Vital Conversations:

Improving Interprofessional Communication

Disclaimer

The information provided through this activity is for educational purposes only. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice.

Getting the Most Out of Virtual Learning

- As much as possible, minimize distractions
- Technical issues may occur; please be patient with us
- Use the chat or Q&A feature to share your thoughts with the presenters
- Questions will be answered at the end of the presentation

We want to hear from you!

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Presenter

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Learning Objectives

Upon completion, participants should be able to:

- Delineate strategies to improve handoff communication
- Outline best practices to promote the development of a shared mental model
- Describe the relationship between clinical debriefing and patient safety

Vital Conversations:

Improving Interprofessional Communication

1999

Institute of Medicine (IOM) Report –

"To Err is Human"

Shocked the public and ignited the Patient Safety movement

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Medical Malpractice Claims

Unstructured Communication

The Hidden Threat to Patient Safety

Howick 2024.

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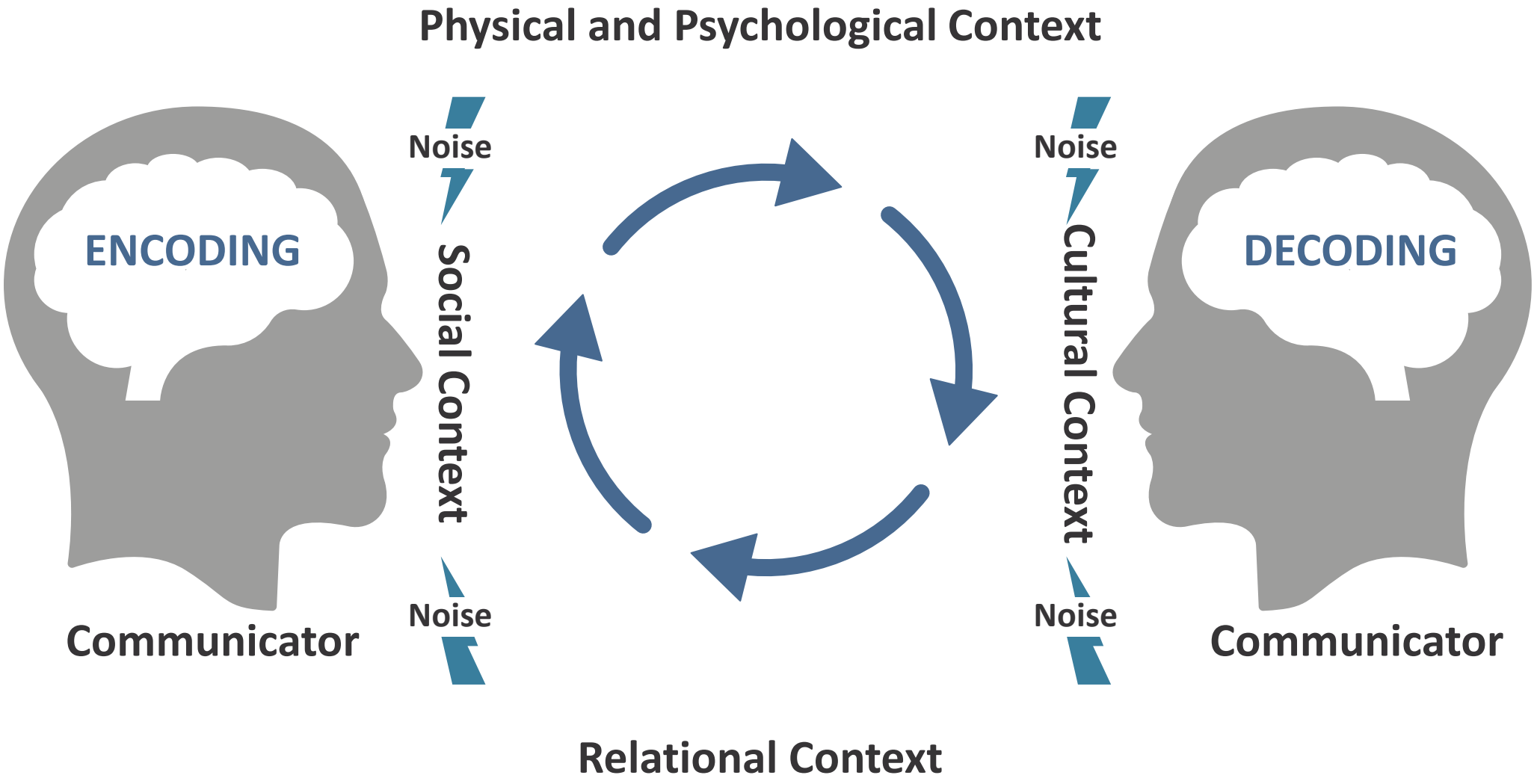
Why Is Communication Difficult?



