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Interdisciplinary Rounds

The Key to Communication, Collaboration, and Agreement on Plan of Care

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ABSTRACT

Purpose/Objectives: In the era of Pay for Performance, multiple auditing entities, and shorter length of stays, Interdisciplinary Rounds are the future of hospital care. This article seeks to take a broad look at this tool in its current and historical perspective and examine how it can provide a stable foundation for improved physician–nurse communication, agreement on the plan of care, successful care transitions, and improvements in quality metrics, and reduced length of stay. These rounds reflect the changing attitudes of nurses and physicians toward a more collaborative cooperation, and teamwork, in the delivery of patient care. When supported by strong, visible leadership, they can transform not only direct patient care, but the perception of that care by the patient, families, and caregivers.

Primary Practice Setting: Acute care hospitals.

Findings and Conclusions: Properly executed, Interdisciplinary Rounds improve communication among the health care team and provide a basis for agreement upon the plan of care.

Implications for Case Management: Case management is a logical and frequent choice for a leadership role in Interdisciplinary Rounds. Creating a sustainable culture that drives improved clinical care delivery and reduces readmissions and length of stay requires efforts to ensure clear, concise care transitions. With hospitalist programs and nursing care shifts spanning 12 hr, and several days' off between work days, case management continues to be one of the few constant members of the health care team—often with more knowledge of the episode of care than even the current attending physician. Embracing rounds is a change for the better.

Key words: *case management, communication, discharge planning, interdisciplinary rounds, multidisciplinary rounds, nurse–physician communication, rounds, teamwork*

Interdisciplinary Rounds (IDRs), Multidisciplinary Rounds (MDR), bed huddle, and patient safety rounds are all names given to a structured gathering of health care teams whose membership comprises several different disciplines: physicians, nursing, case management, social work, quality, pharmacy, and other ancillary services. The deliverable for the group is to concisely discuss each patient, his or her goals for the day, and for the stay, and to offer individual expertise, and ensure that care is delivered in a concerted fashion. Many organizations have found that this tool reduces readmissions and mortality rate, shortens length of stay, improves quality metrics, and increases satisfaction in all team members (O'Mahony, Mazur, Chaney, & Wang, 2007).

Although the concept is not new and IDRs are an acknowledged effective intervention, there can be challenges in deploying IDRs that, if not overcome, can prevent successful and sustainable change. Interdisciplinary Rounds can be the foundation for shifts in patient care quality, but poor execution of vision, training, roll-out, structure, and monitoring can render them ineffective, and create a disorganized approach that is difficult to get back on track. There are key action steps that lead to and sustain successful IDRs. Cultivating an environment in which IDRs can flourish and achieve their potential requires clear purpose identification: strong and consistent leadership; training; structured discussion; active participation of core members; measurement of team performance; and selected metrics. Case management can play a vital role in supporting and driving these efforts.

A Clear Purpose

For IDRs to improve communication, and subsequently impact quality metrics, all participants

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need to share a clear purpose. Ensuring a clear understanding of the intent, and creating "buy-in" of the whole team is crucial if sustainable, efficient, and effective IDRs are the goal. Interdisciplinary Rounds can provide a forum in which to build a team of health care professionals that is focused on efficient, collaborative, cost-effective delivery of safe care transitions, and evidence-based, quality-driven, patient care. A high-functioning patient care delivery team will improve the communication between disciplines.

Properly deployed, IDRs can help the nurse facilitator identify the need for task shifting and the case manager prioritize service delivery to facilitate care transitions. Other disciplines will also benefit from the overall picture of the total care that will need to be delivered to the entire unit of patients. This concept is pivotal; not only are IDRs designed to ensure collaboration and communication among the health care team, but they provide a foundation for the greater purpose of the delivery of care to the entire cohort of patients for which the collective group is responsible. Establishing that the primary focus is the safe transition of the patient through the episode of care helps orient the team and foster an environment where everyone is working toward the same goals.

