Physician-Nurse Teamwork: The Patient Safety Solution

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Overview
• What is teamwork?
• Why teamwork?
  – Outcomes data: patient, staff
• Barriers to teamwork
• Practical Solutions
  – Structured Communication Tools

What Is Teamwork?
• Behaviors?
• Communication Style?
• Content?
• Quality/quantity of information?
What is Teamwork? Research Findings

- Study of Physicians (hospitalists, and non-hospitalist physicians) and Nurses
- Sub-specialists:
  - “Multidisciplinary Team”: in theory only
  - Role on team: Captain!
- Hospitalists and Internal Med Physicians
  - Multidisciplinary Team: efforts to increase interaction
  - Role on team: Coordinator!

Models of Team Performance
Salas et al.

- “Teamwork is a set of interrelated behaviors, cognitions, and attitudes that combine to facilitate coordinated, adaptive performance.”
  - Knowledge: what we think
  - Behaviors/Skills: what we do
  - Attitudes: how we feel


What Teamwork IS and IS NOT (Salas et al)

- Doesn’t require that you like or “feel close” to your team members
- Doesn’t require that you work with team members on a permanent basis
- Requires a willingness to cooperate for a shared goal
  - emphasis on teamwork skills vs interpersonal bond
Models of Team Performance: Coach John Wooden

- **Coach John Wooden-UCLA**
  - 10 national championships in 12 years
  - 7 national championships in a row ’67-73
- “Sports show us so clearly how to work together with others to get the best results. They show that you must think of the group as a whole rather than just of yourself as an individual.”

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Models of Team Performance: Coach John Wooden

- More on the group vs individual
  - “We’ve seen many motion pictures where the star did a terrific job but the movie was a failure. I wanted every member of our basketball team to understand that the goal was to make ourselves into the best team we could possibly be, not to create a star.”
  - “Everyone on the team, from the manager to the coach, the secretary to an owner, has a role to fulfill. The leader must understand this.”

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How Teams and Systems Fail
“Swiss Cheese Model of Error”

[Diagram of the Swiss Cheese Model of Error]

Modified from Reason J. Managing the Risks of Organizational Accidents 1990
Effective Teams Trap Error

- “A preventable adverse outcome is often made up of many “trivial” errors. By reducing a subset of these trivial errors, the adverse outcome may be avoided altogether. Effective teams comprise members who monitor fellow members’ work to catch and correct the small errors that can lead to big problems.”

Why Teamwork?

- JCAHO Sentinel Event statistics
  - "Communication failures were cited as a root cause in approximately 65% of all sentinel events reviewed by the Joint Commission since 1995, making it the most frequently occurring problem associated with all types of serious adverse patient safety events."
  - "The need for improved and increased communication by and among physicians and other health care professionals warrants special focus."

Root Causes of Sentinel Events-JCAHO
(All categories: 1995-2002)
Root Causes of Delays in Treatment  
(JCAHO 1995-2002)

Root Causes of Wrong Site Surgery  
(JCAHO 1995-2002)

Other Data on Teamwork:  
Patient Outcomes

  • strong correlation between collaboration and patient outcome  
  • reduced readmission and death
  • lower than predicted mortality rates
- Shortell et al. Med Care 1994;32:508-525  
  • lower risk-adjusted LOS and nurse turnover
  • lower than predicted mortality
The Evidence on Teamwork and Communication

• Current state is suboptimal
• Good teamwork and communication is correlated with better care, better work environment
• So...what's the problem?

Barriers to Teamwork

• Time
• Logistics
• Disconnect in perceptions of how we’re doing
  • 33% of nurses rated communication and collaboration with physicians high/very high
  • 73% of physicians rated communication and collaboration with nurses high/very high

*Thomas et al. Crit Care Med 2003;31(3):956-959*

Barriers to Teamwork:
Strong Hierarchy and Tolerance of Abusive Behaviors

• Abusive behaviors not unique to nursing, somewhat more tolerated in healthcare
• Rosenstein AH. AJN January 2005;105(1)
  – "...as many as two-thirds of nurses say they've been abused by physicians at least once every two to three months, and these claims are supported by the nursing literature."
  – Only 1-3% of physicians exhibit these behaviors
    • small #s but we remember these incidents
    • significant impact on future behaviors
MD-RN Communication: Why the Disconnect?

- Different expectations
- Different styles of communication due to:
  - the pecking order/hierarchy
  - training-nurses taught to be narrative
  - gender
  - national culture/ethnicity
  - prior relationships- positive or negative

Are Hospitalists Any Different?

- What the nurses say about us. . .

Case Study: MD-Nurse Teamwork

**Study sites:**
- Large teaching hospital with 587 beds
  - 22 Nurses
  - 12 Physicians (6 hospitalists; 6 sub-spec)
- Small community hospital with 103 beds
  - 23 Nurses
  - 12 Physicians (6 hospitalists; 6 sub-spec)
Physician-Nurse Teamwork

• Majority of nurses cited good communication and teamwork with physicians
• Nurses at community hospital expressed most positive interactions with hospitalists, as compared to other physicians
• Nurses were more likely to cite bad communication & teamwork with non-hospitalist physicians

Physician-Nurse Teamwork

• TABLE HERE

Communication Continuum

• Deception
• Making person think it was their idea
• Hint and Hope
• Open and Direct
  – Most likely with accessibility, trust, knowledge
  – Accessibility, trust more likely with hospitalists, and some internal medicine physicians (teaching hospital)
**Good Communication**

