Nurses Participate in Presenting Patients in Morning Rounds

The first test of change was more complex than was anticipated.

This is the third in a series of articles from Massachusetts General Hospital in Boston describing one general medical unit's experiences with Transforming Care at the Bedside (TCAB). An initiative begun by the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Improvement, TCAB was developed as a way to improve care on medical–surgical units, patients' and family members' experience of care, and teamwork among care team members, and to increase the satisfaction and retention of nurses. The TCAB philosophy engages all care leaders but empowers bedside nurses to generate ideas and solutions for change. Mass General is one of 68 hospitals participating in a two-year TCAB initiative led by the American Organization of Nurse Executives and funded by a grant from the RWJF. For more information on TCAB, go to www.rwjf.org/pr/product.jsp?id=31512.

As part of our involvement in Transforming Care at the Bedside (TCAB), all of the staff members who work on our unit—White 10, a 20-bed general medical unit at Massachusetts General Hospital—participated in a retreat to brainstorm ways to optimize care delivery. (See "Implementing TCAB on White 10," October.) One idea was to have nurses participate in presenting their patients in morning rounds, and as a group we selected that as our first test of change. As it turned out, what we initially thought would be a fairly straightforward change was considerably more complex than we'd anticipated. To accomplish this seemingly modest goal, we inadvertently launched a major shift in our unit's culture.

The idea of nurses participating more fully—in fact, *initiating* the presentation of the patient—first arose at the TCAB retreat as part of a discussion about our frustration with what we call "green books." Although the hospital is in the process of transitioning to an electronic medical record system, some patient information, including vital sign flow sheets and medication administration records, continues to be recorded manually in a three-ring binder—the green book—that's usually kept at the patient's bedside. Green books are in high demand from all members of the care team, particularly during morning shift change. For example, nurses use the books when giving report, which usually occurs between 7 and 7:30 AM. Interns also need the books when they visit patients (usually between 6 and 7:30 AM) and gather vital signs and intake and output data. At the same time, patient care associates and operations associates (unit secretaries) need the books to document vital signs and blood glucose values and transcribe new orders.

Although our initial goal—when we planned the strategy—had been to minimize competition for the green book, it quickly became clear at the retreat that the best way to accomplish this was to give nurses an active role in presenting the patient during rounds, summarizing the patient's condition during the preceding 24 hours. The existing procedure for conducting rounds on White 10 was not highly interdisciplinary, and critical nursing input was not provided consistently: the intern would present the data to the care team, including physicians and the patient's nurse; although the nurse attended rounds, she or he typically played a less active role, listening as the intern presented the patient. The nurse might interject information about changes in the patient's vital signs since they were last recorded or let the physician know that new medical orders needed to be written (for example, to discontinue an indwelling urinary catheter and consult physical therapy in preparation for discharge). The team would sometimes ask whether there were questions from nursing, but the care plan had already been developed and, often, they were anxious to move on.

We hypothesized that shifting the responsibility for initiating rounds to nursing would decrease the interns' need for the green book prior to rounds and, at the same time, allow nurses to contribute more consistently to patient care. So in setting out to address a universal source of frustration—access to the green books during busy periods—we created an opportunity to introduce a fundamentally new practice to our unit and even elevate the role of the nurse and enhance patient care.

Planning for the change. We did some initial planning for this test of change during our TCAB retreat in the summer of 2007, but the more detailed planning occurred at the next two "TCAB Tuesday" meetings. People from other hospitals that had participated in the TCAB initiative said that they'd found weekly TCAB meetings to be very beneficial because they set up an expectation among staff members that the work would continue and there would be regular opportunities for discussion of a project. Hour-long TCAB Tuesday meetings helped ensure that projects continued to move forward. The unit-based clinical nurse specialist and I facilitated these meetings, but the nurses themselves led the discussions and planning. Together, we decided which data nurses would present during rounds and the order of presentation, developed a reference card for nurses to carry when learning the new process, planned the communication about the new collaborative process to the physician team, set a proposed timeline for the pilot test of the new procedure, and developed a few open-ended questions to evaluate the change.

We predicted that, if the change proved successful, nurses would assume a more active role in rounds; nurse–physician collaboration around the plan of care would increase; the physician team would have more complete information about the patient's condition; and the green books would be more accessible to non-physician staff because the physicians would no longer need them before rounds.

With our plan in hand, I met with the attending physician then assigned to the unit and explained the background of the TCAB initiative and what we had accomplished at our retreats. I expressed the nurses' interest in collecting, synthesizing, and presenting the vital signs and other data to the team—in place of the intern—and emphasized the potential benefits: the reduction in the time interns spend looking for the green books in the morning and the inclusion of the nurse's perspectives on and familiarity with the patient in the care plan. She was interested. Together, we talked about the content and ordering of the data to be presented, and we were ready to begin a trial.