It is important to foster an atmosphere where the "team goals, aligned with what is best for the patient, are more important than an individual's goals" (Weller, Boyd, & Cumin 2014, p. 149). This helps define the purpose of rounds and build a sense of collaboration. Case management can assist other disciplines in gaining this sense of collaboration as the work of the case manager crosses all disciplines and is a natural contact point for internal and external collaboration.

Be purposeful about sharing the message that IDRs are patient and team focused, aligning the organization with the delivery of patient care. Take advantage of general workplace gathering places like the cafeteria, break rooms, newsletters, and other forums. Inform organizationally—the more heavily promoted the more likely IDRs are to become, and remain, hardwired. Consider direct messaging to medical staff and hospital employees alike. Running banners as screen savers, and posting in dictation areas, and staff lounges are also effective ways to get the message out. Promoting at the whole house' level sends a clear message that leadership is invested and makes IDR an organizational activity rather than a nursing or case management activity. Interdisciplinary Rounds are a best practice that the entire organization should be proud to be engaged in. It is an undertaking proven to reduce patient harm, improve staff satisfaction, and enhance communication throughout the entire team.

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Team Selection

Delivery of modern health care takes the entire team, and working within teams can be challenging, especially interdisciplinary teams. Be cognizant of the varying degree of education, interpersonal skills, and expertise that will exist in the clinical teams. While there is no ideal team roster, there is agreement that the direct care team (the medical provider, nursing, pharmacy, therapies, and case management) be core members. The need for communication and agreement on the plan of care is essential in this group, and they should form the foundation of the team.

Often, case management will be the only discipline that can provide a consistent individual to participate in rounds--primarily because of extended shift hours common in nursing. Depending upon the culture of the organization, this consistent presence may drive assignment of the clinical facilitator role to a geographically assigned case manager. This may pose some issues in terms of coaching and mentoring nursing staff but can be effective in facilities where there is no designated "charge nurse," or where that individual has patient care responsibilities as well as administrative duties. Either way, case management brings a broad view of the patient, the care plan, and transition needs to the table in an overarching way that other disciplines cannot.

Team member selection may be based upon the availability of the discipline and how frequently they interact with the direct care team. The larger the facility the more challenging it will be to pull together representatives from more disciplines than the core group. As an example, physical therapy is likely to have a greater presence on an orthopedic floor than respiratory therapy while there may be a greater need for the presence of respiratory therapy in the intensive care unit. Intelligent selection and development of the team membership will be rewarded with greater success (see Table 1 for suggested mandatory and optional IDR team members).

Gain consensus on role definitions and responsibilities in a prelaunch, planning subcommittee. The subcommittee must have the authority to outline responsibilities and not be undermined by any single discipline. The roles for each of the disciplines should

TABLE 1
IDR Team Member Matrix

IDR Team Matrix	
Mandatory	Optional
Clinical facilitator/charge RN	Pharmacy
Hospitalist	Infection control
Bedside RN	Therapy/rehabilitation
Case management	Dietary
Social work	Wound care
Quality improvement	

Note. RN = registered nurse.

be defined and transparent. Include a representative from each discipline that will be represented during IDRs. Clinical discussion must be such that all members are respected for their expertise and all bring valuable information to the table. Interdisciplinary Rounds are a team effort, not a one-discipline show. This will be most challenging for the physician or mid-level in the team who will be expected to help coach other staff that may need support with critical thinking skills and empowerment.

Leadership

No innovation is successful without leadership, and instituting IDRs are no exception. Leadership by both an executive champion and a clinical team facilitator is integral to effective IDRs. Weak, unwilling, or unsupportive leadership results in poor outcomes. Leadership behavior is defined as "the process of influencing others to understand and agree about what needs to be done and how to do it, and facilitating individual and collective efforts to accomplish shared objectives" (Ten Have, Nap, & Tulleken, 2013, p. 1800).

