Can you hear me now? Survey responses to improve after-hours communication on the Clinical Teaching Unit

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Introduction

- Ineffective communication between nurses and residents is magnified by the intrinsic conditions found on the Clinical Teaching Unit after-hours. When ward patients are acutely deteriorating, the resident is pre-occupied admitting patients from emergency, often is unfamiliar with the majority of the up to sixty patients.
- Pertinent information regarding acute deterioration of a patient needs to available quickly. This supports a timely assessment with appropriate investigations and documentation.
- Implementation of an SBAR based structure has been shown to improve subjective perception of effective communication between nurses and physicians, but more importantly has evidence that there is a decrease in unexpected deaths (and an increase in ICU admissions)[6].
- A randomized trial that compared no communication tool to a problem-specific SBAR form (pain, fever, hypertension, glucose, medications or behavior) found that experienced nurses reliably communicated important information without prompting, but new graduates derived consistent benefit from a standardized reporting tool as they consistently failed to communicate relevant details[7].
- Current concerns on the CTU in Saskatoon Health Region include
  - Lack of timely assessment by residents
  - Important information such as vitals not relayed over phone
  - Lack of closed loop communication and hand-over to day team
  - Large proportion of new graduate nurses and high turnover rate with limited training in phone communication

Purpose

The purpose of this project is to use a survey to gather objective data on the current state of physician–nurse communication on CTU after-hours. If it is determined there is a need for improvement, a communication tool based off the SBAR gold-standard, will be further developed, implemented and evaluated to facilitate the collaborative process.

Methods

The current nursing staff on CTU at Royal University Hospital and internal medicine residents completed a survey of four questions. Questions were ranked from strongly disagree as a 1 to strongly agree as a 5, with the final question for comments.

Residents - PGY 1-3 (n=31 responses)

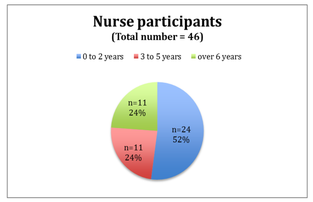
Q1) I am given all the *pertinent information* about the patient to determine the urgency of the situation?
Q2) I believe ineffective communication between physicians and nursing staff is a source of *medical error*
Q3) I think an "on call form" would be *helpful* to organize the pertinent information?
Q4) What information would you like to see on this form? Eg) change in vitals, level of consciousness, admission diagnosis, co morbidities

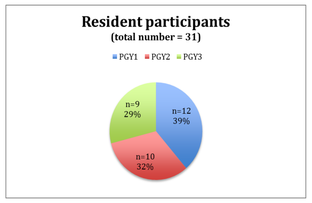
Nursing - RN and LPNs (n=46 responses)

Q1) I give the physician *enough patient info* to make a decision
Q2) I think ineffective communication between physicians and nursing staff causes *medical error*
Q3) An on-call form would be *helpful* to organize pertinent info
Q4) What info would you like to see on this form

Results

The percentage of participants stratified by years of training is outlined below:

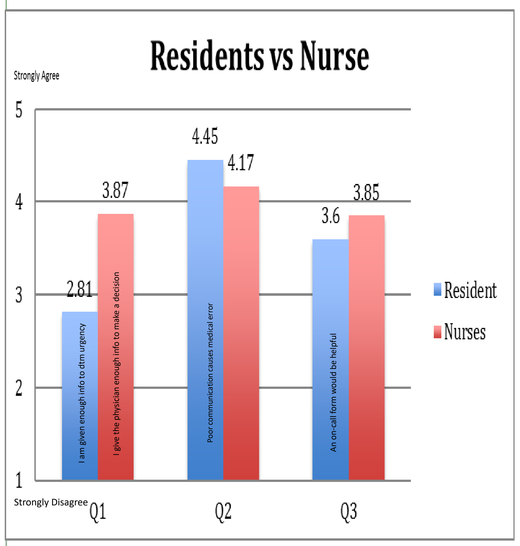


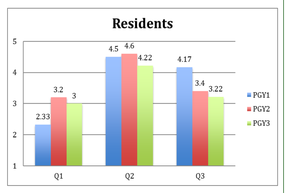


Both residents (n=31) and nurses (n=46) positively endorsed that:

- an on call form would be **helpful**
- poor communication is a current source **of medical error**
- There was a discrepancy between residents and nurses regarding how much information is needed for clinical decision making

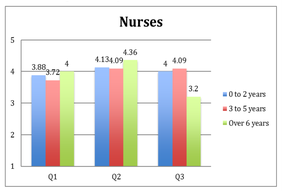
Overall Quantitative Data:





Data breakdown by experience:

- PGY1s felt more strongly that they are NOT given adequate information to determine urgency of assessment
- PGY1s supported the implementation of an on-call form more-so than upper-years.
- Senior nurses were more confident that they relayed enough information, and fittingly also felt that an on-call form would be less useful when compared to junior nurses



Qualitative Data Results:

Resident comments indicated:

- that the most important information to include in an on-call form so that it is readily available includes:
  - change from baseline (e.g. O_2 requirements), vitals, code status, same-day changes that were made, and relevant lab values.
- often the reason for calling is not made clear, and **vital signs** are one of the most pertinent pieces of information but frequently not available.

Nursing comments emphasized:

- the form be short and concise and would not create **double-charting**
- a template to use as a guide while on the phone which included reason for calling, vitals, medication changes, etc. would be helpful
- some staff felt under-supported and noted residents did not assess patients in a timely manner
- As a whole, nursing staff supported a communication tool with the most support from junior nurses with 0-2 years of experience.

Conclusion

Survey results indicate that there is a need for and support from staff for the development and implementation of an on-call communication and documentation form to be used by nurses and residents for acutely deteriorating patients.

Future Research

The natural progression of this project is to create and implement an after-hours nurse and resident assessment form. This would replace the physician and nursing progress notes, serve as a physical document to **detect recurrent night issue**s, and provide valuable information for future cross-covering residents and the day staff. It could also serve as a **hand-over tool**. This form could include:

- Nursing assessment
- Reason for calling
  - E.g.) chest pain, shortness of breath, hypotension, fever, behavior, medication related
- Vitals
- Time of phone call
- Interventions so far
- Phone orders received?

- Resident assessment
  - pertinent history and exam findings
- Time of assessment
- Impression and plan
- Need for day-team follow up?

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