Lapum 2020, AHRQ 2023.

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Handoff

*"A handoff is a **transfer** and **acceptance of patient care responsibility** achieved through **effective communication**. It is a real-time process of passing patient specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the **continuity** and **safety** of the patient's care."*

— The Joint Commission

TJC 2017.

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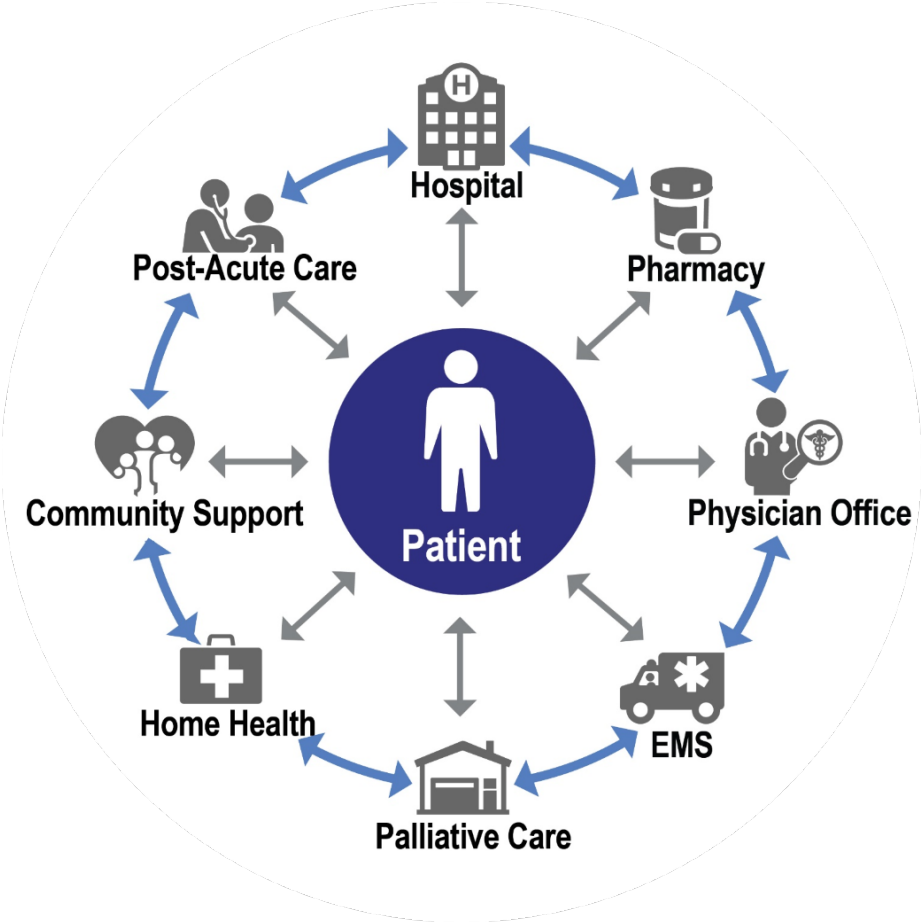
Handoff Communication



4,000 handoffs occur at teaching hospitals each day

- EMS admissions
- Provider sign-outs
- Bedside report
- Inpatient transfers
- Discharge to ambulatory

Blazin 2020.

