QUALITY IMPROVEMENT

Interdisciplinary medical rounds improved patient care efficiency and the care process and decreased costs


**Question**
Can interdisciplinary rounds improve efficiency of patient care and staff satisfaction and decrease costs on inpatient medical wards?

**Design**
Randomized controlled trial.

**Setting**
3 medical firms and 6 inpatient health care teams of an acute care, tertiary referral, and teaching hospital in Cleveland, Ohio, USA.

**Patients**
Patients who were admitted to and discharged from medical wards. Patients were excluded if they spent < 50% of their hospital stay on the medical ward, were transferred to another service, or were not admitted to their assigned firm.

**Intervention**
On their first admission, patients were randomly allocated to 1 of 3 medical firms from which they received all services including those for any subsequent admissions; all admissions were considered separately. Each of the 3 firms comprised 2 independent ward services; the 6 ward services were divided so that 3 conducted daily interdisciplinary rounds, designed by a continuous quality improvement team, and 3 continued traditional rounds. Interdisciplinary rounds included physicians, a nurse patient-care coordinator, a pharmacist, a nutritionist, and a social worker, and orders were written during rounds with the patient charts present. Traditional rounds included physicians only on a daily basis with interdisciplinary rounds once a week; orders were written throughout the day, and patient charts were left at the nursing station. Of 1102 patient admissions, 567 patients were allocated to receive interdisciplinary rounds, and 535 were allocated to receive traditional rounds.

**Main outcome measures**
Length of hospital stay, total charges (U.S. dollars), hospital death, type of hospital disposition, and self-reported health care provider satisfaction.

**Main results**
Patients who received interdisciplinary rounds compared with those who received traditional rounds had shorter mean lengths of hospital stay (5.46 vs 6.06 d, P = 0.006) and lower mean total charges (U.S. $6681 vs $8090, P = 0.002), but no differences occurred in the rates of hospital death (1.8% vs 1.9%, P = 0.90), discharge to home (73.9% vs 73.1%, P = 0.79), and discharge to an interim care facility (9.4% vs 12.3%, P = 0.12). Factor analysis and comparison of provider satisfaction surveys, completed by 21 providers of interdisciplinary rounds and 19 providers of traditional rounds, revealed 3 factors that represented underlying concepts; comparison of these factors showed that providers of interdisciplinary rounds had a greater understanding of patient care, more effective communication, and more teamwork than providers of traditional rounds (P < 0.05 for each factor).

**Conclusion**
Interdisciplinary health care teams conducted in hospital inpatient services, such as physical or respiratory therapy or consulting medical specialty services, might promote even greater efficiency and communication among providers.

Source of funding: Not stated.

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Abstract and Commentary also published ACP Journal Club. 1999;130:52. A version of this abstract appears in Evidence-Based Nursing. 1999 Apr.