Landon James, RN, BSN, MA, PCP, CEN

# Inter-Professional Communications

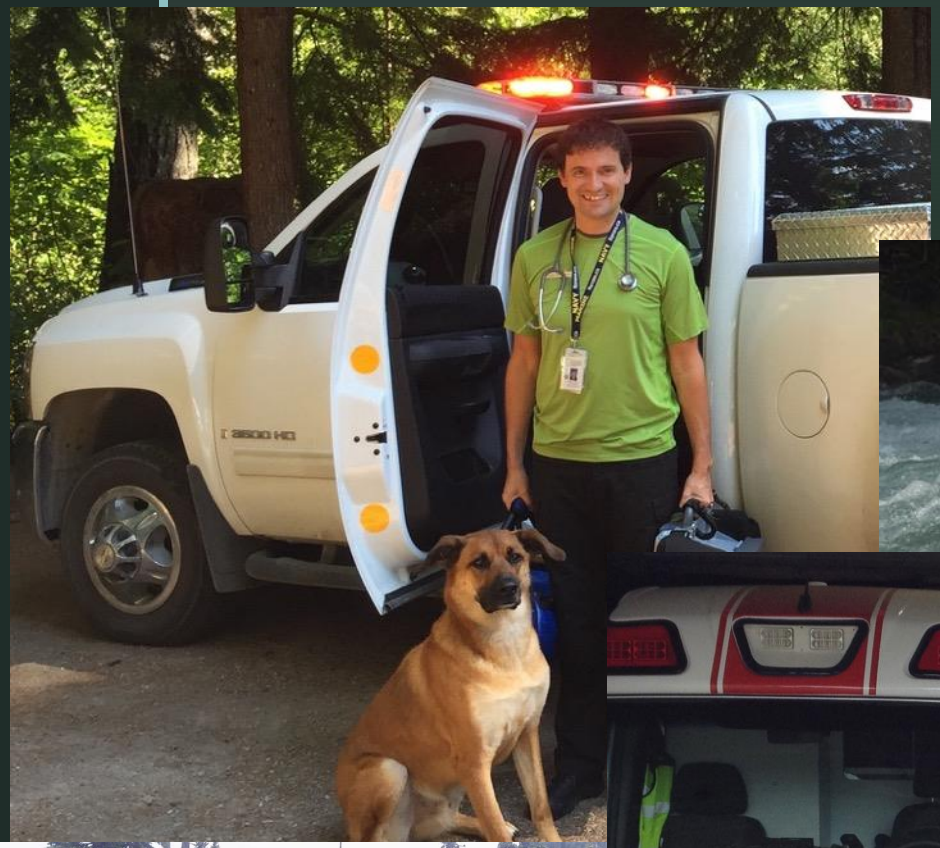
# Objectives

- To explore the fundamental concepts of interprofessional communications
- To identify the common failures of interprofessional communication
- To provide strategies for messaging information between professions in the context of patient care

# Disclosure

- Project lead for EPICC – Emergency Practice, Interventions and Care – Canada program

