

# Risk Rx

Vol.11 No. 4 | October-December 2014

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# Optimizing Physician-Nurse Communication in the Emergency Department: Strategies for Minimizing Diagnosis-related Errors.

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## Summary

Missed or delayed diagnoses in the emergency department (ED) are the leading cause of malpractice liability in Emergency Medicine. In 2010, CRICO and RMF Strategies convened the Emergency Medicine Leadership Council (EMLC) to address this challenge. Applying comparative malpractice data and their own experience and expertise, the EMLC participants (including representatives from the Harvard-affiliated hospitals and RMF Strategies client organizations) worked to identify the underlying factors that contribute to missed or delayed diagnoses, and patient adverse events, in the ED. While diagnosis-related missteps are often attributed to cognitive error on the part of the physician, the group identified communication problems and information gaps as present in many of the malpractice cases. After reaching a consensus that optimal physician-nurse communication at critical junctures in ED care is one key to reducing diagnosis-related errors, each participating organization field-tested one or more communication improvement strategies. Based on feedback from those short-term activities, CRICO has compiled best practices to inform recommendations for optimizing physician nurse communication in the ED. The insights and recommendations of the EMLC are presented in this paper.

## Background

Missed and/or delayed diagnosis remains the most common cause of medical malpractice in Emergency Medicine.<sup>1</sup> CRICO has a rich history of analyzing the trends in malpractice cases and using comparative data to understand the contributing factors in these cases. Armed with this information, CRICO then partners with frontline leaders to develop relevant initiatives aiming to prevent further occurrences and begin to reduce malpractice risk by advancing patient safety.<sup>2</sup> In 2010, CRICO convened a series of



meetings with Emergency Medicine leaders to examine the underlying risk factors in diagnosis-related cases. Representatives included Emergency Medicine chiefs and nursing leadership from each ED at a CRICO-insured hospital as well as ED leadership from the RMF Strategies network.

At the initial meeting, an analysis of the recent malpractice data revealed that missing information or a lack of communication among providers caring for the patient was a frequent theme in ED cases. While cognitive error on the part of the physician may result in a missed diagnosis, in almost every case, essential pieces of information were not available to the physician at the time of decision making. In general, gaps in several key information streams were identified, including:

- the availability of prior historical information from the medical record or referring physician,
- a change in the patient's status or a persistently abnormal vital sign,
- the timeliness of laboratory or radiology data,
- communication from the consultant physician,
- miscommunication at patient hand offs, and
- barriers to effective communication between the nurse and physician caring for the patient.

Each participant then returned to his own

organization and completed a self assessment looking at the communication patterns in his/her department; the results of this assessment informed the second meeting. Participants identified the need to optimize communication among ED physicians and nurses as one of the most pressing challenges to reduce risk and enhance patient safety. In subsequent meetings, the group developed potential strategies to improve nurse-physician communication; many of those strategies were piloted by individual institutions during a four-month interval between meetings. This paper serves to outline many of the key themes and insights from those piloted practices. In general, the recommendations fall into three categories: designing structured communication events, operational and organizational change, and staff development and education.

### Structured Communication Events

Given the hectic ED environment, communication between physicians and nurses caring for the same patient can be fragmented or, occasionally, absent.<sup>3-4</sup> As each provider has different tasks in caring for the patient, their work often proceeds in parallel; each may have information that would benefit the other—but it may not be exchanged. This can include, but is not limited to, a key piece of historical information, a change in clinical status, an abnormal vital sign, or response to therapy.<sup>5</sup>

Designing specific communication prompts or events during the patient's ED visit can facilitate communication and provide opportunities to share critical information. Additionally, structured updates between the resource nurse and attending physician can allow for communication about critical issues in the department, capacity and patient flow, bed availability, and any number of issues that have arisen during the shift. The implementation of a communication strategy must enhance communication without compromising efficiency in caring for the patients. Below are some specific strategies proposed by the EMLC.

