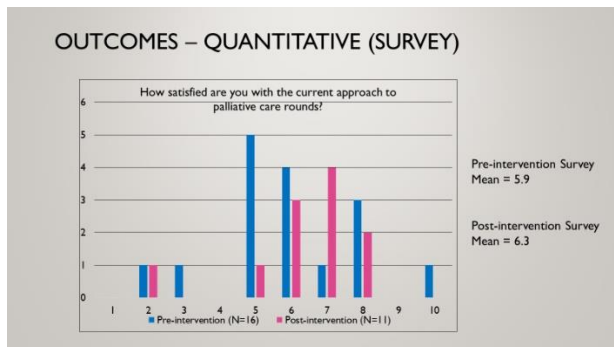
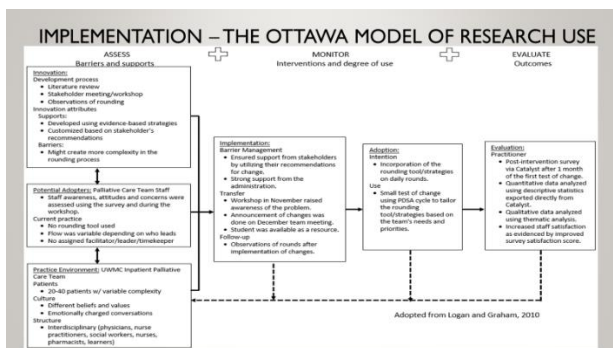
SIGNIFICANCE

- Interdisciplinary team rounding promotes collaboration and teamwork.
- Aligning goals, expectations, and perceptions with each member.
- Creating structure and employing tools and training.
- Structure can be achieved through communication tools, script, or meeting agenda.

PURPOSE

Implement strategies based on the analysis of the current rounding process and review of current best evidence-based practices on interdisciplinary rounding.

Measure the success of implemented changes through a reassessment survey of palliative care team members' satisfaction levels.



OUTCOMES – QUANTITATIVE (SURVEY)

Aspect	Mean Post-intervention Survey Score
Timeliness	3.64
Content of Discussion	3.27
Organization/Structure	3.64
Interdisciplinary collaboration/communication	3.18
Learner's Participation	3.36
Efficiency	3.64
Clarification of meeting objectives	3.45

1 - Worse
2 - Somewhat worse
3 - No Change
4 - Somewhat better
5 - Better

OUTCOMES – QUALITATIVE (OBSERVATION FIELDNOTES)

- Time
 - ✓ Generally start and end on time (1-3 minutes before the end time or after the starting time)
 - ✓ 2/8 occasions of going over 5-7 minutes
- Facilitator/Timekeeper
 - ✓ Usually the on-call provider facilitates, and their style varies.
- Interruptions/Rushing others
 - ✓ Interruptions ranged from 0 to 5 times, likely affected by the challenge of not seeing cues/body language in a virtual discussion.
 - ✓ No rushing of other team members observed.
- Average time spent per patient
 - ✓ Varies from 1 to 5 minutes.

OUTCOMES – QUALITATIVE (OBSERVATION FIELDNOTES)

- Content of discussion
 - ✓ Centered on the patient background, current status, and patient's palliative care needs.
 - ✓ Some team members shares more than others.
 - ✓ Bereavement occurs randomly (before or after patient discussions)
- Interdisciplinary Discussion
 - ✓ Subtle but present.
 - ✓ Providers ask specific team members about their thoughts or if they need their assistance.
- Learner's Participation
 - ✓ Learner didactics on Wednesday did not materialize.
 - ✓ There are active efforts on having the learners present patient cases and provide input during discussion.
- Structure/Organized
 - ✓ The constant muting and unmuting do not help the flow of the conversation.
 - ✓ Rounds typically follows the same structure/format (news, keys, family meetings, all other patients, assigning of work)

OUTCOMES – QUALITATIVE (SURVEY)

What worked well	What did not work well	What can be improved
<ul style="list-style-type: none"> • Wednesday rounds • Key patients • Structure – not running the full list • Recognizing the problem 	<ul style="list-style-type: none"> • Facilitator – flow and style varies • Virtual rounds • Learner's participation – no didactics • Content of discussion – repetition • IDT collaboration – not listening to others • Team dynamics – increased stress due to workload 	<ul style="list-style-type: none"> • Facilitator – consistency • Learner's participation – clear plan for didactics • Content of discussion – keep it concise and relevant • Structure and Flexibility – consistency and understanding • Team Support – awareness of other's needs • Bereavement – having a set schedule

RECOMMENDATIONS FOR FUTURE PDSA CYCLES



ROUNDING GUIDE

Utilizing a rounding guide that can promote structure and consistency.

