Evidence Based Practice on Multidisciplinary Rounding
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Review of Literature
Six (6) articles were graded using the ANC Rating System for Hierarchy of Evidence and the John Hopkins Nursing Quality of Evidence Appraisal:

• 1 Level II (randomized control trial); Grade A (high quality)
• 3 Level IV (well designed case-control and cohort studies); 2 Grade A and 1 Grade B (good quality)
• 2 Level V (systematic review); Grade B

Process of Implementation

• The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care was the model used to implement.

• Formed a pilot team that consisted of Family Medicine attending and resident physicians, staff nurses, inpatient pharmacist, and case manager.

• Staff was educated on purpose and implementation of MDR, supporting patient-centered, collaborative care.

• Prior to each patient visit, the provider would notify the assigned nurse before assessment, facilitating fluid dialogue with consideration to the patient’s preferences and values.

Outcomes

Baseline data:
• 30 day readmission rate of 10.5 patients
• Average LOS of 2.3 days
• Average cost at disposition/patient: $6,920 per month.

Three (3) months post-implementation:
• 30 day readmission rate of 9 patients
• Average LOS of 2.275 days
• Average cost at disposition/ patient: $6,059 per month.

Lower readmission rates, LOS and cost after three months of implementation.

Will collect data again at six (6) months.

Nursing Implications

• MDR is essential in establishing patient-centered communication and collaboration amongst the multidisciplinary team in real-time.

• This increases patients satisfaction, decreases variances in the administration of healthcare services, and decreases adverse events.

References


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