**Triggers:** A patient who is initially unstable or becomes unstable in the ED needs a rapid coordinated effort by all providers. Often, the triage or primary nurse, or an ED assistant, is the first to know of an abnormal vital sign or change in the patient's status. A trigger system sets specific physiologic parameters that trigger an alert to both the nurse and physician

to respond to an unstable patient (e.g., marked tachycardia/bradycardia, hypotension, increased/decreased respiratory rate, hypoxia, nursing concern). In one ED, implementing a trigger alert system cut the time to initial physician contact and the mean time to the first therapeutic intervention by half. Not surprisingly, the length of stay was decreased for these patients as compared to similar patients before the trigger system was implemented.

**Physician-Nurse Huddle:** Several institutions have implemented a structured MD-RN huddle, either at a defined moment in the patient's care to review key information, or at regularly scheduled intervals during the shift. During the huddle, key elements of the patient's course are reviewed and any potential questions clarified. This is particularly important at the time of disposition of the patient, as the decision to admit or discharge often depends on clinical details of which the physician making that decision may not be aware.

One institution is implementing an MD-RN huddle at the time of the admission, using the mnemonic **STOP: Significant issues, Therapies, Oxygen and last vital signs, and Pending issues.**

This communication is designed to identify any pending issues that could be missed as the patient transitions from the ED to the inpatient wards. Others have included a structured update between the charge nurse and the attending physician at key points in the shift to review the department as a whole, and to identify any potential issues that may have arisen during the shift. Many leaders from EDs with robust electronic patient tracking and charting systems noted that much of the MD-RN communication occurs electronically, and emphasized the need to supplement electronic information with structured times for closed-loop verbal communication. One institution has implemented bedside rounding with physicians and nurses so that the patient is also included in the update.

### Discharge Timeout

At the time of discharge, patients are safest when all providers are aware of their treatment plan and all pending issues have been resolved. At one participating institution, a coordinated discharge process had been implemented that includes a review of all patient information by both the physician and nurse prior to discharge. Preliminary data demonstrate that many near misses have been

identified and remedied before discharge of the patient.

### Reconciliation of Abnormal Vital Signs

A frequent theme in medical malpractice cases is the discharge of a patient from the ED with persistently abnormal vital signs. One of the most important pieces of information to relay at the time of discharge is a persistently abnormal vital sign (e.g., tachycardia despite intravenous fluid therapy), which may be the only indication of a patient at risk for an adverse event upon discharge. Routine communication of vital signs prior to discharge is an effective way to identify some of these patients in which a potentially serious diagnosis has been missed.

### Operations/LEAN Strategies

Improving ED efficiency and minimizing the waste of unnecessary work and delays is also a key part of improving clinician-to-clinician communication. Strategies such as those borrowed from LEAN manufacturing can help improve efficiency and reduce waste. According to LEAN philosophy, processes are standardized as much as possible to eliminate errors, and unnecessary work that does not add value to patient care is eliminated. Direct observation of work and inclusion of all staff in the job of process improvement is also emphasized.<sup>6</sup> Many of the EMLC organizations have introduced LEAN methodology into their EDs to make process improvements. LEAN methods can be used to directly observe communication patterns to identify areas of improvement. As process improvements are introduced into the workflow, unnecessary work (e.g., looking for equipment, redundant paperwork, phone calls) is removed, leaving physicians and nurses more time for relevant communication during the care of patients. In order for LEAN principles and techniques to be effective in an organization, leaders must create an environment conducive to all staff participating in the continuous improvement process.<sup>7</sup> Critical to the success of these process improvements is the participation of all frontline workers in all disciplines in the design and implementation of these initiatives.

## Education

### Team Training/Simulation

In the pressured and chaotic environment of the ED, teamwork among providers, particularly physicians and nurses, is essential for patient safety. High performance teams, including those in health care,

function more efficiently and effectively when they have developed and practiced specific communication skills and team behaviors.<sup>8-10</sup> Members of the EMLC recognized the need for formal development and practice of teamwork behaviors in their EDs.

