

# Good practices for effective communication: the experience of the interdisciplinary round in orthopedic surgery



*Boas práticas para comunicação efetiva: a experiência do round interdisciplinar em cirurgia ortopédica*

*Buenas prácticas para la comunicación efectiva: la experiencia del round interdisciplinar en cirugía ortopédica*

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## ABSTRACT

**Objective:** To report the experience of interdisciplinary round in care of patients with proximal femoral fractures hospitalized in a surgical unit.

**Method:** Report on the experience of clinical discussion shared by the multiprofessional team in a surgical hospitalization unit of the Hospital de Clínicas de Porto Alegre referred to in orthopedics, from October 2017 to June 2018.

**Results:** Six steps were systematized sequenced to be followed during a weekly with time optimization and patient focus. New approaches were agreed upon based on scientific evidence and multiprofessional vision, with repercussions on prevention of pressure injury, dressing, removal of urethral catheter, nutritional support and early organization of hospital discharge.

**Conclusion:** The implementation of the structured interdisciplinary round has had positive implications for effective communication, reducing risks and failures in the care process, and can be considered good practice with regard to patient safety.

**Keywords:** Interdisciplinary communication. Patient safety. Orthopedics.

## RESUMO

**Objetivo:** relatar a experiência da sistematização de round interdisciplinar no cuidado a pacientes com fratura da extremidade proximal de fêmur internados em unidade cirúrgica.

**Método:** Relato da experiência de discussão clínica compartilhada pela equipe multiprofissional em unidade de internação cirúrgica do Hospital de Clínicas de Porto Alegre, referência em ortopedia, no período de outubro de 2017 até junho de 2018.

**Resultados:** Sistematizou-se seis etapas a serem seguidas sequencialmente durante encontro multiprofissional semanal, com otimização do tempo e foco no paciente. Novas condutas foram acordadas com base em evidências científicas e visão multiprofissional, com repercussões sobre a prevenção de lesão por pressão, realização de curativo, retirada de sonda vesical, suporte nutricional e organização precoce da alta hospitalar.

**Conclusão:** A implementação do round interdisciplinar estruturado trouxe implicações positivas para a comunicação efetiva, reduzindo riscos e falhas nos processos de cuidado, podendo ser considerada boa prática no que tange à segurança do paciente.

**Palavras-chave:** Comunicação interdisciplinar. Segurança do paciente. Ortopedia.

## RESUMEN

**Objetivo:** Relatar la experiencia de la sistematización de round interdisciplinario en el cuidado a pacientes con fractura proximal de fémur internados en unidad quirúrgica.

**Método:** Relato de la experiencia de discusión clínica compartida por el equipo multiprofesional en una unidad de internación quirúrgica del Hospital de Clínicas de Porto Alegre, referencia en ortopedia, en el periodo de octubre de 2017 a junio de 2018.

**Resultados:** Se sistematizaron seis etapas a ser seguidas secuencialmente durante un encuentro semanal con la optimización del tiempo y el foco en el paciente. Los nuevos conductos se acordaron a partir de evidencias científicas y una visión multiprofesional, con repercusiones sobre la prevención de lesión por presión, realización de curativos, retirada de sonda vesical, soporte nutricional y organización precoz del alta hospitalaria.

**Conclusión:** La implementación del round interdisciplinario estructurado trajo implicaciones positivas para la comunicación efectiva, reduciendo riesgos y fallas en los procesos de cuidado, pudiendo ser considerada buena práctica en lo que se refiere a la seguridad del paciente.

**Palabras clave:** Comunicación interdisciplinaria. Seguridad del paciente. Ortopedia.

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## ■ INTRODUCTION

The quality of health services is linked to the safety that health institutions provide to their patients. The development of a safety culture has been a challenge experienced by health professionals in the last decades and this subject has instigated all professional categories to seek improvements to the care practices<sup>(1)</sup>.

In the constant search for safety and for the minimization of damages to patients, advances have been perceived by health managers and workers, as revealed by study<sup>(2)</sup> who also highlighted the role of Brazilian public university hospitals in boosting discussions around patient safety, which shows the concern of managers to provide quality patient care. Despite advances, one of the greatest challenges has been the lack of communication during care of patients in health facilities, generating unwanted injuries, adverse events and even death, which requires solutions with procedural changes and new technologies<sup>(3)</sup>.