Begin by identifying an executive champion who is invested in the outcomes that will be driven by the adoption of IDRs. This ties the success of IDRs to metrics and allows the organization (and the executive champion) to track and celebrate successes. Although clinical in nature, the results will impact metrics used in calculations for reimbursements and other information that is publically reported. Quality metrics such as those impacting Value-Based Purchasing—Healthcare Acquired Infections and Conditions (HAI and HAC), Patient Falls, Decubitus Ulcers—and other financial drivers are more of a concern to health care organizations than the clinical team realizes, and yet the clinical team is fundamentally in control of those outcomes. The executive champion can demonstrate support through encouraging and attending training, as well as ensuring an avenue to communicate the successes in terms of financial and quality impact to the organization.

The clinical facilitator must also bring strong leadership skills. There are several options for clinical leadership and the discipline selected may vary on each nursing unit. For example, a facility that has an intensivist program may opt to have this provider drive rounds in the ICU. Nursing may be an optimal choice for a telemetry unit, while case management may lead rounds in rehabilitation and other areas where significant discharge to postacute vendors is frequent. Often, case management is the optimal choice for this leadership position for several reasons—consistency, broad knowledge of transition plans, payers, and available benefits to meet the next level of care. Regardless of position, or the leaders training and discipline, he or she sets the tone and establishes the atmosphere in which the team executes the discussion of each patient. This role is responsible to actively lead the rounds, encouraging participation, and eliciting information when missing, to ensure that a complete picture of the patient is present for the team to reach agreement on the plan of care. "Failure to ensure a common understanding regarding the purpose of rounds along with ambiguity about who will assume the leadership role may lead to confusion and frustration amongst team members" (Walton & Steinert, 2010, p. 551).

Observation of IDRs by supervising staff such as nurse managers or case management directors will assist in identifying knowledge deficit and provide opportunity for coaching, and mentoring, for all disciplines. Understanding the differing roles of the team allows the clinical facilitator leader to recognize a need for assistance with "task overload" and provides opportunity to redistribute tasks or provide assistance as needed (Weller et al., 2014). Both case management and nursing have this knowledge base and can serve equally well.

The clinical facilitator is responsible for the quality of the teamwork and collaboration that is driven by IDRs. Achieving a high level of collaboration and communication is the goal. Significant study and research have been done regarding IDRs by a

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group from Northwestern University, in Chicago, IL. Leading this group is Dr. Kevin O'Leary from the Department of Hospital Medicine. One aspect of the research included assessing the attitudes and barriers to teamwork on nursing units. "If nurses perceive collaboration as poor, they may be reluctant to express concerns to physicians" (O'Leary, Ritter, et al., 2010, p. 117). It is in the purview of the leader to foster an atmosphere of collaboration, encouraging open discussion of patient goals, designed to reach agreement on the plan of care. In addition, the research identified that "physicians may not appreciate that there is suboptimal communication and therefore may not elicit additional information about their patients" (O'Leary, Ritter, et al., 2010, p. 117). This is one of the primary challenges the facilitator will have.

The key players—physicians and nurses—have very disparate views of communication. This, sometimes dysfunctional communication, has been identified as one of the leading causes of patient harm. According to O'Leary, Thompson, et al. (2010), "A Joint Commission study of 3548 sentinel events reported from 1995 to 2005 indicated communication failures were the root cause for two-thirds of them" (p. 195). Structured IDRs can improve communication and agreement on the plan of care among the health care team—especially between the key players, nurses, and physicians. Research shows that there is often disagreement on the plan of care, and that nurses and physicians do not consistently communicate (O'Leary, Boudreau, Creden, Slade, & Williams, 2012). Strong leadership and IDR advocacy keep a team focused and achieve the desired result of improving communication and collaboration among the team members.

Training

For an institution to prepare for rounds, it is important to adequately train the participants. Training will be required for both clinical leaders and team members. Once clinical leaders are selected (or decided by virtue of their position), train them for their leadership role. Case managers selected for the clinical facilitator role may require specific guidance on coaching direct care nursing staff. An organization may also opt to develop a method of communicating knowledge deficit to nursing management so they can provide coaching.