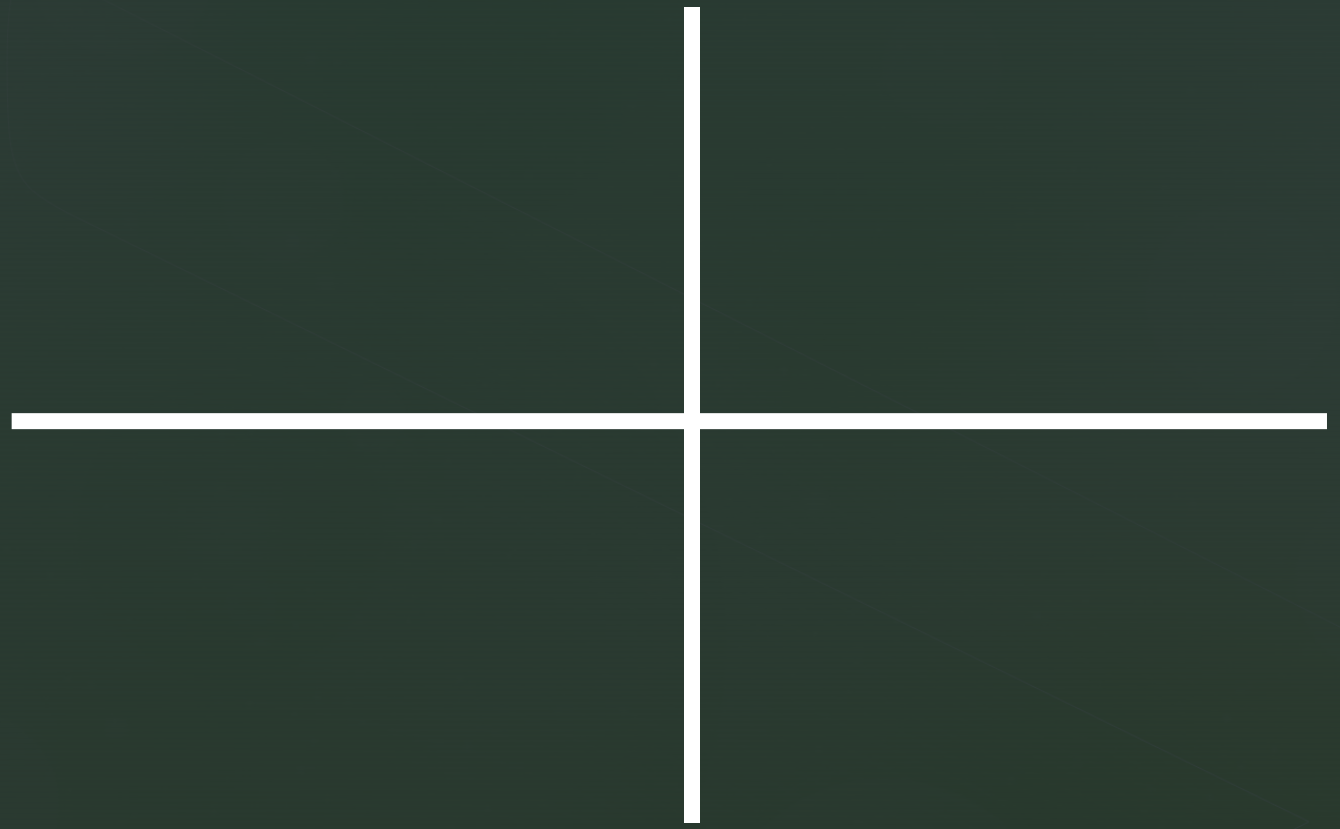
# Who Am I?