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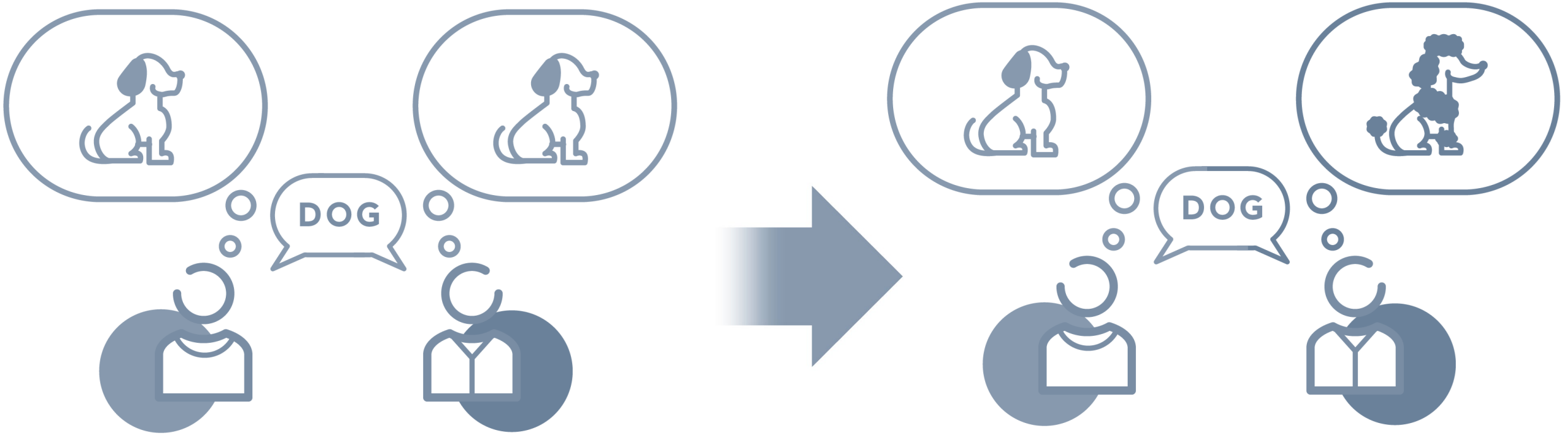
Shared Mental Model



2022 AHRQ Surveys on Patient Safety Culture (SOPS)

56-63%

of HCPs reported inadequate information exchange during transitions of care

AHRQ 2022.

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Best Practices

Adopt a Standardized Framework

Encourage Face-to-Face

Implement a Team-Based Approach

Practice, Practice, Practice!

Blazin 2020, Koo 2020, AHRQ 2023, AHRQ 2017.

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Adopt a Standardized Framework

- Implement standardized, structured handoff
- Develop handoff policy
- Ensure ongoing training is provided
- Be sure handoff format includes:
  - Patient's condition
  - Recent changes
  - Care plan

Blazin 2020, Koo 2020, AHRQ 2023, AHRQ 2017.

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Calls for Structured Handoff

- National Institutes of Health (NIH)
- Agency for Healthcare Research and Quality (AHRQ)
- Association of periOperative Registered Nurses (AORN)
- American Nurses Association (ANA)
- American Association of Colleges of Nursing (AACN)
- Accreditation Council for Graduate Medical Education (ACGME)
- The Joint Commission (TJC)
- American College of Emergency Physicians (ACEP)
- Association of American Medical Colleges (AAMC)
- Society of Hospital Medicine (SHM)

