Critical Communication in Escalation of Care

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Problem Statement

This presentation will discuss a critical event, the barriers within escalation and what can be done within debriefing to improve outcomes. Critical events occur throughout hospital environments. Communication during critical events can be very stressful for the family, nurse, critical care team, and the patient**.**

Debriefing can pinpoint areas of improvement while providing emotional support for those involved in the events.

Critical events occur when patients need escalation of care such as the patient experiences a change in heart rate, blood pressure, levels of oxygen saturation, decreased level of consciousness. These events need to be examined in a safe and effective way that improves patient safety and decreases cost.

Goals

1. The learner will be able to identify a critical event on a medical surgical unit.
2. The learner will recognize the importance of information exchange in a critical event.
3. The learner will be able to express two benefits of debriefing.

Case Study

65 year old black male admitted to medical floor. Patient complains of tightness in chest and has visible trouble breathing. The vital signs are as followed: blood pressure 88/46, heart rate 118, respiratory rate 32, and oxygen saturation 89% on 100% non re-breather. Nurse initiates emergency team for assistance. Team arrives, stabilizes patient with a breathing treatment, and a bolus. Patient is left on the floor. ICUs are full. Patient remains on 70 % open face tent, heart rate 105, blood pressure 94/63. The team recommends getting the following labs : ABG, CBC, BMP, PT/PTT. A chest x-ray and EKG are done with signs of slight pulmonary edema.

No Debriefing was done—

2 days later: A different nurse activates the emergency team again for assistance due to the patient in respiratory distress on 100 % non re-breather, abdomen tight, rapidly decreasing consciousness. Emergency team arrives and begins to try and stabilize patient. Patient begins to vomit large amounts of coffee ground emesis. Suction is quickly set up at bedside, no heart beat, emergency team initiates chest compressions and code measures. Resuscitation measures unsuccessful.

Assessment

Communication is vitally important to patient safety. Communication must be open and intentional for the best patient outcome possible. During a critical event chaos can ensure causing communication to be interrupted which then becomes a patient safety issue. Teams that do not communicate well have been correlated to high patient morbidity and mortality. (Raboll, L., McPhail, A., Ostergaard, D., Anderson, H., Mogensen, T., 2012). After the critical event is over a important opportunity for communication is often missed. The critical event team leave and the medical surgical nurse unsure of where his/her actions could have helped or harmed the patient.

Debriefing could have been used to identify the patient's distended abdomen, or foul smelling stools that the nurse previously reported to another team of 'off' going doctors before the first event.

Barriers to Communication	Promoters of Communication	Vulnerable Situations
Lack of standard assignments or procedures. Confusion over who does what.	Establishing a time to communicate and agreements on how to proceed, confirmations of agreements after a task (example: after larger emergencies)	Handing over critical, detailed and comprehensive information.
Diverging agendas- due to different professional backgrounds, staff groups have diverging agendas regarding instances for care and creates talk of cross purposes.	Knowing the other team members. Appreciation of others skill level and experience.	Establishing Skills and roles during multi-professional teamwork in larger acute care teams.
Interruptions or many similar tasks. High workloads, multitasking and interruptions.	A flat hierarchy that promotes a team members ability to speak up at any time.	Dividing Tasks and establishing a plan for communication during teamwork- rounds.

Chart 1: "Promoter and barriers in communication. A focus groups study." Article published in the Journal of Communication in Healthcare, 2012.

Debriefing as an Educational Strategy

A literature search for 'peer evaluation in teams success' yielded 276,143 results for peer reviewed articles. Debriefing should be the peer/ self evaluation of critical events within the hospital. A conversation about ' "how' and "why" this event happened.

Peer evaluation is a substantial educational strategy that works. It encompasses personal reflection and evaluation.

Debriefing identifies the good an bad of a situation and uses multiple viewpoints to establish a better course of action and to identify strengths and areas of improvement. The purpose is to be better next time not to punish!

Debriefing is the a discussion and analysis of a shared experience . Within debriefing is the basis for evaluation and increased awareness of processes and events (Gardner, 2013). Debriefing allows the critical care team to share their knowledge of critical situations and ways to improve how emergencies are handled.

Implementation

1. Develop a tool that identifies minimum areas to be covered during debriefing.

***A debriefing should cover the events that transpired, identify areas that the all could improve on, areas of great contributions, and lessons learned from the event. Debriefing will strengthen each team member and improve/standardize established roles. Debriefing should also help manage and identify knowledge deficits that need to be addressed on the unit. ***

2. Debrief after every critical event that required intervention from an emergency assistance team, regardless of whether code occurred or not.

3. Follow up with team members, by insisting on the completion of an evaluation.

4. Evaluate using patient events and outcomes to visualize a difference, before and after the implementation of debriefing.

Solutions

Active involvement of the entire team involved (including floor nurses) encourages patient safety and improved management of patients during critical events.

Debriefing improves patient safety and reduce cost.
Debriefing identifies the knowledge gaps of the nursing staff.
Debriefing allows the hospital to address inconsistencies in critical situations and educate to improve patient care.
Debriefing reduces the costs by reducing errors and helps save lives.

"An analysis of briefing content revealed that a substantial number of the briefings benefitted clinical work by revealing knowledge gaps or provoking a change in the care plan." (Lingard, 2014)

References

Dean, M. M., Oetzel, J. J., & Sklar, D. D. (2014). Communication in acute ambulatory care. *Academic Medicine*, doi:10.1097/ACM.0000000000000396
Gardner, R., (2013). Introduction to debriefing. Seminars in Perinatology. 37, 166-174.
Johnson, S., & King, D. (2012). Nurses' Perceptions of Nurse-Physician Relationships: Medical-Surgical vs. Intensive Care. *MEDSURG Nursing*, *21*(6), 343-347.
Lingard L, Regehr G, Doran D, et al. Evaluation of a preoperative team briefing: a new communication routine results in improved clinical practice. *BMJ Quality & Safety* [serial online]. June 2011;20(6):475-482. Available from: CINAHL Plus with Full Text, Ipswich, MA. Accessed September 19, 2014.
Rabøl, L., McPhail, M., Østergaard, D., Andersen, & Mogensen, T. (2012). Promoters and barriers in hospital team communication. A focus group study. *Journal Of Communication In Healthcare*, *5*(2), 129-139. doi:10.1179/1753807612Y.0000000009