Thus, effective communication becomes one of the international goals of patient safety and refers to the shared information that concerns the care provided to the patient, involving the most diverse professionals in the hospital scope. Failure to communicate among health care professionals implies harm to the patient and is characterized by lapse in the care process, lack of integration between the members that attend the patient and incoherence in the behaviors<sup>(4)</sup>.

In this context, the failures in teamwork and communication among health professionals are the main factors that lead to medical errors, adverse events and reduced quality of care provided<sup>(5-7)</sup>. Some researchers say that the way communication between teams is fundamental to ensuring safe health care<sup>(8)</sup>.

Effective communication among health team members occurs when there is eye contact, active listening, confirmation of message comprehension, clear leadership, involvement of all team members, healthy discussions of pertinent information, and the ability to accurately anticipate future problems<sup>(9)</sup>. Studies show that there is a need to develop communication skills training programs for professionals involved in health care, in addition, there are reports that these programs have shown improvement in the performance and communication of the interdisciplinary team<sup>(5-6)</sup>, as well as ensuring more safety in care practices<sup>(7)</sup>.

Investments and advances in information technology have gained prominence in the quest for effective communication, however, they do not replace verbal communication due to rich interactions. In this way, verbal communication continues to be an important tool for sharing

information about patients, conveying urgency and highlighting situational nuances<sup>(10)</sup>.

In this direction, interdisciplinary *rounds* are resources that favor communication between team members<sup>(11)</sup>, since they can reduce the patient's stay in the hospital and improve quality indicators. In order to guarantee the safety in the care provided to patients with proximal femoral fractures (FEPF), in 2017, at the Hospital de Clinicas de Porto Alegre (HCPA), a structured interdisciplinary *round* to discuss the care, treatment and management of patients with proximal femoral fractures.

FEPF is a serious event that affects many elderly people with previous comorbidities and can cause disabling damage, with mortality reaching 30% in the first year. It is known that length of hospital stay, type of surgery, antibiotic use, postoperative physiotherapy, adequate mobilization and nutrition, and surgical wound care may alter the prognosis and mortality rate of these patients<sup>(12)</sup>.

The complexity of FEPF patients' demands requires integration of the care team, as well as the uniformity of information needed for safe care. It is understood that the systematic planning of interdisciplinary actions can be considered a model of good practices in the field of health, especially regarding effective communication. The objective of this article is to report the experience of the interdisciplinary *round* for caring patients with fractures of the proximal end of femur hospitalized in a surgical unit.

## ■ METHOD

This is an experience report of systematized practice for discussion of care for patients with proximal femoral fracture referred to HCPA through the Municipal Health Department. The HCPA is a public and university institution, part of the network of university hospitals of the Ministry of Education (MEC) and academically linked to the Federal University of Rio Grande do Sul (UFRGS).

The interdisciplinary *round* for patients with FEPF started in October 2017, with the diagnosis of FEPF being the criterion of inclusion of patients in the *round*, being excluded those under 18 years old. In the period from October 2017 to June 2018, all inpatients with the mentioned diagnosis ( $n = 34$ ) composed the sample of patients who had their care discussed in interdisciplinary *round*. They were between 45 and 95 years old, 14 men and 20 women. Participants included nurses, physicians (anesthesiologists, orthopedists, clinicians), social worker, nutritionists, pharmacist and physiotherapists. When referred to the HCPA, patients with a proximal femoral fracture are treated by a multidisciplinary team, who is notified of the pa-

patient's hospitalization through instant messages in the free WhatsApp® application, providing a common interface with members in a single group, thus triggering the initial assessments of all professionals involved in the care of this patient. Despite WhatsApp® not being an institutional application, it was consensus among the professionals of your choice to trigger instant contact and easy access. However, cautious use is made of maintaining patient confidentiality, which was shared only by the electronic medical record.

The present study did not use a free and informed consent term because it was not a research with human beings, but rather an experience report based on the perception of some professionals who were involved in the systematization of the interdisciplinary *round*.