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Structured Handoffs

Situation

Background

Assessment

Recommendation

Communicate critical information requiring immediate attention and action

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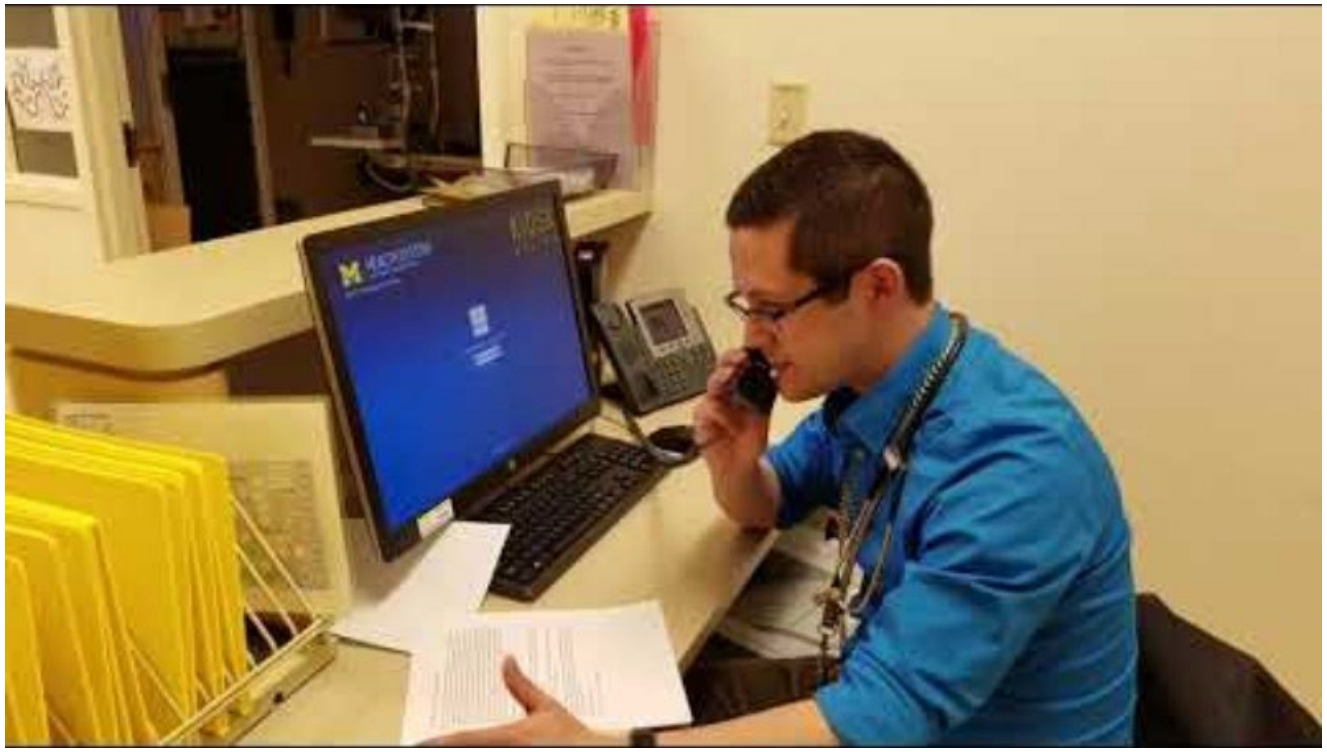
Structured Handoffs: I-PASS Framework

I	**Illness Severity**	Stable, "Watcher," Unstable
P	**Patient Summary**	Summary HPI, hospital course, ongoing assessment, plan
A	**Action List**	To-do list timeline, ownership
S	**Situation Awareness, Contingency Planning**	Know what's going on; plan for what might happen
S	**Synthesis by Receiver**	Receiver summarizes what was heard, asks questions, restates action items

Blazin 2020.

Handoff Example

- **I** — **Illness Severity**
- **P** — **Patient Summary**
- **A** — **Action List**
- **S** — **Situation Awareness, Contingency Planning**
- **S** — **Synthesis by Receiver**



In reflecting on your own handoffs, which area(s) need improvement?

- **I** — **Illness Severity**
- **P** — **Patient Summary**
- **A** — **Action List**
- **S** — **Situation Awareness, Contingency Planning**
- **S** — **Synthesis by Receiver**

In reflecting on your own handoffs, which area(s) need improvement?

Encourage Face-to-Face

Use in-person handoffs whenever possible

- ✓Direct communication
- ✓Opportunity for questions, clarification

Conduct handoffs

- ✓In quiet location
- ✓At bedside to involve patient/family

Blazin 2020, Koo 2020, AHRQ 2023, AHRQ 2017.

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Implement a Team-Based Approach

- Provides a comprehensive clinical picture
- Helps develop a shared mental model
  - ✓Salient patient issues
  - ✓Plan of action
  - ✓Team responsibilities

Blazin 2020, Koo 2020, AHRQ 2023, AHRQ 2017.

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Practice, Practice, Practice!

- Practice is important for new skills
- Practice supports skill acquisition and retention
- Skills need practice to become habit
- Practicing handoffs helps HCPs become proficient in conveying critical information

Blazin 2020, Koo 2020, AHRQ 2023, AHRQ 2017.

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Question slide

What are the barriers to using a structured handoff?