In a study designed to measure the effect training had on leadership skills during IDR in the intensive care unit, Ten Have, Nap, & Tulleken (2013) determined that specific leadership training had a positive effect on the quality and outcomes of the rounds. Invest in the training of these leaders using teach-back methodology and role playing. Training will prepare these team members to manage group focus and minimize interpersonal conflict.

Take the time to properly "roll out" training–-promoting IDRs to all clinical staff—including the medical staff. Consider a whole-house approach to the rounds. This helps the organization "hard wire" IDRs and makes sustainability easier, as well as passes the same message to a larger group of people. The venue is less important than the actual training. Training can take place in large or small groups but remember—the more people trained at the same time the more that hear the same message.

Provide access to multiple training sessions throughout the day so all shifts can attend. Making training mandatory for all direct patient care staff demonstrates a commitment by administration to the success of IDRs. Be sure to incorporate training into orientation programs either live or video. Provide a "coach" or mentor for the new direct care staff during rounds as part of their on-boarding. Performance and participation in IDR are a precursor to positively impact patient care.

Structure and Tools

Improving communication, and collaboration, requires a standard data set and discussion sequence. Several studies have looked at the importance of structure in effective IDRs. This structure refers to not only the logistics—time, place, and attendees—but structured communication covering elements of patient care that are essential to care planning. It is important to keep to the agreed-upon structure. Diversion from this structure can undermine the intent and focus of the rounds. Interdisciplinary Rounds are a concise sharing of current patient status and response to treatment. Side bar conversations should be avoided and managed by the clinical facilitator.

Rounds can be held at the bedside, or in a separate area with, or without, patient and family attendance. The population of the nursing unit will help the IDR subcommittee determine which type of rounds will best achieve the primary focus and goal. Each format, bedside or centralized, has pros and cons. What is known is that localization of the physician to the nursing unit improves communication among team members and supports agreement on the plan of care. Specifically, localization of physicians allows for improved understanding of planned examinations, and tests, and length of stay, as well as supporting positive team dynamics.

Bedside Rounds

Bedside rounds originally were teaching rounds, driven by the physician leader and involving residents,

and interns, and are still useful in today's health care environment. These rounds are used to further medical education and require much preparation by the presenters. Typically, the resident or intern has reviewed the care of the patient, the medical record, and often has examined the patient before rounds begin, and then provides a comprehensive report for the attending physician. The attending physician then clarifies, corrects, and offers direction as needed.

Bedside rounds may also be primarily discharge planning rounds and can be attended by the entire team, including the physician, or solely nursing and case management. This format works well in the family-centered care model popular in pediatric units and children's hospitals. "A central principle of family-centered care is transparency and effective communication between the medical team and the patient and family to promote information sharing and active collaboration in medical decision making" (Subramony, Schwartz, & Hametz, 2012, p. 730). Bedside rounds are becoming increasingly visible, and preferred, in pediatric settings where the patient and his or her family are present. According to Priest, Bereknyei, Hooper, and Braddock (2010), there is a "weak preference by patients and families for bedside rounds due to increased time with the physician and a better understanding of the care provided" (p. 2). Both families and medical care providers believe that the increase in communication is one of the prime reasons these "Family Centered Rounds" are useful.

These rounds at the bedside focus a great deal on discharge planning, helping the family be aware of pending discharges and better understand the medical plan. Key in these rounds is ensuring that the family, or caregiver, understands the discharge medications, the day of discharge, and specific discharge goals. In fact, "studies in adult populations have documented high rates of preventable adverse events that occur after hospital discharge because of medication errors; hence, preparing patients for hospital discharge by reviewing all medications has become a prime intervention point for decreasing poor outcomes" (Subramony et al., 2012, p. 51).

The very nature of bedside rounds requires more time than the 1–2 min per patient that can be achieved in a centralized setting such as a conference room. Communicating team decisions occurs during bedside rounds. In fact, a major dissatisfier for patients and families with bedside rounds is the lack of understanding of medical terminology when the medical team does not speak in laymen's terms.