## ■ RESULTS AND DISCUSSION

The present report of the experience of the systematization of interdisciplinary *round* in care in patients with FEFP hospitalized in a surgical unit will be presented through the systematic description used to perform the *round*> (change implemented in the work process) and, subsequently, the perceived impacts on the assistance (observed results).

### The systematization of the Interdisciplinary Round: the change in the process

In the model of assistance prior to *round* a technical discussion took place at the patient's bedside, only between the preceptors and the residents of the orthopedic surgery of this hospital. However, considering that FEFP represent problems with a high cost of treatment, a high mortality rate and greater involvement of the elderly with comorbidities<sup>(12-13)</sup>, patients often became potentially serious. The previous model, centered on the physician, made impossible the conclusive or satisfactory answers to many problems that arose during the hospitalization, mainly associated with the social, cultural and / or subjective components that accompany to a greater or lesser degree the process of illness.

Considering the situation of preventable situations in the evolution of the cadres, it was noticed the need to structure an interdisciplinary *round* with weekly discussion of extended characteristics in assistance aspects, with optimization of the time and focus on the patient. To this end, the multiprofessional team constructed a sequence of six steps to be followed in the team meetings: (1) Brief presentation of team members; (2) Review of the clinical case and results of exams: medical staff (orthopedic surgeon, clinical

doctor and anesthesiologist) reports the case, reports of exams, expected surgery and discharge date; (3) Updating of the recent clinical condition: nurses present the vital signs of the last hours and changes (if any), risks of fall and pressure injury, among other nursing care provided to these patients; (4) Review of safety items: nurse addresses the time of permanence or need for use of bladder catheter delay, use of central venous catheter; Clinical pharmacist addresses drug therapy, drug reconciliation, adequacy of prescription to institutional protocols, such as venous thromboembolism prophylaxis, prevention of infections in surgical patients, oral anticoagulation and pain in adults; (5) Treatment plan: multiprofessional team informs the evolution of the patient and their treatment plans; Physiotherapist describes about mobility and ambulation; Social worker reports family situation and organization for discharge; Nutritionist presents data on dietary acceptance and diet offered; (6) Definitions: physician summarizes the care plan, confirming the actions defined jointly by the team.

As predicted in the time distribution, it was estimated that the *round* had a duration of 4 minutes per patient. However, in the experience the mean time was 10 minutes, which may be related to the large number of comorbidities and relevant information to be discussed. During all *rounds* the participants were able to express their views, thus building a shared assistance plan and defining the best conduits for the unique need of each case.

Australian study<sup>(14)</sup> indicates that although the *rounds* were originally designed as a means of educating medical students, today its use aims to support clinical practice. The study emphasizes that in *rounds* the process of communication between the multiprofessional team has as central subject the patient and the priorities are defined together.

### Effective communication as good practice in health care: observed results

The experience with interdisciplinary *rounds* provided the sharing of information and experiences from day to day, enabling a participatory process. In this context, effective communication aims at solving, in a team, problems of various aspects that may arise during hospitalization.

The profile of patients with femoral fracture associated with immobility caused by trauma predisposes to the development of pressure lesions<sup>(13)</sup>. From this, several prevention measures for pressure injury in these patients were discussed during the *round*. One example is the use of an airflow mattress, which was contraindicated in the institution for patients with FEFP and became a procedure instituted after reviewing the scientific literature instigated by

the *round*, evidencing that there was no evidence of contraindication to its use.

Thus, effective communication has triggered the need to incorporate evidence-based practices. The use of evidence was highlighted in a previous study as a strategy that, together with the removal of barriers and opportunities, promotes patient safety. The same is true of the assertion that tacit knowledge, experience, values and skills in developing actions that prioritize patient safety constitute a different kind of evidence, with a strong influence on decision making for the patient. care management planning<sup>(4)</sup>.

The curative exchange routine was also discussed during the interdisciplinary *round*, and after communication between the professionals and routine alignment, it was agreed the need of exchange in case of drainage, considering the risk of infection, which previously did not occur, because the exchange was released only after 48 hours post-operatively. All nursing staff was informed by e-mail and in the passages on call about the new routine established after the systematization of the interdisciplinary *round*, which until then was kept under restriction of medical conduct.