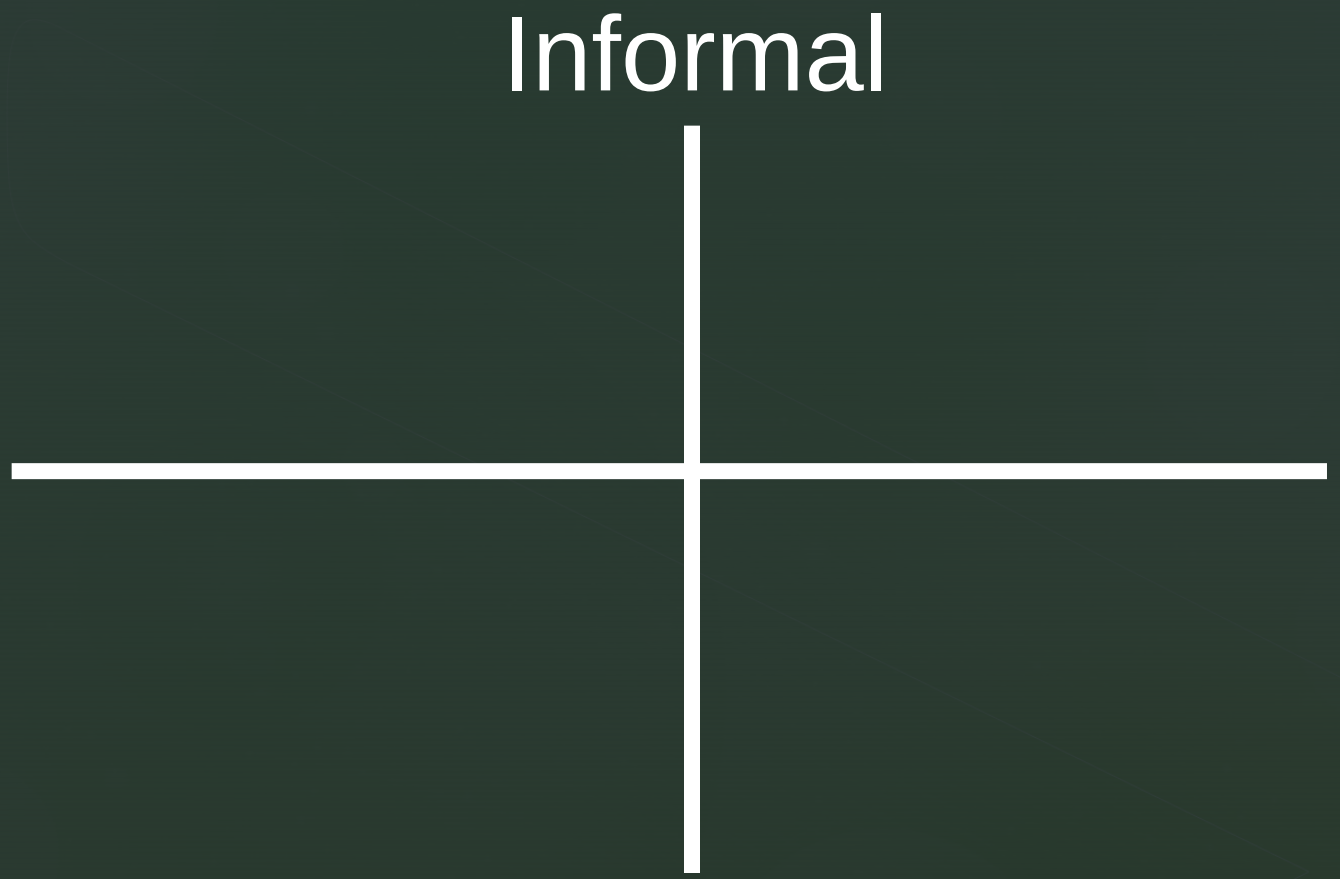

# Communication

- the imparting or exchanging of information or news
- Sender and Receiver

