

Systematic Rounding Tool for Nurse Practitioner Students

Effective communication in health care is essential to ensure patient safety and improve patient outcomes. The use of a systematic rounding method can reduce opportunities for miscommunication and misunderstanding. The SBAR (situation, background, assessment, and recommendation) method is effective in enhancing communication among providers (Thomas et al., 2009). Although a successful method of communication for experienced providers, SBAR lacks the detailed body system review needed for novice advanced practice nursing students.

For graduate nursing students, the additional responsibility of reporting on patient status and plan of care can contribute to anxiety and hinder the learning process. Graduate nursing faculty sought to optimize the clinical learning experience through the implementation and use of a systematic rounding tool to assist students in addressing essential components of care related to specific body systems.

The implementation of a standardized, detailed reporting tool early in the graduate nursing curriculum can better equip students for rounding during clinical experiences and reinforce the importance of effective communication in health care. This article explores the efficacy of a systematic, clinical rounding tool on communication and student anxiety during the clinical experience.

Learning Activities

Through previous clinical course evaluations and feedback, neonatal nurse practitioner (NNP) students, NNP preceptors, and supervising staff members identified weaknesses in clinical rounding. Students expressed anxiety related to inexperience in the rounding process and what information to communicate. Preceptors and supervising staff members reported students appeared disorganized when delivering pertinent patient information and failed to relay a plan of care in a well-organized succinct format. Supervising staff members also voiced

TABLE 1	
Rounding Tool for Neonatal Nurse Practitioner Students	
General reason the infant is in the neonatal ICU:	
History: include relevant information from mother's history and delivery	
Maternal (G, P, PMH, prenatal care, medications, laboratory values, etc.)	
Delivery history (method, presentation, NRP, immediate postdelivery activities, etc.)	
Course to date (vented, antibiotics, fluids, etc.)	
Active diagnoses	
Review of system: include relevant diagnostics and laboratory values with each body system	
Respiratory (support, settings, recent ABG, etc.)	
Apnea and bradycardia (frequency, severity, stimulus, etc.)	
Cardiovascular (status, PDA, consults, echocardiogram, differential diagnosis, murmur)	
Neurological (status, HUS, medications, pain control, etc.)	
Gastrointestinal (growth, intolerance, stools, etc.)	
Fluids, electrolytes, and nutrition (I/O, kcal/kg/day, mL/kg/day, plan, laboratory values, feedings, breast milk, etc.)	
Hematology (hematocrit, bilirubin, photo, etc.)	
Infection (current antibiotics, culture results, treatment plan, levels, etc.)	
Renal (voiding, I/O, any laboratory values or diagnostics, etc.)	
Eyes (last examination, follow-up, etc.)	
Health maintenance: include relevant diagnostics, plans, laboratory values, information, etc.	
Maintenance/screening discharge plan (status, plan, follow-up, consults, state screening, hearing screening, car seat, vaccines, etc.)	
Social (family, communication, etc.)	
Evidence-based practice: Review the literature surrounding aspects of your patient's care; be prepared to respond to questions regarding the infant's condition, diagnoses, and management	
<p><i>Note.</i> ICU = intensive care unit; G = gravida; P = para; PMH = past medical history; NRP = Neonatal Resuscitation Program; ABG = arterial blood gas; PDA = patent ductus arteriosus; HUS = head ultrasound; I/O = input/output.</p>	

frustration that many students could not effectively identify and communicate the patient's need for interprofessional care. Based on this feedback, a standardized rounding tool for use during clinical experiences was developed (**Table 1**).

The rounding tool provided students with a standardized process for communicating essential patient information and a plan of care during rounds. The tool was a concise, one-page document that

addressed content such as prenatal and delivery history, clinical issues and diagnostic tests within the past 24 hours, a review of systems, and discharge planning.

The tool was subdivided into history (e.g., admission reason and prenatal and delivery history), diagnoses (active and resolved), review of systems and diagnostics (e.g., cardiac and respiratory), medications (current and past), health maintenance (e.g., immunizations, eye

examinations, and parent involvement), and discharge readiness (e.g., cardiopulmonary resuscitation training, infant car seat test, and pediatrician appointment). One side of the tool provided a series of content prompts to guide students on the important elements to include. Students were required to use the rounding tool during clinical and virtual rounds.

Student and Preceptor Evaluation

Feedback was overwhelmingly positive. Many students expressed feeling better prepared to formulate a plan of care and deliver essential information during rounds and virtual sessions. Students reported increased confidence and less anxiety when using the rounding tool to communicate patient information to preceptors and other health care team members.

Preceptors reported students were better prepared during rounds to discuss various components of patient care management regarding history, diagnosis, diagnostic testing, medications, and other

pertinent information. Several preceptors reported student comprehension of the patient's overall clinical picture was enhanced.

Supervising staff members and preceptors reported a dramatic improvement in students' ability to discuss various aspects of patient information without interrupting rounds to review the patient's chart, thereby increasing the efficiency of the rounding process. The decrease in interruptions also allowed more time for teaching and questions. Supervising staff members noted students were better able to recognize the need for interprofessional care and include referrals and consults in the patient's treatment plans.

Implications for Education

By using the tool, students were guided to systematically identify pertinent patient information as well as effectively communicate the essential components of care during clinical rounding. Effective communication, including the organized presentation of critical information

and a thorough and thoughtful response to questions, results in safe and high-quality care (Merlino, 2017). As graduate nursing students build communication and reporting skills as a provider, they can transition to other communication methods found in health care settings such as SBAR.

References

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