Simulation of critical incidents followed by debriefing and reflection is an effective method for this practice and an opportunity for team members to improve their skills. Simulated incidents allow for practice of skills in a realistic, but low-risk environment. Simulation is of particular value in emergency medicine, as provider teams are rarely if ever constant (due to variable schedules). Simulation scenarios highlight and teach role clarity, leadership skills, effective closed-loop communication, and resource management as teams deliver coordinated care through the exercise. Developing a shared mental model among team members as well as encouraging all team members to speak up is also emphasized.<sup>11-12</sup> One EMLC organization has begun pilot work on an ED-based team training simulation program and several members agreed that formal education to develop team behaviors is critical to improving communication among ED physicians and nurses.

### Clear Roles and Responsibilities/Charge Nurse Professional Development

In addition to improving teamwork skills of all providers, many EMLC participants felt that better professional development of the resource or charge nurse was important to consider when optimizing the coordination between ED physicians and nurses. A skilled resource or charge nurse is essential to the flow of patients through an ED. The many responsibilities of this role include providing leadership and support to staff, bringing essential information to the physicians, assisting in patient care, and overseeing many functions in the department. Recognizing the critical role of the charge nurse in the overall functioning of the ED, many members have implemented specific charge nurse training to develop these essential leadership skills. Others have begun to assign team leaders to assist the charge nurse in given areas of the ED to oversee the flow of patients and enhance communication of critical information. Many emphasized the need to clearly define the responsibilities of the charge or resource nurse, and to free him or her from excessive clinical work to provide oversight of the department and better identify and address critical issues. Ongoing professional development is also essential.

## Conclusion

In summary, a busy ED provides care for multiple sick, undifferentiated patients at once and providers often work with limited time, information and resources. Therefore, missed or delayed diagnosis is the most common contributor to ED medical malpractice cases. Optimizing communication between ED physicians and nurses is an effective strategy to address this risk. This can be done through process improvements, structured communication events, and ongoing professional development and education.

## Key Recommendations

1. Structured communication events between physicians and nurses should be included at critical points in the patient's course through the ED and at key points in the shift. This includes evaluation of the unstable patient, a change in clinical status, during diagnosis and the formulation of treatment plan, at the time of disposition or discharge, and at shift change or transitions in care.
2. Effective process improvement in the ED involves continuous collaboration between physician and nurse leadership and involvement of frontline workers from all disciplines.
3. Ongoing staff education, in the form of teamwork training and professional development, is essential to optimize communication between ED physicians and nurses.

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## *The Pivotal Role of Communication in Healthcare Reform and Risk Reduction*

by Arnold Mackles, MD, MBA, LHRM



It's all about communication! Despite having superbly trained healthcare providers, state-of-the-art medical technology, and well-established therapies at provider's fingertips, the American healthcare industry remains beleaguered by unacceptable numbers of preventable medical and surgical mistakes. A significant percentage of adverse events are

simply caused by the inability to communicate effectively. Given the major focus today on healthcare reform and improved patient safety protocols, successful healthcare organizations will realize that effective communication is the key to reaching the Triple Aim of Better Health, Improved

Care Experience, and Reduced Costs.

Although errors resulting in patient harm have plagued the medical profession for generations, it has only been in recent years that healthcare professionals began to identify the root causes of these events. Since IOM's "To Err is Human: Creating a Safer Health System" came out 15 years ago, this landmark report has served as a thunderous wake-up call to the industry, leading to private initiatives and governmental reforms to improve patient safety and quality care.

The healthcare industry now faces wide scale reforms that impact traditional methods of practice and provider reimbursement. Payments to providers will be linked to performance and patient outcomes. Third party payors no longer reimburse providers for hospital acquired conditions considered to be "never events." Hospitals with excessive 30-day readmission rates are currently facing reimbursement penalties for

specific conditions. The Institute for Healthcare Improvement (IHI) considers healthcare reform to be a key component of an overall strategy to achieve the “Triple Aim.”