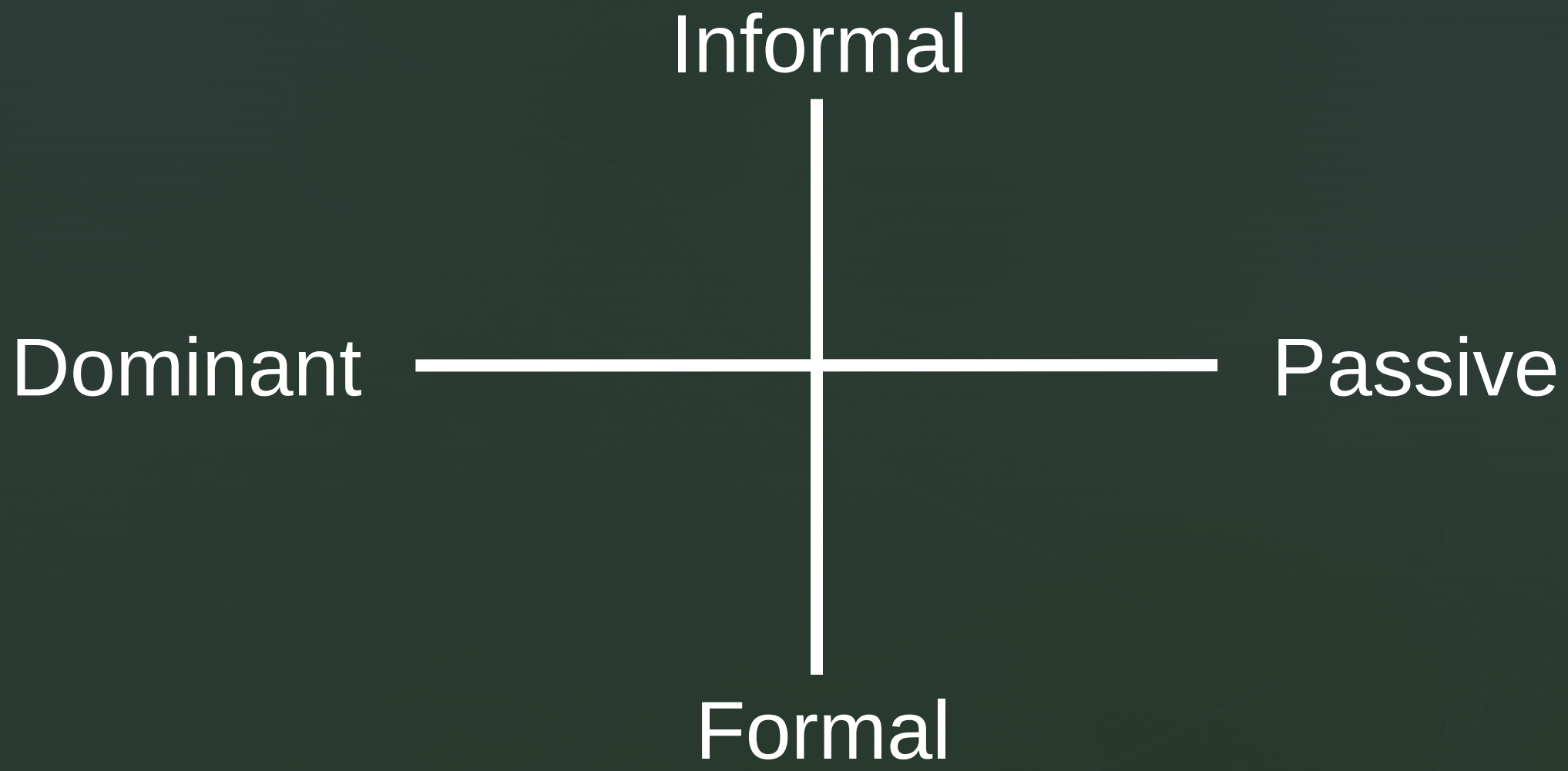
# Where are you?



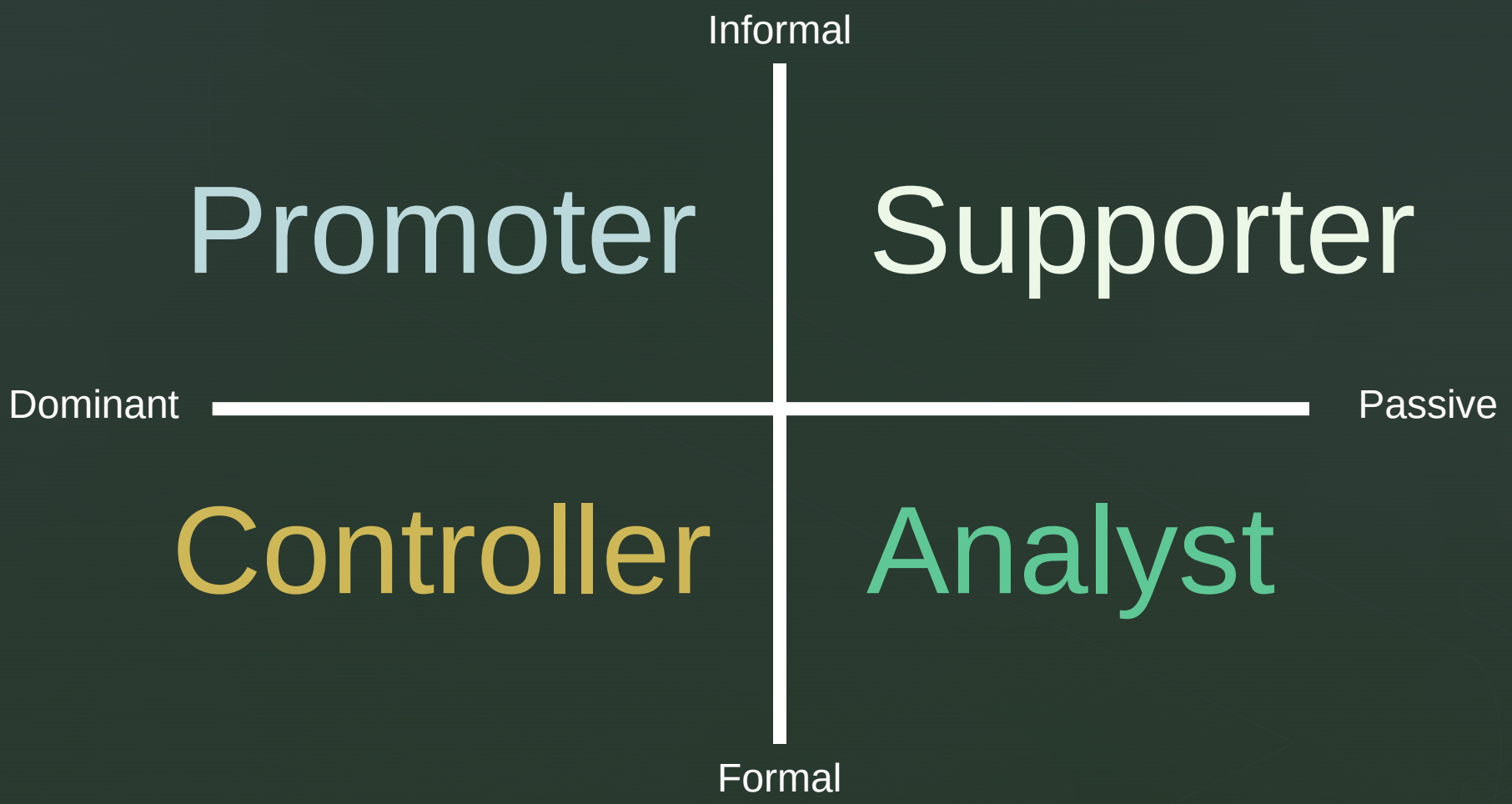
Where are you?



