Getting teams to talk: An Evaluation of Structured Inter-professional Bedside Rounds (SIBR®) in Birth suite


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Research Setting – Monash Health

Pilot: July-Sept 2016

Endorsed by Practice Improvement committee in March 2017.

 Rolled out as process in Clayton Birth Suite in March 2017

Rolled out to Dandenong and Casey Hospital Birth Suites – August 2017.
Methodology

ACTIONS RESEARCH

Spiral
Within a setting
Empower participants
Understand
Data Analysis
Participatory
Process
Provide evidence
Participatory
Practical
Observe
Share

Relevant
Influence policy change
Change
Immediate impact
Having a voice
Address Problems
Goals
ACTION

Qualitative Communication
Questions

Interviews
Influence
Cyclical
Intervention
Enthusiasm
Lewin
Identified Problem

- Disciplines working in silos
- Teamwork loose in the system
- Weak or no “Shared mental model”
- Not partnering patients/women in their care
- Deficiencies in communication and information sharing
- Patient safety
Can we improve teamwork?

From left to right:
Consultant, RMO, Registrar, Midwife, AUM
Aim

To develop a single inclusive process, incorporating the contribution of both professional groups as well as the mother

Promoting a shared understanding of the status of the mother

Unifying the multi-disciplinary plans for subsequent care

SIBR* was created by Dr. Jason Stein of Emory University in Atlanta, Georgia and is a registered trademark of Centripital, Inc.
Structured Interprofessional bedside Rounds (SIBR) in Birth Suite

A process to ensure everyone is on the same page

• Patient based
• Team approach to planning care
• Team meets outside the birth room
• Team (MW & Dr’s) enter birth room together
• The woman/family are members of the team
• Plan of the day is communicated to everyone

Adapted from Clinical Excellence Commission- Insafe hands (www.cec.health.nsw.gov.au)
Mixed Method

• Observation, field notes, questionnaires and interviews were used to elicit the perceived effects of SIBR.

• Pre-pilot surveys were collected from \(n=47\) midwives and \(n=15\) doctors, and post-implementation questionnaires from \(n=29\) midwives and \(n=11\) doctors.

• Semi-structured interviews were collected from \(n=3\) midwives and \(n=2\) doctors immediately after the pilot project.

• This project was approved by Monash Health Human Research Ethics Committee and the Deakin University HREC Ref: 16253L.
## Key findings

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Midwives</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n=47$</td>
<td>$n=15$</td>
</tr>
<tr>
<td></td>
<td>$n=29$</td>
<td>$n=11$</td>
</tr>
<tr>
<td></td>
<td>Baseline</td>
<td>Post SIBR</td>
</tr>
<tr>
<td>Contributions from all members of the health care team are considered when developing the patient management plan</td>
<td>11 % Agreed</td>
<td>78 % Agreed</td>
</tr>
<tr>
<td>All women in birth suite are active participants in their care and are acknowledged as part of the team</td>
<td>15 % Agreed</td>
<td>62 % Agreed</td>
</tr>
<tr>
<td>Members of the clinical team communicate well regarding the care of the woman</td>
<td>15 % Agreed</td>
<td>64 % Agreed</td>
</tr>
<tr>
<td>Midwives are better placed to advocate for a woman and her birth plans</td>
<td>N/A</td>
<td>93 % Agreed</td>
</tr>
</tbody>
</table>
What do you think are the negative features of the current handover and bedside round process?

‘Rounds are unorganised and exclude midwifery assessment majority of the time.’

‘Medical staff proceed to do bedside rounds when midwives are not present.’

‘Unclear communication if midwife was not in attendance in the room regarding plan.’
What do you like most about the new structured team bedside rounds?

Midwife:
‘The opportunity for the whole team to voice concerns and the midwife to take part/ be aware of the plan without needing it communicated through the AUM at a later opportunity.’

Midwife:
‘Opportunity for everyone to discuss plan for care, allows women to understand what is happening and what to expect. Allows opportunity for everyone to have their questions answered.’

Doctor:
‘It requires members of the team to be organised and efficient and engaged to work well. This is something that should be promoted on labour ward in patient care. I also think it’s a good opportunity to clarify questions/concerns that arise in the morning medical/midwifery handover with the midwife actually caring for the woman.’
What do you like most about the new structured team bedside rounds?