The low food intake was identified in elderly patients, knowing the importance of adequate caloric intake in the recovery of patients with FEPF submitted to surgical intervention, the need for nasoenteral catheterization was considered in some cases. After discussion of the team in *round*, and a review of the literature, it was decided not to institute early nasoenteric catheterization because there was no evidence to justify early intervention, opting for conservative management and daily food intake and dietary adjustments were evaluated, allowing a high without use of probe<sup>(15)</sup>.

Another change of conduct promoted by effective communication through the interdisciplinary *round* approach refers to the length of time the bladder catheter is delayed. In the surgical procedure, the patient with FEPF needs a bladder catheter of delay and, traditionally, after discharge from the recovery room, the moment of withdrawal of this probe was defined. In order to reduce the length of stay and, consequently, the risk of infection, it was defined in the *round* that the early withdrawal of the bladder catheter from delay, still on discharge from the recovery room, after medical evaluation<sup>(16)</sup>.

The hospital discharge planning of patients with FEPF also received increments from the systematization of interdisciplinary *round*, and it was instigated that each member of the multiprofessional team evaluated individually and in advance the clinical demands and social needs related to hospital discharge, since they were patients in need of equipment for home use, such as hospital bed, pyramidal mattress, crutches, walkers, among others. The articulation

of discharge planning to the care lines existing in the institution was highlighted through the *round* and, therefore, patients with FEPF received early support regarding the use of oral anticoagulants and chemotherapeutics, the administration of insulin, as well as the use of oral inhalers, probes and ostomies.

In view of the above, studies indicate that the reduction of risks and damages, and the incorporation of good practices favor the effectiveness of the care and its management in a safe way<sup>(4)</sup>. This improvement depends on the necessary culture change of the professionals for security and, in the experience shared in this article, it is still highlighted that the use of WhatsApp® for virtual meeting of all participants in the *round* with instant messaging, promoted greater agility in communication, especially regarding the solution of daily doubts, besides serving as a quick dialogue for intercurrents.

## ■ FINAL CONSIDERATIONS

Effective communication in the work of the health team is a challenge. The implementation of the structured interdisciplinary *round* has shown to contribute to the communication among the members of the team, patient and family, improving the quality of care, reducing risks and failures, ensuring safer patient care. These aspects represent contributions with high potential for impact on management, as well as the use of *round* while communication modality raises a peculiar need for the teaching of health professionals and can be understood as a field to be investigated regarding the effects on care.

By changing the *round* centered on the medical knowledge for the interdisciplinary model, a greater interaction between the professional knowledge was achieved, as well as greater participation of the involved members was promoted according to their specific and complementary level of competence.

In addition, a decrease in hospitalization time was observed from the early and shared organization of hospital discharge. Improvements in specific processes such as prevention of pressure injury, review of the protocol of not using airflow mattress in patients submitted to orthopedic surgery, accomplishment of dressing according to evaluation, nutritional support and reduction of length of stay with bladder catheter of delay, were conduits based on scientific evidence and multiprofessional vision.

As a future perspective, it is intended to carry out the interdisciplinary *round* at the bedside, with the participation of the patient and family, aiming the involvement of the patient in their care and the success of the treatment. Still,

it is intended to develop research that makes it possible to highlight the improvement of clinical outcomes already perceived empirically by professionals, and the lack of such evidence may be considered a limitation of the study.

However, the experience reported here is highlighted as an initiative to increase effective communication with a view to patient safety. In addition to bringing improvements to the institution of origin, the *round* can instigate other institutions to invest in improvements in communication processes.