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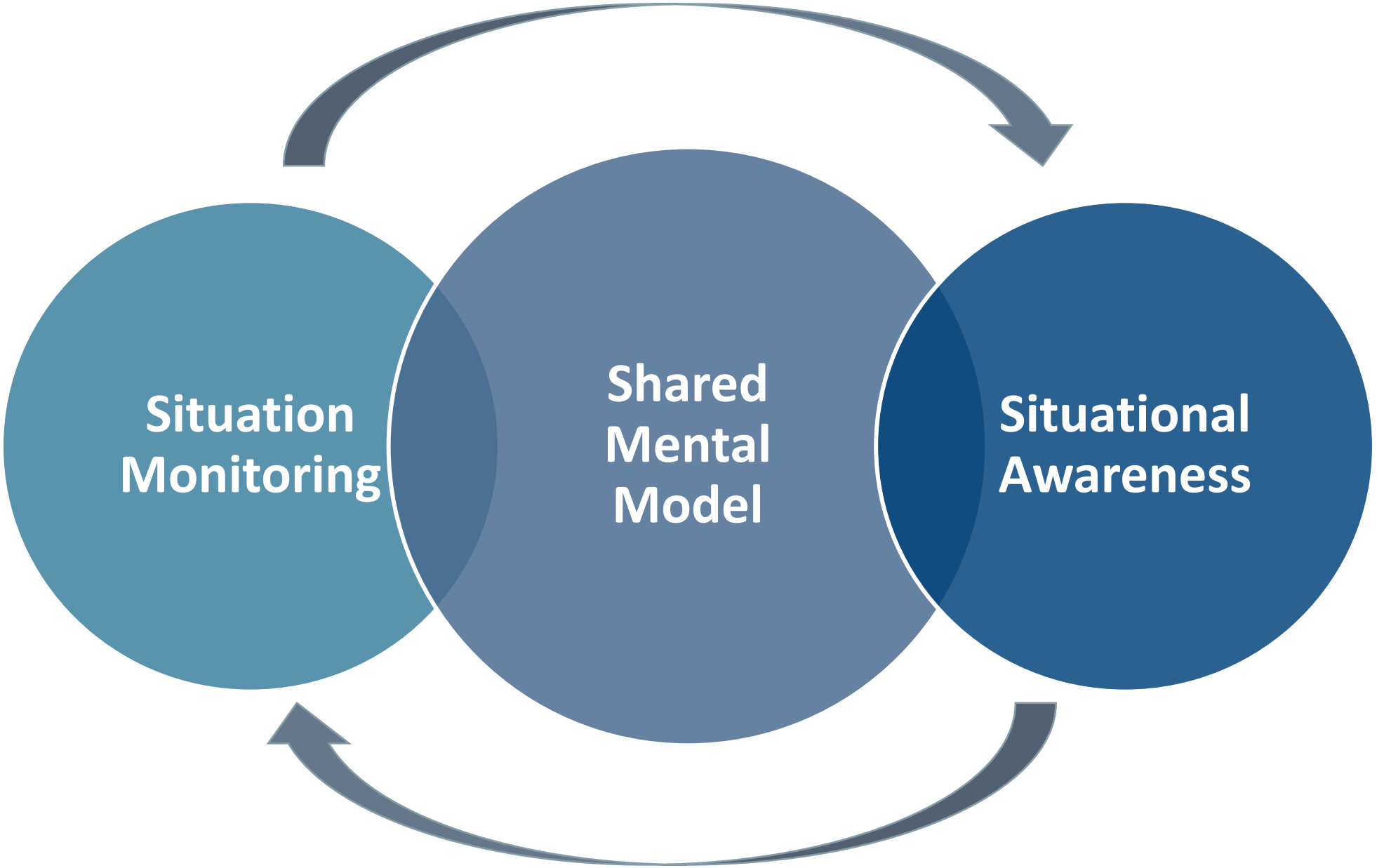
Situation Monitoring
Shared Mental Model
Situational Awareness

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Developing a Shared Mental Model

Call-Out

- Informs team of critical information during emergent situations
- Helps team anticipate next steps
- Directs responsibility

Obstetrician: *"We have a stage 1 postpartum hemorrhage. Nurse 1, start a second large-bore IV, run normal saline wide open, and administer oxytocin per protocol. Nurse 2, we need 2 units of PRBCs; notify the OR."*

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Developing a Shared Mental Model

Check-Back

- Closed-loop communication to ensure information conveyed is understood

Physician: *"Administer 1 mg of epinephrine IV push now."*

Nurse: *"1 mg of epinephrine IV push now, correct?"*

Physician: *"Yes, that's correct."*

Nurse: *"Pushing 1 mg of epi now."*

AHRQ 2024.