The logistics of nursing assignments will also be a challenge in deployment of bedside rounds if nursing is expected to attend without significant disruption to the entire unit. Hospitals that make nursing care assignments based upon acuity may find bedside rounds more taxing, as patients may not be closely geographically located. The impact is less in institutions that assign patients by consecutive room numbers. Moving rounds from one room to the next provides minimal disruption for the nursing staff if nurse's patients are next to each other. The need to move from one side of the unit to another can be quite disruptive, take more time, and can certainly foster an atmosphere of disorganization.

The timing of the rounds themselves will also need to be considered if physicians are expected to be prepared to discuss current and future care plans with the patient and family present. It is unrealistic to expect a physician to be present at the bedside and to have a discussion about medical conditions and treatments without advance preparation. Size and focus of the nursing unit will play a role in selecting the optimum time to hold rounds. Medication passes, patient care, visiting hours, staff breaks, and lunches must be considered when planning for a new daily activity for the nursing unit.

Centralized Rounds

There is much to support IDRs taking place in a centralized location-–usually the nursing unit-–in a conference or break room. Centralized rounds require follow-up with the family and the patient to ensure understanding of the care plan, discharge plan, and instructions, but can be more expediently performed. Information can be quickly transmitted, and plans made without the need to "translate" for the patent and family, and there is no loss of time traveling between patient rooms. The potential obstacle of nongeographical nursing assignment is overcome as each nurse can discuss all of their patients at once, not remaining with the entire team during a progression through the nursing unit. In centralized rounds, the team gathers at a designated place and time with each nurse aware of their presentation time, so a smooth rotation can occur.

Another important factor that must be considered when determining the location of rounds-–centralized or bedside-–is patient confidentiality. Obviously, private patient rooms will support confidentiality whereas semiprivate, or ward rooms, will not. The problem is not eliminated in centralized rounds if the selected meeting place is more public, like the nurse's station that, by design, allows nursing staff to see and hear patients better. Regardless of location, rounds must be performed with patient confidentiality in mind.

Communication Tools

There is likely to be a variety of personal preferences for discussion content. This will be driven by

the current nursing culture and the physician participants. It is imperative that the team agrees upon what content will be included, or reported, by which discipline. Many facilities find that a nurse review of the past 24 hours of laboratory and diagnostics results, and medication changes, along with key treatments, are key pieces of information that enhance collaboration and agreement upon plan of care between the disciplines. "Collegial relationships are characterized by equal trust, respect and autonomy over patient care" (Tang, Chan, Zhou, & Liaw, 2013, p. 292).

This study has also shown that the use of communication tools has an impact upon rounds. O'Leary, Wayne, et al. (2010) support the use of structured communication tools. In their work at Northwestern Memorial Hospital, in Chicago, they determined that structured communication had "a positive effect on nurses' ratings of collaboration and teamwork on a medical teaching unit" (p. 826). They go on to state: "A growing body of evidence indicates that nurses, rather than physicians, are the members of the team least satisfied with collaboration and teamwork" (p. 830). Because of this, efforts must be made to address discussion content when developing IDRs. Structured communication tools provide a framework for discussion and support team member professionalism and sense of value.