## ■ REFERENCES

1. Capucho HC, Cassiani SHB. The need to establish a national patient safety program in Brazil. *Rev Saúde Pública* 2013;47(4):791-8. doi: <https://doi.org/10.1590/S0034-8910.2013047004402>.
2. Reis GAX, Hayakawa LY, Murasaki ACY, Matsuda LM, Gabriel CS, Oliveira MLF. Nurse manager perceptions of patient safety strategy implementation. *Texto Contexto Enferm*. 2017;26(2):e00340016. doi: <https://doi.org/10.1590/0104-07072017000340016>.
3. Joint Commission International (US) [Internet]. Oakbrook Terrace: JCI; c2015-2018 [cited 2018 Jul 5]. Patient Safety. Sentinel event statistics released for 2014; [about 1 screen]. Available from: <https://www.jointcommission.org/issues/article.aspx?Article=jjLkoltVZhkxEyGe4AT5NDyAZaTPKWxc50lc3pERKGw%3D>.
4. Oliveira RM, Leitão IMTA, Silva LMS, Figueiredo SV, Sampaio RL, Gondim MM. Estratégias para promover segurança do paciente: da identificação dos riscos às práticas baseadas em evidências. *Esc Anna Nery*; 2014;18(1):122-9. doi: <https://doi.org/10.5935/1414-8145.20140018>.
5. Bagnasco A, Tubino B, Piccotti E, Rosa F, Aleo G, Di Pietro P, et al. Identifying and correcting communication failure among health professional working in the Emergency Department. *Int Emerg Nurs*. 2013;21(3):168-72. doi: <https://doi.org/10.1016/j.ienj.2012.07.005>.
6. Daniels K, Auguste T. Moving forward in patient safety: multidisciplinary team training. *Semin Perinatol*. 2013;37(3):146-50. doi: <https://doi.org/10.1053/j.semperi.2013.02.004>.
7. Martins CCF, Santos VEP, Pereira MS, Santos NP. The nursing team's interpersonal relationships v. stress: limitations for practice. *Cogitare Enferm*. 2014;19(2):287-93. doi: <https://doi.org/10.5380/ce.v19i2.36985>.
8. Maxfield DG, Lyndon A, Kennedy HP, Keeffe DO, Zlatnik MG. Confronting safety gaps across labor and delivery teams. *Am J Obstet Gynecol*. 2013;209(5):402-8.e.3. doi: <https://doi.org/10.1016/j.ajog.2013.07.013>.
9. Johnson HL, Kimsey D. Patient safety: break the silence. *AORN J*. 2012;95(5):591-601. doi: <https://doi.org/10.1016/j.aorn.2012.03.002>.
10. Wu RC, Lo V, Morra D, Wong BM, Sargeant R, Locke K, et al. The intended and unintended consequences of communication systems on general internal medicine inpatient care delivery: a prospective observational case study of five teaching hospitals. *J Am Med Inform Assoc*. 2013;20(4):766-77. doi: <https://doi.org/10.1136/amiajnl-2012-001160>.
11. Walton V, Hogden A, Johnson J, Greenfield D. Ward rounds, participants, roles and perceptions: literature review. *Int J Health Care Qual Assur*. 2016;29(4):364-79. doi: <https://doi.org/10.1108/IJHCQA-04-2015-0053>.
12. Ricci G, Longaray MP, Gonçalves RZ, Ungaretti Neto AS, Manente M, Barbosa LBH. Evaluation of the mortality rate one year after hip fracture and factors relating to diminished survival among elderly people. *Rev Bras Ortop*. 2012;47(3):304-9. doi: <https://doi.org/10.1590/S0102-36162012000300005>.
13. Bortolon PC, Andrade CLT, Andrade CAF. O perfil das internações do SUS para fratura osteoporótica de fêmur em idosos no Brasil: uma descrição do triênio 2006-2008. *Cad Saúde Pública*. 2011;27(4):733-42. doi: <https://doi.org/10.1590/S0102-311X2011000400012>.
14. Perversi P, Yearwood J, Bellucci E, Stranieri A, Warren J, Burstein F, et al. Exploring reasoning mechanisms in ward rounds: a critical realist multiple case study. *BMC Health Serv Res*. 2018;18:643. doi: <https://doi.org/10.1186/s12913-018-3446-6>.
15. Avenell A, Smith TO, Curtain JP, Mak JC, Myint PK. Nutritional supplementation for hip fracture aftercare in older people. *Cochrane Database Syst Rev*. 2016;11:CD001880. doi: <https://doi.org/10.1002/14651858.CD001880.pub6>.
16. Conternero LO, Lobo JA, Masson W. The excessive use of urinary catheters in patients hospitalized in university hospital wards. *Rev Esc Enferm USP*. 2011;45(5):1089-96. doi: <https://doi.org/10.1590/S0080-62342011000500009>.

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