Escalating Concerns

Advocacy and Assertion

- Advocate for the patient
- Assert a corrective action in a firm and respectful manner

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Example: Advocacy and Assertion

Resident: *"I'm concerned about the medication dosage. The order states 5 mg but, based on the patient's weight and condition, the usual recommended dose is 2.5 mg. Should we double-check before proceeding?"*

Attending Physician: *"I've prescribed this dose before—it should be fine."*

Resident (escalating assertion): *"I'm really worried about potential toxicity at this dose. I'd feel more comfortable if we reviewed the guidelines or consulted pharmacy to confirm the safest option."*

Escalating Concerns

Advocacy and Assertion

- Two challenge rule
- Empowers team to stop the line in the name of patient safety

Escalating Concerns

Advocacy and Assertion

- "I am **C**oncerned"
- "I am **U**ncomfortable"
- "This is a **S**afety issue!"

STOP THE LINE!!!

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Planning

Briefs

- Task-specific
- Share the plan
- Discuss team roles
- Establish expectations
- Anticipate outcomes
- Plan for contingencies

"We're about to perform a thoracentesis on patient X, for a moderate left-sided pleural effusion under US guidance."

"Concerns are pneumothorax, bleeding, or vasovagal response."

"If the patient shows signs of distress, S.O.B., hypotension, or coughing, call it out immediately."

"RT: Be prepared with suction and oxygen."

Checking In

Huddle

- Check in with team
- Maintain situational awareness
- Reinforce plan
- Make adjustments to plan

AHRQ 2024, Pimentel 2021.

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Impact of Huddles on Team and Clinical Care Outcomes

Outcome Category	Specific Outcome	% of Studies Reporting Positive Impact
Team Process Outcomes	Overall team communication, collaboration, and/or coordination	67.7%
	Efficiency, process-based functioning, and communication across clinical roles	64.4%
	Situational awareness and staff perceptions of safety and safety climate	44.6%
	Staff satisfaction and engagement	29.7%
Clinical Care Outcomes	Patients receiving timely and/or evidence-based assessments and care	31.4%
	Decreased medical errors and adverse drug events	24.3%
	Decreased rates of other negative outcomes	20.0%

Pimentel 2021.

Improvement

Feedback

- Timely
- Respectful
- Specific
- Directed
- Considerate

AHRQ 2024.

Example: Feedback

"You did a great job identifying that the patient was deteriorating.

I thought you should have administered epinephrine earlier.

Overall, you did a great job of managing the situation."

Don't bury the lead in the "Feedback Sandwich"

Example: Feedback

Invitation to discuss:

"That was a difficult situation; can we take a couple of minutes to discuss?"

Observation:

"I noticed there were moments when the team seemed unsure of the next step—particularly when you were planning for the insertion of the chest tube."

Reflection:

"How did you feel about the flow of communication during that moment?"

Actionable takeaway:

"In the future, during an emergency, using call-outs with specific directives for the team will enable everyone to be on the same page and will help the team anticipate next steps."

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Improvement

Debrief

Discussion of team performance

- What went well?
- Opportunities for improvement?

"Define and discuss gaps in medical knowledge, clinical performance, and behaviors that directly relate to patient care."

— Kessler 2015

AHRQ 2023, AHRQ 2024, Kessler 2015.

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Myths of Debriefing

- Only needed when something bad occurs
- Only leadership should determine when debriefs are needed and what is debriefed
- Debriefers must remain neutral
- It is NICE to do but NOT NECESSARY

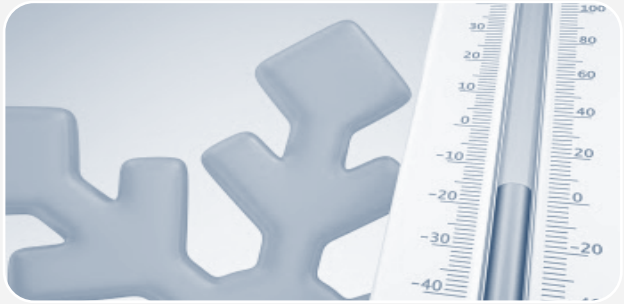
Seelandt 2021.