## The First Component of the “Triple Aim:” Better Population Health

The core principle of Better Population Health is that of identifying individuals in the community who are “at risk” for specific health issues and providing appropriate services needed to proactively improve health. This can be accomplished by reaching out with patient interviews, surveys, obtaining clinical information and data from payors. This requires functional collaboration and communication among diverse healthcare providers to identify “at risk” patients requiring services and support.

Although Better Population Health is a forthcoming goal for entire geographic areas, research has already shown how specific populations of high risk patients can receive safer and healthier care. For example, Lu and co-workers evaluated a population of hospital patients being discharge to skilled nursing facilities. Hospital readmission rates, at both 30 and 60 days post-discharge, were significantly reduced by utilizing pharmacist medication reconciliation techniques, nursing oversight, and communication with providers to resolve discrepancies in discharge orders.

The American retail industry has courted consumers for decades with phrases such as “the customer is always right.” For whatever reason, healthcare organizations are late arrivals to the notion that customer satisfaction is directly associated with higher quality products, services, and financial success. As a result, government healthcare reform has instituted measures to improve both patient satisfaction and patient outcomes.

## The Second Component of the “Triple Aim:” An Improved Patient Care Experience

A report by Health Grades revealed the important

role that communication plays in both patient education and providing high quality care. The Health Grades study compared results of a patient satisfaction survey, the HCAHPS Survey (Hospital Consumer Assessment of Healthcare Providers Systems) with the number of hospital adverse events as determined by specific patient safety indicators (PSI), established by the Agency for Healthcare Research and Quality (AHRQ). The report found that “Hospitals with the highest ratings on nursing and physician communication had better track records with lower rates of the 13 patient safety indicators.”

By practicing safe, quality patient, care hospitals can maximize bottom line performance by avoiding non-reimbursement situations and penalties imposed by governmental and third party payors.

— Arnold Mackles, MD, MBA, LHRM

## The Third Component of the Triple Aim:” Reduce Per Capita Healthcare Costs

Reducing costs while providing optimum patient care is the third facet of the triad of initiatives to improve overall healthcare. To accomplish this goal, healthcare providers will need to practice evidence-based medicine and eliminate unnecessary tests and procedures. In addition, the Centers for Medicare and Medicaid Services (CMS) have introduced the Hospital Value Based Purchasing (VBP) Program, which provides financial incentives for quality of care, rather than for the numbers of medical and surgical procedures performed.

By practicing safe, quality patient care hospitals can maximize bottom line performance by avoiding non-reimbursement situations and penalties imposed by governmental and third party payors.

Preventable medical errors considered to be “never events” and excessive hospital readmissions can often be avoided by instituting effective communication initiatives coupled with process improvements.

A good example is the ability to decrease hospital 30-day readmission rates by instituting a “Transition of Care Model.” Essentially, these care models utilize an interdisciplinary team that helps a patient transition from hospital admission through discharge and the post-discharge period. The teams coordinate care throughout the process and educate patients as to their specific condition and care plan, both as an inpatient and after discharge. Follow-up calls or visits are made within 24-48 hours after discharge to check for any problems and to, once again, confirm that the patient is following the post-discharge plan. A study by Coleman evaluated a transition of care model for hospitalized elderly patients. One group of patients had an intervention consisting of a transition coach, encouragement to participate in the care process, and post-discharge home visits and follow-up calls. The second or control group received routine care. Results revealed that the intervention group had an 8.3% 30-day readmission rate while the control group was as high as 11.9%, providing further evidence that simple and effective communication does make a difference!

Indeed, significant progress has been made in the area of patient safety in recent years. Yet, there remains a great deal still to accomplish. Future success, and even the very survival of healthcare organizations, will depend on the ability of providers to utilize effective communication to promote quality care, patient satisfaction, and cost savings.

