Interacting with Staff in the Nighttime Role

National Pediatric Nighttime Curriculum

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Leadership in education, research, patient care, and advocacy

Objective

- To learn effective techniques for communication with nursing staff, including difficult/angry staff

Background: Poor communication harmful to patient care

- Dysfunctional communication between nurses-physician has been linked to increased **Medication errors**
- Poor communication, communication overload shown to directly correlate with
  - **Adverse events**
  - **Poor patient outcomes** (including M&M)
  - **Provider stress**

Case: It's Wartime

- For your leukemic patient receiving chemo-therapy you receive nightly text pages with the patient's temperature, which has never exceeded 38. Daily blood counts are normal and standing daily cultures remain negative.
- You receive the page "Room 331 has fever of 38.0. Please advise." You access your sign out which reads "Pan-culture for temp > 39."

Case:
It's Wartime continued

- Frustrated, you call the nurse, telling her you 'don't care about the temperature since it is not a real fever'. She apologizes profusely for disturbing you. You hang up, roll your eyes at your senior resident, and wittily brag that you have won a tiny battle in the 'war' that is nighttime patient care.
  - Why is this not ideal communication?
  - How could you have been more effective with your communication?

Case:
On the ‘sick side’

- A 3 month old RSV bronchiolitic developed an elevated respiratory rate on day shift. They ordered a VBG; the nurse calls results at 9 PM: pH 7.31 pCO2 57 Base excess -3.
- You are reassured overall but recognize potential risk; you quickly thank the nurse, examine the patient, and tell her you will enter some orders.
- At 10 PM you order: ‘Q 8 hr VBG’ ‘notify doctor for RR >70 or <25, sats <90% , increasing O2.’

Case:
On the ‘sick side’ continued

- The nurse sees the order an hour later, which delays placing the patient on a monitor. Since the timing of the lab order conflicts with change of shift, the VBG ordered is not performed or resulted by the time of AM rounds.
  - How could you have been more effective with your communication?

Improving Nighttime: Introductions and Checking-in

- Get to know staff; learn and use names
- Physician-charge nurse introductions
  - At the start of the rotation
  - At the start of each shift
- Planned night rounds with nursing staff; at least check-in
- End of shift wrap-up
  - Address learning points from shift, continuing concerns

Improving Communication: Attitude

- Strive for open communication
  - Non-punitive environment
  - Non-authoritarian approach
  - Respectful atmosphere
- Collaborative decision making: "all stakeholders count."
  - Patient, parents, nurses, ancillary staff

Improving Encounters: Two Techniques

- **LEARN-Confirm**
  - Allows individuals with different perspectives to “bridge the gap.”
  - Well-suited for difficult encounters

- **STICC**
  - Reveals reasoning behind plans
  - Well-suited for high-risk encounters, large amount of information to communicate

LEARN-Confirm Background

- Adapted from cross-cultural literature specifically for nighttime pages/encounters
- Encourages back-and-forth, bridges communication ‘gap’
- Employs techniques to help individuals with different perspectives reach a common patient-centric solution
  - Physician-nurse
  - Physician-physician
  - Physician-patient

LEARN-Confirm

- **Listen** to the nurse's perspective on the problem
- **Explain** your perception *Include "why"*
- **Acknowledge** differences and similarities
- **Recommend** your treatment plan *Include "why"*
- **Negotiate** a plan
- **Confirm** nurse understanding, nurse buy-in

Adapted from Berlin EA and Fowkes WC: A Teaching Framework for Cross-cultural Health Care. W J Med 139:130-134; 1983.

Case: It's Wartime LEARN-Confirm

- **Listen** "So I see you paged me because our patient has a temp of 38.0—what's your concern, tell me why you paged, do you have any concerns about his care?"
- *Nurse: "Oh, yes! He keeps having fevers and I don't fool around with temps and cancer patients. I had this leukemia patient just last week and she had fevers and her line was infected."*

Case: It's Wartime LEARN-Confirm continued

- **Explain** "You're right-- in some cancer patients, a temp of 38 might be concerning. ***But*** Charlie has a normal white cell count, no central lines, and blood cultures done yesterday are still negative, so because his immune system is OK we really think this is a virus and not a bacterial illness. Also he is old enough that a 38 temp is not concerning; my concern rises with a temp of 39 in kids his age."