MW: ‘Outside the room it is easier to raise concerns with doctors and discuss rationales for care.’

MW: ‘More input from the woman rather than doctors telling them the plan. Need to give pros and cons of induction more and need to consider women’s options and opinions more.’

MW: ‘That the woman’s needs are heard jointly by Midwives and Doctors in the planning of care. It makes future decisions a smoother process. It promotes an effective team environment, adding reassurance to the women that they are receiving the best care.’

DR: ‘The midwife is more involved in making a patient care plan, advocating for the patient, and understanding the medical priorities.’
The Midwife as the Advocate – Including the woman in her care.

**Case example**

‘The midwife is the woman’s voice by in large, the midwife is also the doctors voice, I mean that is part of the role of the midwife’ (Obstetric Registrar).

‘It’s a really obvious opportunity for the woman expectations to be laid out for everybody. I think it’s something we did up to now really poorly. The midwife is the woman’s voice by in large, the midwife is also the doctors voice, I mean that is part of the role of the midwife. The voice between the woman and the medical’ (Obstetric Registrar).

‘I think sometimes the doctors don’t have the time that we spend with the woman one on one. So being able to get from her, ideas on what she wants from her labour and birth and then be able to pass that onto the doctors in a concise way that the doctors have time to listen to is beneficial’ (Snr Midwife).
### Key findings

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<tr>
<td></td>
<td>Baseline</td>
<td>Post SIBR</td>
</tr>
<tr>
<td>Bedside rounds are structured in relation to content and personnel</td>
<td>23 %</td>
<td>90 %</td>
</tr>
<tr>
<td></td>
<td>Agreed</td>
<td>Agreed</td>
</tr>
<tr>
<td>During bedside rounds there is good opportunity for informal learning</td>
<td>26 %</td>
<td>43 %</td>
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<tr>
<td>between members of the inter-professional team</td>
<td>Agreed</td>
<td>Agreed</td>
</tr>
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*Deakin University*

*Monash Health*
Improvements to SIBR going forward

DR- Consultant:
Reiterating the structure, presenting what we are interested in, not just rehashing what we have already gone over five minutes ago. I think it would be good if midwives were encouraged to be more active in the discussion because it still feels like they are giving a sort of cursory handover and waiting for us to tell them what to do. It would be better if they were more proactive.

DR:
Not having to chase midwives down as we move room to room and rounds moving a bit more efficiently.

MW:
More supportive behaviour from senior medical team in regards to them (rounds) occurring, less resistance to midwifery input and assessment.

MW:
Making it consistent, making sure everyone does it. I think once becomes as routine as writing admission notes we will be professional and providing good care. It’s a good tool, its just getting everyone on board using it.

Dr: Encourage midwives to voice their opinions more.
Learning from each other

Midwife:
‘Yes, definitely, sometimes you have complex patients and you don’t really know what’s going on and you feel embarrassed to ask too many questions. Sometimes it’s really nice to listen to doctors talk to each other.’

Midwife:
‘If you were looking after someone and it’s a new experience to you, then definitely yes. We learn without realizing sometimes, we have those discussions and I think you do learn from them (doctors).’

Doctor:
‘If it’s a complicated case, sometimes we find that the midwives don’t have a great understanding of what’s going on.’

Midwife:
‘I think that’s how we all learn. Certainly with the high risk things, listening to discussions, even reflecting afterwards, going back and asking questions as a team makes a big difference to learning.’
Midwife: ‘I think it goes hand in hand with trust. I think they are learning to trust us more and maybe learning to pace things more. I think it's really good for residents, they're always quite willing to learn form us anyway.’

Midwife: ‘One SIBR situation I said, ‘I don’t think it’s a good idea if a lot of people come in...she’s very highly strung and needs a relaxed environment. Then the doctors came in and started talking at a normal level and then I started to talk back in a smooth quiet level and they sort of went ‘oh (whisper) and started talking quietly. So, its little things like that, like learning how to behave around labouring women.’
Conclusion

The main aim or incentive of the study was realised in terms of a team approach, promoting a shared understanding for care and ensuring all team members; including the woman (patient) have the same understanding.

The findings demonstrated evidence to preserve the SIBR process on morning shifts in birth suite. However, the structure and efficiency of team rounds still require improvements.

For the future, the recruitment of a larger cohort of health professionals and the recipients of care would be advised.
The Team Exists For The Woman
It’s all about information sharing