The team can modify and iterate the guide as they see fit for the team's needs and priorities.



CREATE A PLAN

Definitive plan for incorporating learner didactics on Wednesdays.

A set schedule for bereavement.



FACILITATOR


Having the more constant people in daily rounds facilitates (pharmacists) to increase consistency and decrease variability in style.




END CUE

Using an end cue like "done", "over", or "period" to denote that the team member is done talking to reduce interruptions.


CONCLUSIONS




There is an increase (6.8%) in staff satisfaction after the first PDSA cycle.




The mean post-intervention survey score for the all the aspects of rounds lie between no change to somewhat better.



Facilitators greatly affect the structure and timing of rounds.



Limitations includes lack of evidence, potential bias, and the ever-changing format of rounds.



It is important to find the right balance of structure, flexibility and consistency.

THANK YOU!

I LOOK FORWARD TO YOUR QUESTIONS.

Appendix J: Observation Fieldnotes

Date/day: 1/18/2022 - Tuesday

Start Time: 09:01

End Time: 10:00

Leader/Timekeeper: Meegan

Participants: # of healthcare professionals

Attending Physicians	2
Advance Practice Providers (APPs)	2
Fellows	0
Social Worker/Spiritual Care	1/1
RNs	0
Medical Residents	1
Pharmacy	1
Others (students)	1

Interruptions/Rushing others tally: 0

Census: 26

New consults/key patients: 8

Content of discussion: First 5 minutes were spent checking in on each other and introducing new faces to the team. At 9:07, discussion on new consults and family meetings started, followed by key patients and the whole patient list (alphabetically). At 9:56, the delegation of responsibilities and patients occurred.

Interdisciplinary discussion: **YES** NO

Notes: Attendings and APPs would specifically ask the social worker or spiritual care if they need help from them. If not, they would ask whether they have seen the patient or their thoughts regarding the patient's needs. They also coordinate a time to be present during consults or family meetings.

Learner Participation: **YES** NO

Notes: The resident and medical student were given opportunities to share their patient cases.

Structure/Organized: **YES** NO

Notes: Started a minute late but finished on time.

Time spent per patient: 1-3 minutes

Date/day: 1/21/2022 - Friday

Start Time: 09:02

End Time: 10:07

Leader/Timekeeper: Laura

Participants: # of healthcare professionals

Attending Physicians	2
Advance Practice Providers (APPs)	2
Fellows	1
Social Worker/Spiritual Care	2
RNs	1
Medical Residents	1
Pharmacy	1
Others (students)	1

Interruptions/Rushing others tally: 1

Census: 30

New consults/key patients: 7

Content of discussion: We started the rounds with checking in on each other then with bereavement from 9:05 to 9:09. At 9:10, the new consults/patients and key patients were discussed. The rest of the time was spent with the list of palliative patients (alphabetically). The assigning of roles did not start until 10:01.

Interdisciplinary discussion: **YES** NO

Notes: There was more interdisciplinary discussion noted as the RN is present during this meeting and was able to connect with the providers on the updates for some patients and collaborate with spiritual care and social work as well. There were patients that the RN is the one mostly following.

Learner Participation: **YES** NO

Notes: There were 3 learners in this meeting, and all of them got to present their patient cases. It does take more time when the learner's present, which could have affected the timing of the meeting.

Structure/Organized: **YES** NO

Time spent per patient: 1-5 minutes

Date/day: 1/24/2022 - Monday

Start Time: 09:03

End Time: 09:57

Leader/Timekeeper: Katie

Participants: # of healthcare professionals

Attending Physicians	1
Advance Practice Providers (APPs)	2
Fellows	0
Social Worker/Spiritual Care	2/1
RNs	0
Medical Residents	0
Pharmacy	1
Others (students)	1

Interruptions/Rushing others tally: 0

Census: 27

New consults/key patients: 8

Content of discussion: The team started with announcements then new consults/patients. The team talked about the urgency of other consults over others and discussed family meetings that are happening this afternoon. At the end of the patient list and assigning of patients, the team did bereavement.

Interdisciplinary discussion: **YES** **NO**

Notes: It is apparent how important the role of spiritual care is in this team. The providers work closely with him, and he also functions independently.

Learner Participation: **YES** **NO**

Notes: Only 1 medical student was present in the meeting as the other fellow could not make it. The medical student was able to share about her patients and coordinate with the providers on the patients she would like to follow for the day.

Structure/Organized: **YES** **NO**

Notes: First, they talked about not doing bereavement because it was Monday, but then there was more time at the end of the rounds, so the facilitator decided to do bereavement.