Case: It's Wartime LEARN-Confirm continued

- **Acknowledge "**So I know you're worried about him, but I feel he is safe and does not need interventions for a temp of 38."
- **Recommend** "What if I write an order in the EMR to "notify doctor for temp >39 (102.2)." That way it is clear what the team is thinking and then you know when to call for a temperature that would prompt me to come see the patient and maybe give a med, check labs, intervene?"

Case: It's Wartime LEARN-Confirm continued

- **Negotiate** *NURSE: "But what about before? Mom says he went to the ICU last time he was here; his only problem was he had a low-grade fever like this one and looked sick*.**"**
- "That's different. If he's ill looking, I want to know about it. But well-appearing with a temp of 38: I'm OK with that, no need for the ICU. Makes sense?"

Case: It's Wartime LEARN-Confirm continued

- *NURSE: "Yes, it does."*
- **<u>C</u>onfirm** "OK, so I'll write the order and only expect calls for temp > 39, ill appearance, or new symptoms or complaints. Plus we check counts daily-we'll change the plan if his counts change."

STICC Background

- Communication technique employed by US Forest service to prevent adverse events in high-risk situations
- Good for when involved parties can’t see the same things, when danger involved, high risk situations
- May be better than LEARN-Confirm for time crunches

STICC

- **Situation**: Here's what I think we face.
- **Task**: Here's what I think we should do.
- **Intent**: Here's why.
- **Concern**: Here's what we should keep our eye on.
- **Calibrate**: Now talk to me. Tell me if you don't understand, can’t do it, or know something I do not.

  - Adapted from Weick. Puzzles in organization learning: an exercise in disciplined imagination. *Br J Manage*. 2002;13:S7-S17

Case: On the ‘sick side’ STICC

- Infant with RSV and tachypnea, VBG resulted.
- (Non-STICC approach: written orders)
- STICC approach:
  - **Situation** The gas shows a high but not critical CO2. I am reassured because his retractions aren’t too bad.
  - **Task** I need you to do his labs every 8 hours and place him on a monitor to follow his sats and respiratory rate now.

Case: On the ‘sick side’ STICC continued

- STICC continued:
  - **Intent**: With the monitor we can catch respiratory rate changes (worse distress or fatigue) and hypoxia. With the labs we can see if he has CO2 elevation which would raise concern for CO2 retention.

Case: On the ‘sick side’ STICC continued

- STICC continued:
  - **Concern**: While he may continue to do well, I need to know quickly if he has a RR in the 70’s, RR lower than 30, falling sats, or a pCO2 on his gas >60 so I can intervene: might mean he goes to the PICU. We need the gas completed before 9AM rounds

Case: On the ‘sick side’ STICC continued

- STICC continued:
  - **Calibrate**: Now talk to me please--tell me if this doesn’t make sense, if you can’t do the labs or follow him as closely as he needs, or if you see something I don’t’ know/ something I have not considered.

Important Principles of **LEARN-Confirm** and **STICC**

- Collaborative approach (even if the doctor makes the ultimate decisions)
- Ensure nursing perspective knowledge when making your decisions
- Ensure each other's understanding of the plan and the 'why' behind it
- Facilitate respectful interactions

Techniques for use in Challenging Situations

- Recognize changes in your own emotional state and in others; time out if necessary
- Confidence vs. Deference
  - Try the other if one is not working
- Apologizing goes a long way
- Don’t judge the past: help “from here on”

Case: Test Yourself

- You are caring for a 3 month old infant with infantile botulism. It is hospital day 14; over the past 2 days, she has more spontaneous movement with an active gag reflex and reassuring swallow study, so the day team approved advancement to PO feeds.

Case: Test Yourself continued

- *A nurse finds you in the hallway and asks: 'What do you mean with an order like "D/C NG Tube, ad lib feeds?" Do you even know how sick this kid was? She vomited twice on day shift. You Doc's are crazy if you think I'm doing that. Was anyone even going to tell Mom?!?*'
  - What effective communication techniques can help here*?*

Take Home Points

- Effective communication is essential for patient safety.
- The memorable mnemonics **LEARN-Confirm** and **STICC** employ effective communication elements for nighttime physician-staff interactions.

References

- **Physician-Nurse Interactions**

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Tjia J, Mazor KM, Field T, Meterko V, Spenard A, Gurwitz JH. Nurse-Physician Communication in the Long-Term Care Setting: Perceived Barriers and Impact on Patient Safety. *J Patient Saf*. 2009 September ; 5(3): 145–152.

Arford PH. Nurse-Physician Communication: An Organizational Accountability. *Nurs Econ*. 2005;23(2):72-77.

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- **LEARN-Confirm**

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- **STICC**

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