Debriefing Facts

- Debriefing should occur when needed
  - Coaching for skill development
  - Low-frequency/high-risk event
  - Serious safety event, critical near misses
  - High-stress/high-impact events
  - Failed resuscitations
- Debriefing can and should be called by anyone when needed and feasible
- Conducting a critique in a psychologically safe setting is crucial
- Without understanding how the error occurred and examining opportunities for improvement, THERE WILL BE NO IMPROVEMENT

Seelandt 2021.

Timing of Debriefing



Hot

Warm

Cold

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Framework for Debriefing

The PEARLS Healthcare Debriefing Tool

		Objective	Task	Sample Phrases
1.	**Setting the Scene**	Create a safe context for learning articulate the basic assumption	State the goal of debriefing;	*"Let's spend X minutes debriefing. Our goal is to improve how we work together and care for our patients."* *"Everyone here is intelligent and wants to improve."*
2	**Reactions**	Explore feelings	Solicit initial reactions and emotions	*"Any initial reactions?"* *"How are you feeling?"*
3.	**Description**	Clarify facts	Develop a shared understanding of the case	*"Can you please share a short summary of the case?"* *"What was the working diagnosis? Does everyone agree?"*
4.	**Analysis**	Examine performance domains	-	**Preview Statement** *(Use to introduce new topic)* *"At this point, I'd like to spend some time talking about [insert topic here] because [insert rationale here]."* **Mini Summary** *(Use to summarize discussion of one topic)* *"That was a great discussion. Are there any additional comments related to [insert performance gap here]?"*

Any Outstanding Issues or Concerns?

5.	**Application summary**	Identify takeaways	Learner-centered Instructor-centered	*"What are some takeaways from this discussion for our clinical practice?"* *"The key learning points for this case were [insert learning points here]."*

Meguerdichian 2022, Bajaj 2018.

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Case Presentations

Scenario 1: **Missing Details**

- Patient dx with ESRD and on dialysis arrived with symptoms of N/V
- Family member said patient was “dialyzed 3x per week”
- Workup ensued; labs drawn
- 2 team members checked labs, K+ pending when viewed
- At some point, resulted as hemolyzed
- Patient displayed arrythmias on monitor
- Patient later went into cardiac arrest
- Labs reviewed, noting sample hemolyzed, critical K+ level

Which tools could be applied?

I-PASS/SBAR

0%

Advocacy/Assertion

0%

Call-outs/Check-back

0%

Briefs/Huddles

0%

Debriefs/Feedback

0%

Which tools could be applied?

I-PASS/SBAR

0%

Advocacy/Assertion

0%

Call-outs/Check-back

0%

Briefs/Huddles

0%

Debriefs/Feedback

0%

Scenario 2: **A Dangerous Delay**

- 19-month-old child transported to ED via EMS for drowning
- ED team anticipated intubation, gathered supplies and meds
- RSI induced for airway protection
- Post-intubation, ETT confirmed by auscultation and chest rise
- Imaging was called to confirm ETT placement
- SpO_2 continued to drop over several minutes
- ED team decided to re-intubate
- RT arrived on unit and found O_2 tubing misconnection

Which tools could be applied?

I-PASS/SBAR

0%

Advocacy/Assertion

0%

Call-outs/Check-back

0%

Briefs/Huddles

0%

Debriefs/Feedback

0%

Which tools could be applied?

I-PASS/SBAR

0%

Advocacy/Assertion

0%

Call-outs/Check-back

0%

Briefs/Huddles

0%

Debriefs/Feedback

0%

Scenario 3:

- Teenage Somalian refugee, new dx murmur, sent to OR for valve repair
- Scrub nurse noticed blood oozing around cannulation site
- Scrub nurse applied gauze, called out to surgeon
- Surgeon asked resident to assess bleed
- Resident peered over drape, said, “Not much blood”; surgeon continued
- Within minutes of removing bypass, BP dropped; bypass reinstated
- Perfusionist added several units to bypass reservoir
- Patient removed again from bypass; unstable
- Resuscitation initiated; patient admitted to ICU in critical condition

Which tools could be applied?