Average time spent per patient: 1-4 minutes

Date/day: 2/1/2022 - Tuesday

Start Time: 09:50

End Time: 10:45

Leader/Timekeeper: Rashmi

Participants: # of healthcare professionals

Attending Physicians	3
Advance Practice Providers (APPs)	1
Fellows	1
Social Worker/Spiritual Care	2/1
RNs	1
Medical Residents	0
Pharmacy	1
Others (students)	1

Interruptions/Rushing others tally: IIII

Census: 38

New consults/key patients: 12

Content of discussion: The meeting started with introductions and checking in on each other using the weather metaphor for the first 10 minutes. Given the overwhelming number of new consults/patients, the team discussed which ones need to be prioritized over the others and what specific palliative care needs are important to address today. From 10:41-10:45, the team divided up the consults and family meetings.

Interdisciplinary discussion: **YES** **NO**

Notes: Other providers volunteered to see more patients as their load is lighter to help the team. For some of the patients, the social work, RN, and spiritual care will see the patient without the provider, and they will just ask the provider to come if necessary.

Learner Participation: **YES** **NO**

Notes: Because the meeting started later due to the grand rounds in the morning and there was a long list of patients, one provider started sharing about the patient instead of allowing the learners.

Structure/Organized: **YES** **NO**

Average time spent per patient: 1-2 minutes

Date/day: 2/3/2022 - Thursday

Start Time: 09:06

End Time: 09:45

Leader/Timekeeper: Rashmi

Participants: # of healthcare professionals

Attending Physicians	3
Advance Practice Providers (APPs)	1
Fellows	0
Social Worker/Spiritual Care	1/1
RNs	0
Medical Residents	0
Pharmacy	1
Others (students)	2

Interruptions/Rushing others tally: 1

Census: 39

New consults/key patients: 14

Content of discussion: The meeting started with housekeeping then the new patients and key patients. There were many patients on the list, so the providers were assigning themselves to the patients as they went. The final assigning of patients occurred at 9:40-9:45. One of the providers had to address an urgent matter while in the meeting, and he came back afterward.

Interdisciplinary discussion: **YES** NO

Notes: The pharmacist did not join the whole meeting. He popped in to discuss one patient and left. The providers and social workers team up to do the family meetings and consult. The RN updated the providers on some of the patients she's following.

Learner Participation: **YES** NO

Notes: The learners did not have patients they were following yet. They were assigned to the providers, and they discussed which patients to see.

Structure/Organized: **YES** NO

Notes: There were a lot of patients on the list, but the rounds finished 15 minutes earlier.

Average time spent per patient: 1-2 minutes

Date/day: 2/7/2022 Monday

Start Time: 09:02

End Time: 09:42

Leader/Timekeeper: Melissa

Participants: # of healthcare professionals

Attending Physicians	3
Advance Practice Providers (APPs)	1
Fellows	0
Social Worker/Spiritual Care	2/1
RNs	0
Medical Residents	0
Pharmacy	1
Others (students)	3

Interruptions/Rushing others tally: 1

Census: 30

New consults/key patients: 7

Content of discussion: The team started with check-ins, then the news by 9:05, family meeting by 9:16, and then the patient list alphabetically. A question for the pharmacy about PCA came up as there was a shortage recently.

Interdisciplinary discussion: **YES** NO

Notes: One provider discussed the patient's pain regimen with the pharmacy. There was a lot of independence in the pharmacist's practice in this team.

Learner Participation: **YES** NO

Notes: The SW talked about having an educational session with the learners after rounds. This was a good time as there were 3 learners for this day.

Structure/Organized: **YES** NO

Notes: This meeting went smoothly with the providers, making sure they are following the patients and mentioning the important things the other team members need to know. About 1-2 minutes were spent for each patient.

Average time spent per patient: 1-2 minutes

Date/day: 2/8/2022 Tuesday

Start Time: 09:00

End Time: 10:06

Leader/Timekeeper: Melissa

Participants: # of healthcare professionals

Attending Physicians	3
Advance Practice Providers (APPs)	1
Fellows	0
Social Worker/Spiritual Care	2/1
RNs	1
Medical Residents	0
Pharmacy	1
Others (students)	2

Interruptions/Rushing others tally: IIIII

Census: 33

New consults: 4

Content of discussion: The team started the meeting with bereavement for 3 patients, which lasted from 9:05 until 9:20. Topics regarding ethics and health equity were brought up during bereavement. Everyone who cared for the patients was able to share. The team proceeded to new patients, family meetings, and then the patient list (discussed in the reverse alphabet).