Where are you?



# Where are you?



# Questions

- When I am communicating with you it is important that you…
- When you are communicating with me it is important that you…

# The Four Types

- Controller – Control (of self)
- Promoter – Energy and Creativity
- Supporter – Relationships
- Analyst – Organization

# Communication Failure

- Content
- Purpose
- Audience
- Occasion

**A mixed-methods study of the causes and impact of poor teamwork between junior doctors and nurses** FREE

Paul O'connor ✉, Angela O'dea, Sinéad Lydon, gozie Offiah, Jennifer Scott, Antoinette Flannery, Bronagh Lang, Anthony Hoban, Catherine Armstrong, Dara Byrne

*International Journal for Quality in Health Care*, Volume 28, Issue 3, 1 June 2016, Pages 339–345, https://doi.org/10.1093/intqhc/mzw036

Lingard L, Espin S, Whyte S, *et al.* Communication failures in the operating room: an observational classification of recurrent types and effects, *BMJ Quality & Safety* 2004;**13:**330-334.

# Solution: Understanding Styles

- Storytelling to a Controller?
- Directing a Supporter?
- Boring a Promoter?
- Rushing an Analyst?
- Can you verbalize how you like to be communicated with?

# Solution: Crew Resource Management

- Design of systems to absorb errors through redundancy, standardization, and checklists
- Movement from placing blame to designing safe processes and procedures
- Assurance of full immunity while implementing a nonpunitive approach
- Debriefing of all events, including near misses, that have learning potential. Focus on the severity of the potential risk rather than on the severity of the event's final outcome is more conducive to establishing effective prevention programs.
- Institutionalization of a permanent program for risk identification, analysis, and dissemination of the lessons learned throughout the professional community

Cooper, G.E., White, M.D., & Lauber, J.K. (Eds.) 1980. "Resource management on the flightdeck," Proceedings of a NASA/Industry Workshop (NASA CP-2120)

# Solution: Improved Messaging

***FM 5-0**

Headquarters
Department of the Army
Washington, DC, 26 March 2010

## SMEAC

- Situation
- Mission
- Execution
- Administration/Logistics
- Communication/Command

## STICC

- Situation
- Task
- Intent
- Concern
- Calibrate

Weick K, Sutcliffe K. 2007. Managing the unexpected: Resilient performance in an age of uncertainty. San Francisco, CA: Jossey Bass.