TABLE 2
Quality Metrics Impacted by IDRs

Quality Metrics Impacted By IDRs		Case Management Role	Case Management Standard
Core measures	Pneumonia	Recognition of patient disease process	Facilitation, coordination, and collaboration
	Heart failure	Share information from case management assessment	
	Venous thromboembolism		
	Stroke		
	Tobacco treatment		
	Substance abuse		
	Acute MI		
Hospital Consumer Assessment of Healthcare Providers and Systems survey	Care from the nurses	Patient assessment	Client assessment
	Care from the doctors	Understanding of patients disease process, prognosis, personal desires/outcomes/goals	Planning
	Discharge process	Share knowledge of discharge plan, home needs, discharge needs	Advocacy
	Understanding care after discharge	Obtain orders for needed DME, physical or occupational therapy assessment, O_2 evaluation	Cultural competency
		Provide patient choice	
Hospital-acquired conditions (HAC)	Pressure ulcer stages III & IV	Share knowledge gained from case management assessment, specifically:	Problem or opportunity identification
	Falls and trauma	Health literacy, nutritional status, living situation	Monitoring
	Poor glycemic control		
	DVT following certain orthopedic procedures		
Hospital-acquired infections	Central-line associated infection	Identification of chronic, indwelling, urinary catheters	Client assessment
	Catheter-associated UTI	Identification of previous admissions	
	Clostridium difficile		
	Certain surgical site infections		
Patient safety indicators	Decubitus ulcer	Documentation of poor nutritional status	Client assessment
	Infection	Age	
	Pulmonary emboli/DVT	Baseline mobility	
30-day readmissions	Pneumonia	Identification and assessment of readmission risk	Client selection process
	Heart failure	Admissions within 90 days (POA window)	Client assessment
	Hip replacement	Share risk level and issues, i.e., multiple medications, repeat admissions, end stage disease process etc.	Problem or opportunity identification
	COPD		Outcomes
	Knee replacement		

Note. DME = durable medical equipment; DVT = deep vein thrombosis; MI = myocardial infarction; POA = present on admission; UTI, urinary tract infection.

All of the disciplines represented at IDR contribute valuable information to the overall health care episode outcome, and each should be encouraged to participate at the highest clinical level possible. As IDRs mature, refine the discussion tools with group consensus, to accurately reflect the information each discipline is responsible to contribute for each patient, as appropriate. The scripting of information can range from reporting complex clinical results, and responses to treatment, to basic demographics and administrative data. There are several "Nurse Brain" tools available on the internet that can provide a clear scripting for IDRs or an organization can develop their own tool. Regardless, structured communication in terms of discussion content and flow is essential to successful rounds.

Metrics and Measurement

Several studies indicate that IDRs improve collaboration and teamwork, resulting in improved quality metrics and staff satisfaction (Collins et al., 2014; Dodek & Raboud, 2003; O'Leary et al., 2012; O'Mahony et al., 2007). The metrics that an organization can track will vary. Metrics impacted by improvement in the delivery of care fall into several categories and are typically already collected by the organization. Some organizations may wish to have a profound effect on the health care-acquired infections and will ensure the presence of quality management at rounds to help the teams identify potential red flags that are precursors to health care-acquired infection such as indwelling urinary catheters or central catheters. Some of the metrics that can be tracked are listed in Table 2. A column has been created to depict the role case management plays, the activities undertaken, and the corresponding case management standard in each metric grouping.

Not only are IDRs a fertile ground for improving quality metrics, but measurement extends to the process of the rounds themselves. Identify early who will be responsible to monitor the quality of the IDRs and help the clinical leaders develop action plans to maintain process and focus. Ensure that these individuals are involved with the planning and deployment of the rounds from the beginning. The better understanding those who monitor have of the purpose and goals of IDRs, the more consistent, and accurate, their observations will be. Develop tools to measure, and display, the timeliness, content, and participation in rounds. Create graphics that trend improvement over time to fuel celebration of success. Involve the team in improvement activities that relate to the group process. The more successful the process of rounds, the greater benefit they will drive.

TABLE 3
IDR Assessment Indicators

Clinical	Process
Primary problem/diagnosis	Timeliness of meeting
Last 24 hr of abnormal results	Structure/leadership/facilitation
Services that require hospital level of care	Attendee preparedness
Discharge/transfer needs	Follow-up items identified
Patient/family education	Communication to family and patient
Procedures scheduled that can be done as an outpatient	
Barriers or obstacles to plan of care or discharge	

Equally important is assessing the quality of the rounds themselves. An assessment instrument "provides feedback on the process and aim of the IDRs, namely, to increase the quality of patient care by sharing information, addressing patient problems, and planning and evaluating treatment" (Ten Have, Hagedoorn, et al., 2013, p. 480). Two key areas that need to be addressed during rounds for them to achieve a desirable effectiveness are patient-specific plan of care and process. It is reasonable to develop a tool to assess how well the rounds incorporate these factors during the discussion of each patient. See Table 3 for "IDR Assessment Indicators" for suggested areas that should be addressed, and assessed, during rounds. These indications are not all inclusive but do provide a basic set of indicators for monitoring. Each organization may have specific issues it wishes to track, assess, and report. Consider a simple form with "present or not present" identifiers. This should allow easy translation to a graph that will show opportunity, as well as success, in the elements of successful IDRs.