- Hospitalists are more accessible. [*Quote 1*]
- Hospitalists know the nurses and the “floor” better. [*Quote 2*]
- Accessibility and trust are key to open, direct communication.
- Nurse is more likely to communicate freely—especially about potential problems. [*Quote 3*]

**Bad Communication**

- Often, physicians did not treat nurses as part of their team. [*Quote 1*]
- Then, nurses must use “strategies” to get physicians to listen to them. [*Quote 1*]
- These problems in communication led directly to problems in patient care. [*Quote 2*]

**Take Home Points From Research Findings**

- Overall, positive findings
- Hospitalists are in a key position to create the environment for optimal teamwork and collaboration
  - You’re there, they know you, and this opens the door for clear communication
    - Trust and knowledge overcomes hierarchical and other barriers to communication
- Subtle issues
  - Include nurses as part of the team
Approaches to Optimizing Communication and Teamwork

- Set the tone for good communication to occur
- Create an Infrastructure
  - Consider rounding together, increasing face to face interaction with nurses/managers, ie unit leaders
- Specific structured communication tools
  - Adapted from aviation, crew resource management (CRM), SBAR

Setting the Tone... Society of Hospital Medicine (SHM) Core Curriculum

- Team Approach and Multidisciplinary Care:
  - Hospitalists should be able to
    - “Emphasize the importance of mutual respect among team members”
    - “Create an environment of shared responsibility with patients and caregivers, and provide opportunities for patients and/or caregivers to participate in medical decision making”
    - “Act as a role model in professional conflict resolution and discussion of disagreements”

Setting the Tone... Behaviors That Promote Mutual Respect

- Know and use the names of people when possible
- Share your plan with residents, nurses, and support staff
- Solicit input, listen and respond to suggestions from nursing or other support staff
- Be willing to pitch in
- Praise good work and success, thank others
- Debrief after events
Creating Infrastructure
Concord Collaborative Care Model

- Cardiac surgery team rounds together
- 8:45am to 9:30am
  - MD, RN, PA/NP, Home Care Coordinator, Pharmacist, PT or OT, RT, Dietician, Diabetic Educator (if DM), Cardiac Rehab Specialist, Clinical Care Coordinator
- Review specific components of care and provide patient and family a chance to participate


• Operative Mortality Graph

Creating Infrastructure
Concord Collaborative Care Model

• Results:
  - Reduced mortality
  - Patient satisfaction 97-99th percentile nationally
  - Staff satisfaction: Quality of Work Life Survey-mean scores for all 8 dimensions improved significantly

• Other benefits:
  - Good overall picture and don’t have to spend time trying to figure out what the other 10-11 caregivers are thinking
Creating Infrastructure
Physician Unit Leaders
Kaiser Permanente Santa Clara

• Represents a true partnership between physicians and hospital managers
• Each medical-surgical unit has a physician leader to work with nurse manager
  – paid 4 hours/week
  – cost is split between hospital and physician group
• Roles
  – liaison between physicians and nurses
  – problem-solve, roll out carepaths, work on quality, service, and efficiency goals

Structured Communication Tools

• Communication Tools to
  – ensure information is complete
  – address conflict resolution
  – ensure a mutually acceptable plan is reached
• Examples
  – Closed Loop Communication model
  – SBAR
  – Escalation policies

Teamwork Failures Noted in Malpractice Claims

• “Medical students, residents, nurses, and support staff often hold a critical piece of information, have a “gut feeling”, or observe a pattern that they have seen before. Unfortunately, if the stage is not set for collaborative practice and good team communication, that important piece of information is not shared.”
• A “bad feeling” about a fetal heart rate. . .

Groff H. Forum July 2003; 23(3). (Risk Management Foundation of the Harvard Medical Institutions)
Structured Communication Tools
Closed Loop Communication

- Model to guide and improve assertion in the interest of patient safety

  GET PERSON'S ATTENTION
  REACH DECISION
  EXPRESS CONCERN
  STATE PROBLEM
  PROPOSE ACTION

GET PERSON'S ATTENTION

• Video Clip

The Common Pattern in Sentinel Events

- The overwhelming majority of untoward events involve communication failure
  - CONCERN was expressed
  - The PROBLEM was stated, often not clearly
  - A DECISION was not reached

- Somebody usually knows there is a problem but can’t seem to get action
The Missing Components

- Respect for each other’s clinical assessment
- Open communication and a sense of safety in asserting an idea
- Use of conflict resolution resources
- A shared plan of care
- Flexibility in managing a patient

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Structured Communication Tools:
S-B-A-R To the Rescue

- Situation
- Background
- Assessment
- Recommendation

How is SBAR Used?

- The SBAR model is a simple method to help standardize communication
- SBAR allows all parties to have common expectations
  - Content: Required elements/what information is communicated
  - Organization: the order in which information is communicated
- Information more likely to be complete
Effective Teamwork

• Requires
  – Knowledge
  – Skills
  – Attitudes
  – Opportunities for interaction and two-way dialogue

A Personal Story

• 2am, call from RN
• “He’s all out of breathe…”
In Summary... 

• There is a need for better teamwork  
  • create opportunities and acquire skills  
• There is value in teamwork  
  • better team performance = better patient outcomes  
• There are tools to help you  
  • team training, Human Factors, Crew Resource Management, SBAR  

Effective Teamwork Can Save Lives...  

• Go Team!