I-PASS/SBAR

0%

Advocacy/Assertion

0%

Call-outs/Check-back

0%

Briefs/Huddles

0%

Debriefs/Feedback

0%

Which tools could be applied?

I-PASS/SBAR

0%

Advocacy/Assertion

0%

Call-outs/Check-back

0%

Briefs/Huddles

0%

Debriefs/Feedback

0%

Scenario 4:

- Premature infant, 35 weeks' gestation, 2353 grams, admitted to NICU
- Patient began exhibiting signs of respiratory distress
- NICU team, led by fellow, initiated support and then ventilation
- SpO_2 dropped, despite adjusted ventilator settings
- Diagnostic imaging revealed TEF, which would require surgery
- OB had identified "area of concern" on routine US; follow-up fetal MRI could not rule out TEF; OB documented this in his note and shared during handoff to neonatologist
- NICU fellow was not aware of these concerns

Which tools could be applied?

I-PASS/SBAR

0%

Advocacy/Assertion

0%

Call-outs/Check-back

0%

Briefs/Huddles

0%

Debriefs/Feedback

0%

Which tools could be applied?

I-PASS/SBAR

0%

Advocacy/Assertion

0%

Call-outs/Check-back

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Briefs/Huddles

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Debriefs/Feedback

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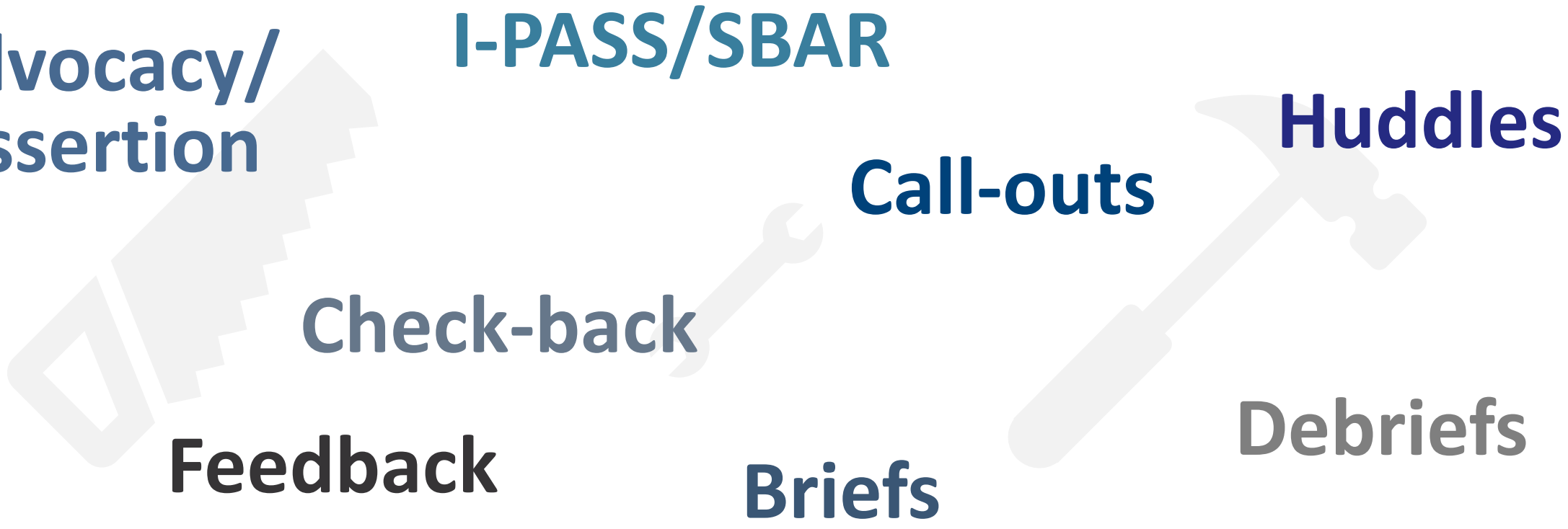
Which Tool Will You Add to Your Toolbelt?



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Which Tool Will You Add to Your Toolbelt?

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Questions?

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Thank You

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