Assigning of roles occurred as the meeting went.

Interdisciplinary discussion: **YES** NO

Notes: There is always a lot more interdisciplinary collaboration when the RN and social workers are present. The providers are good with scheduling and coordinating things together with the other team members. During this meeting, there were more interruptions as they were assigning roles and coordinating schedules during patient discussion instead of the end. Also, it was hard to know whether someone was done speaking when they didn't immediately mute themselves.

Learner Participation: **YES** NO

Notes: The learners were able to present their patient cases, even the SW student. They are also getting better at being concise with their sharing.

Structure/Organized: YES **NO**

Notes: The meeting went over time because of the amount spent on the bereavement in the first part of the meeting, but it was worth it. The team seems to appreciate the bereavement time so maybe having it scheduled regularly with structure and efficiency.

Average time spent per patient: 2-5 minutes

Date/day: 2/9/2022 Wednesday (Shorter Rounds)

Start Time: 09:01

End Time: 09:28

Leader/Timekeeper: Melissa

Participants: # of healthcare professionals

Attending Physicians	2
Advance Practice Providers (APPs)	1
Fellows	0
Social Worker/Spiritual Care	2/1
RNs	0
Medical Residents	0
Pharmacy	1
Others (students)	4

Interruptions/Rushing others tally: 0

New consults/key patients: 4

Content of discussion: The meeting started with new patients/consults and key patients, then family meetings. At 9:11, the team began assigning patients, and at 9:16, the team started coordinating the visits.

Interdisciplinary discussion: **YES** NO

Learner Participation: **YES** NO

Notes: After discussing key patients, the learners, SW, spiritual care, and the providers stayed to collaborate and coordinate their day. Each student paired up with a provider to see patients. No learner didactics occurred.

Structure/Organized: **YES** NO

Notes: The facilitator had to leave the rounds early to start seeing patients as she has commitments in the afternoon, but the rest of the team took turns discussing the patients they would see.

Average time spent per patient: 2-3 minutes

Appendix K: Palliative Care Rounding Guide for Zoom Meetings

Meeting Objectives:

1. Discuss palliative care patients (new consults, new patients, key patients, family meetings, other patients on the list)
2. Encourage and support interdisciplinary communication and collaboration
2. Assign responsibilities
3. Address issues and concerns
4. Remember the lives of those who passed (bereavement)
5. Attend to the well-being of each other
6. Promote learners' participation (case presentation, didactics on Wednesday)

Ground Rules:

1. Be punctual and come prepared
2. Listen actively and avoid interrupting
3. Keep an open mind and respect other's opinion
4. Share with purpose and be concise
5. Let everyone contribute and participate

Monday through Friday (except Wednesday)

Time: 9:00 - 10:00 AM

Meeting Agenda

1. Housekeeping (5-7 minutes)
 - a. If a new person is joining, the facilitator will start the introductions, and the rest of the team can introduce themselves. (Every new person joining the rounds should be provided with the rounding tool)
 - b. Announcements, concerns, and check-ins
2. Patient Discussion: Present patient by stating their name, age, primary diagnosis, the reason for consult or palliative care involvement, palliative care issue to address or being addressed, then ask specific team members for their thoughts or support as needed. If the patient is stable or there are no updates, the provider caring for the patient will affirm that they are following the case without discussing the patient. (30-40 minutes)
 - a. New consults and new patients
 - b. Key Patients
 - c. Family Meetings
 - d. All the other patients on the list
3. Assigning role and coordinating care (5-7 minutes)
4. Bereavement (Every Tuesday and Thursday) (5-7 minutes)
 - If this is not feasible, set a schedule that works for the team

Wednesday

Time: 9:00 - 10:00 AM

Meeting Agenda**1. Housekeeping (5-7 minutes)**

a. If a new person is joining, the facilitator will start the introductions, and the rest of the team can introduce themselves. (Every new person joining the rounds should be provided with the rounding tool)

b. Announcements, concerns, and check-ins

2. Patient Discussion: Present patient by stating their name, age, primary diagnosis, the reason for consult or palliative care involvement, palliative care issue to address or being addressed, then ask specific team members for their thoughts or support as needed. If the patient is stable or there are no updates, the provider caring for the patient will affirm that they are following the case without discussing the patient. (10-15 minutes)

a. New consults and new patients

b. Key Patients

c. Family Meetings

3. Assigning role and coordinating care (5-7 minutes)

4. Learner Didactics (Each learner will choose a topic that they would like to talk about or a topic they are interested in that the team members can present – assign or have a volunteer/s who can connect with the learners to discuss topics of interest for the didactics early on their rotation) (10-15 minutes)