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## Communication Tips in the Trauma Setting

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Even under ideal conditions, communication in the health care setting, whether among providers or between providers and their patients, continues to be a challenge from a patient safety and customer service standpoint. Data from The Joint Commission indicates that poor communication has contributed to approximately 70% of the sentinel events reported and has consistently been listed as one of the top three root causes since 2005.

Communication failures between providers and patients during an encounter in any setting increases the opportunity for a complaint or malpractice claim. Trauma teams are faced with a combination of medically complex patients who in many instances have no prior medical history with the facility and operating under extreme time pressures with very narrow intervention windows. Trauma and emergency medicine teams are expected to rapidly perform the substantial tasks of assessing, getting ancillary tests, diagnosing and determining the best resuscitative and interventional course to take.

There are three general aspects of communication in the trauma setting discussed in this article.

### Communication with the Patient

A primary area of concern with respect to communication is obtaining informed consent from a patient who may or may not be able to participate in the consent process at the time of initial evaluation or before a procedural intervention is required. In circumstances where obtaining informed consent is impossible because the patient is incapacitated, consent is implied, however, documentation should reflect the emergent nature of the patient's condition and procedure. It's always a plus if the patient comes in with outside medical records or has been a patient in the facility enabling review of records for significant historical clinical information, presence of an advanced directive and identify next-of-kin or other listed emergency contact who can be notified and participate in the consent process.

Communication with the patient and family members by the trauma team while perhaps succinct



and to-the-point out of necessity, should always be

respectful. Presenting a caring demeanor and addressing the patient by name promotes trust, respect and rapport with the physician and team members. Active listening, providing clinical information in terms consistent with the patient's level of understanding and encouraging patient feedback goes a long way to help patients cope with what may be a dramatic, overwhelming, and life-changing event.

### Communicating Bad News

Delivering bad news is a reluctantly-performed task, fraught with stress that takes a heavy toll on care providers as well as the patient and family. Before meeting with the patient or family, team members should take a little time to come to terms with their own emotions to ensure information is relayed in a compassionate and empathetic and, to the extent possible, non-hurried manner. Setting a fast pace just to get a painful task over with is not the best approach. Patients and family need time to absorb and process what they are being told and made to feel comfortable about asking questions. When the prognosis or outcome is grim, speaking with all present family members during the exchange of

information is a good idea so that everyone hears the same message at the same time from the same person. Stress-provoking medical statistics or “survival odds” or other medical jargon may be saved for a future conversation. Keep it simple, understandable and

In a setting where time is of the essence, multiple staff with varying roles, responsibilities, and experience levels can create logistical issues and confusion with regard to chain of command and handoff communications.

— Paul Acedera, Jan Rebstock, J. Bracken Burns, Jr.

human.

As patient conditions can rapidly change in the trauma setting, it is important that trauma staff be prepared to compassionately deal with the patient’s or family’s expressions of grief that can manifest in shock and denial, anger, fear, guilt, despair and tears. Through it all, maintaining a calm, caring, non-judgmental, and non-defensive demeanor as difficult as it may be, will go a long way. Allowing the patient or family to express their emotions helps them cope and begin the acceptance process. Having specialized staff resources or the skills to deal with the range of emotions that can be encountered is very helpful as is the availability and support of clergy to provide spiritual support.

## Communication Among providers

Resuscitation in a trauma setting involves multiple disciplines usually led by surgical teams. However, many trauma centers incorporate emergency department physicians and staff resulting in shared, cross-disciplinary decision-making. In a setting where time is of the essence, multiple staff with varying roles, responsibilities, and experience levels can create logistical issues and confusion with regard to chain of command and handoff communications. Consequently, effective leadership and training of the team is crucial to the smooth coordination of operations to ensure the most timely and optimal patient outcome.

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*-Jan Rebstock, RHIT, LHRM, CPHRM  
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