Courtesy of Amanda L. Stefancyk

RN Natacha Nortelus presents a clinical snapshot of a patient during morning rounds on White 10.

Day 1: testing the change. Clinicians who had participated in TCAB at other hospitals suggested starting with a simple change that was sure to work, saying that an "easy win" would boost staff confidence. Following this advice, and in keeping with the TCAB principle of small tests of change, we conducted a trial of the new process with only two nurses—a simple strategy that couldn't miss. Or so we thought: within 30 minutes we could see that, with only two of eight nurses presenting patients, physicians were confused and skepticism was mounting. Rounds lasted a little longer than usual that day. I remember asking myself later that morning, "Why did we *ever* start with *this* test?" The formal TCAB initiative was supposed to last two years—was it going to be like *this* every day?

Day 2: adapting the change. The following day, we adapted our test so that all nurses on the unit presented their patients. Although things did go more smoothly, it was still a big adjustment for the nurses. Two days earlier, they had been engaged in a lot of listening during morning rounds; now they were initiating the dialogue: "Mr. S. in room 22A: temp 98.6; blood pressure 105 to 118 over 59 to 66; heart rate 78 to 90, normal sinus rhythm; respiratory rate 18 to 22; oxygen saturation 95% to 98% on 2 L nasal cannula; intake and output. . . ." Despite the bumpy start—and

Table 1. Implementing Rapid Change Using the Plan–Do–Study–Act Model

Steps	Definition	White 10 plans, results, and modifications
PLAN the test or observation, including a plan for collecting data.	• State the test's objective. • Predict what will happen and why.	• Objective: to formalize a role for the nurse in morning rounds. • Decide what patient information is to be presented. • Discuss with and obtain buy-in from the physician group. • Design evaluation and feedback questions. • Predictions: more active RN participation, improved nurse–physician collaboration.
DO: try out the test on a small scale.	• Carry out the test. • Document problems and unexpected observations. • Begin analysis of the data.	• Start the test of change with two nurses, then include more. • This plan caused confusion; it would've been better to have all nurses presenting on Day 1. • Solicit feedback from nurses and physicians.
STUDY the data and study the results.	• Complete the analysis of the data. • Compare the data with the predictions. • Summarize and reflect on what was learned.	• RNs said they had more of a voice and that the change provided physicians a better view of nursing's contribution. • Physicians said rounds were more meaningful with RN input. • Nurse–physician collaboration appeared improved. • Predictions were accurate.
ACT: refine the change, based on what was learned from the test.	• Determine what modifications should be made. • Prepare a plan for the next test.	• The types of data to be presented by RNs were modified. • The physicians suggested nurses present current medications. • Speed of presentations and RNs' comfort with them are increasing each day. • A plan is needed for continuing the process when the physician team changes each month.

Editor's note: For more on the Plan–Do–Study–Act (PDSA) cycle and how it functions in the Model for Improvement promulgated by the Institute for Healthcare Improvement, see www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove and Langley GJ, et al., editors. The improvement guide: a practical approach to enhancing organizational performance. San Francisco: Jossey-Bass Publishers; 1996.

with a lot of encouragement—the nurses adapted quickly.

Evaluating the change. After three weeks it was time to evaluate our efforts with informal, open-ended queries to both nurses and physicians, and the feedback was overwhelmingly positive. One nurse said, "I feel like we have more of a voice during rounding now . . . and I think it gives the team of doctors a better view of nursing care. . . . It also allows us to be incorporated as part of the team." Physicians said, "Are there any plans to spread this approach to other medical units?" and "I think the new approach is excellent. Having just spent two weeks on a medical unit where nurses do not present the patient, I have to say the rounds are much less meaningful—blood pressures and finger sticks are many hours old and less pertinent when hastily gathered by a hurried intern at 6 AM." and "Overall, I liked this system. The nurses know the details of the data, such as whether a blood glucose test was truly fasting and the timing of blood pressure readings and medications, and it's helpful in general to have input on the other issues that come up."

So what began with a seemingly small test ended up challenging the status quo. Based on my own observations and feedback from the staff, I can say that nurses began to have more of a voice, collaborate better with physicians, and exude greater confidence.

Then, four weeks into the new rounds process, it was time for a new medical team to rotate onto the unit. And with them came a new set of challenges and lessons to be learned. ▼

Were we able to continue on course with the changes we initiated? Next month I'll let you know how the nurses on White 10 and our new rounds structure fared.

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