# Solution: Improved Messaging

- TeamStepps®
  - SBAR
  - Call-Out
  - Check-Back
  - Handoff

About TeamSTEPPS®. Content last reviewed April 2017. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/teamstepps/about-teamstepps/index.html

# Solution: Debriefing and Learning

- Focus is on system and solutions not on individual performance

# Texas Children's Hospital - Debriefing In Situ Conversation in Emergency Room Now (DISCERN) Form

This info is privileged and confidential pursuant to TX Health & Safety Sections 161.031-033, TX Occupations Code Section 160.007 &/or TRCP 192.5

**ALL patients need this section completed - NURSE must decide with the doctor whether a debrief is necessary for EVERY resuscitation**

Place Patient Sticker Here

1. Date (MM/DD/YY)
2. Physician Team Leader
3. 1° Nurse filling this out:
4. If team leader & 1° nurse together decide not to do a debriefing, state reasoning: (check one box to the right) (skip #4 if doing debrief)
   - ☐ Too many urgent patient care issues to make time
   - ☐ Did not feel it was needed.
   - ☐ Other reason: _____
5. Resuscitation Type (check all that apply)
   - ☐ Respiratory
   - ☐ Medical (includes seizure)
   - ☐ Trauma
   - ☐ Pulseless
6. Interventions (check all that apply)
   - ☐ Intubation
   - ☐ Defibrillation
   - ☐ Code 3 Trauma Activation
   - ☐ CPR
7. Time Resusc Ended (Either "time of death" or "time left EC", whichever was 1st)
8. Patient outcome
   - ☐ Alive
   - ☐ Expired

**Fill out this section only if debriefing occurs**

1. Members Present ("X" box if present during debriefing)
   - ☐ Chaplain
   - ☐ Charge Nurse
   - ☐ Child Life
   - ☐ Family Advocate
   - ☐ Pediatric Emerg Medicine Fellow
   - ☐ Pharmacist
   - ☐ Physician Team Leader
   - ☐ Primary /Documenting Nurse
   - ☐ Resident
   - ☐ Respiratory Therapist
   - ☐ Secondary Nurse
   - ☐ Other:
   - ☐ Other:
2. Debriefing Physician. Team Leader Name:
3. Debriefing Documenter Name (**NOT** same as #2 above; can be RN or Dr.)

**Fill out this section during the debriefing**
**(Person writing not the person leading debriefing)**
**(Write on the back of form if there is not enough space)**

1. Time Debriefing Started: _____
2. What went well during our care for the patient?

2. What could have gone better during our care for the patient (ADD potential solutions if able)?
3. Was the Physician Team Leader (PTL) the **only** doctor calling out medication orders? YES NO
4. Was **anyone** confused at any time during the resuscitation about who was the PTL? YES NO
5. Time Debriefing Ended
6. State: "If anyone wants counseling support, please see referral numbers at the bottom of this form"

***Advice for Running A Team Debriefing***

1. Pick a quiet or isolated space if possible - start by thanking members for being present & encouraging all members to participate.
2. State: "The purpose of debriefing is for education, quality improvement, & emotional processing; it is not a blaming session. Everyone's participation is welcome & encouraged."
3. State: "These debriefings usually take several minutes and if you have urgent issues to attend to, you are welcome to leave at any time."
4. State: "I will briefly review the patient's summary and then we as an entire team can discuss what went well and what could have gone better. Please feel free to ask any questions."
5. Proceed as team leader with a brief summary of the patient's course (<1 minute) and then proceed to the group discussion. Documenter (not team leader) records on this form.

* If anyone needs or requests referral for free counseling, call the appropriate institution at 832-824-3327 (TCH) or 713-500-3327 (BCM)

*Updated 2/3/2012*

# When Things Are Going Wrong…

- “CUS” Approach
  - I am CONCERNED
  - I am UNCOMFORTABLE
  - This is a SAFETY issue
- Pre-Arranged Team Approach
  - Alert
  - Alert & Recommend
  - Abort

# What is your experience?

- We’ve all got bad stories – let’s talk about what works!