Documentation

In addition to process, participation, and occurrence of IDRs, organizations should identify key care-related issues that can be included in the treatment or care plan. Although each discipline documents as per their individual scope of responsibility, there must be an overarching documentation of the rounds themselves. There is little in the literature about best practice in documenting IDR efforts other than the use of treatment or nursing care plans in conjunction with daily goals work lists. There is, however, concurrence that documentation must be in the medical record, daily entry is necessary, and documentation must include one to two, patient-specific, goals or medical milestones. The approach necessary to achieve this level of documentation will depend upon the presence of an electronic medical record versus nonelectronic.

The medical record should demonstrate that IDRs occur and the patient is transitioned through the episode of care. This documentation goes hand in hand with clinical pathways or guidelines. Integrate rounds documentation with "bundles," protocols, and pathways for ease of documentation.

A standard, unit-specific, daily worksheet can be developed and may differ from nursing unit to nursing unit. This allows the team to keep track of the care plan and what has been accomplished. This can be either electronic or paper. A paper form can be completed during rounds, passed from shift to shift, and placed in the medical record and the end of 24 hr. An electronic version of the form can also be created with notes added during rounds to document the patient-specific goal. Each discipline may also wish to note any changes to the plan of care in their own assessments as addendums as appropriate. The medical record should demonstrate that IDRs occur and the patient is transitioned through the episode of care. This documentation goes hand in hand with clinical pathways or guidelines. Integrate rounds documentation with "bundles," protocols, and pathways for ease of documentation.

Regardless of the format, there are several recurring themes and actions that your organization can take to ensure adequate documentation of IDRs.

- Produce an organizational umbrella policy that instructs about the rounds, their timing, unit-specific location, discussion content, membership, intent, and monitoring activities;
- Add attendance and participation to the Scope of Practice for each department or discipline; and
- Add IDRs to the Nursing Care Plan for all patients and document in each medical record, every day, occurrence, and changes in care plan based upon rounds.

Implications for Case Management

A great deal of effort has been spent reviewing the intent and deployment of IDRs. There are, however, specific implications for case management. Robust rounds can inform not only for care transitions but for utilization review activities. Properly informed, case management can intervene to reschedule diagnostics based upon the length of stay and clinical acuity. The need for postacute services, and other consults, becomes apparent when the entire care team comes together to share expertise, and provide input, into patient care. Potential delays in care can be eliminated and tasks can be organized. Patterns can be identified, and functions such as the collection of avoidable days, can be enhanced, and that awareness transmitted to the whole team. Active, robust rounds are enhanced with case management involvement and transitions to the next level of care are more fluid, and less stressful, for the patient and caregivers, as well as the treatment team.

The intent of IDRs is to improve communication, enhance patient safety, and ultimately improve care delivery. These are also key steps in successful care transitions.

Conclusion

The intent of IDRs is to improve communication, enhance patient safety, and ultimately improve care delivery. These are also key steps in successful care transitions. With proper deployment, IDRs can elevate the delivery of patient care to a level that increases staff, and patient satisfaction, and drive metrics that support the financial future of the organization. With all direct care providers coming together to review the goals for the patient's episode of care, and agree on what that plan is, the whole team can move the patient to the next level of care effectively. Together, the patient care team can identify issues and create solutions. Being clear in purpose, supporting the distinct role each discipline plays, and promoting a desire to enhance care delivery, IDRs can transform your organization.

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