Nursing Executive Center

Building the Nurse–Physician Partnership
Restoring Trust, Fostering Collaboration

- Revitalizing the Nurse–Physician Relationship
- Establishing Clinical Collaboration

The Advisory Board Company ∞ Washington, D.C.
Nursing Executive Center Staff

Project Directors
Aliina Hirschoff

Contributing Consultants
Alicia Daugherty

Lead Designers
Kinsey Holder
Katie Hosmer

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Building the Nurse–Physician Partnership

Restoring Trust, Fostering Collaboration

- Revitalizing the Nurse–Physician Relationship
- Establishing Clinical Collaboration
Anger: It’s All the Rage
THE CASE FOR STRENGTHENING NURSE–PHYSICIAN RELATIONS
Taking Evasive Action

Percentage of Nurses, Physicians, and Hospital Executives Reporting…

n=1,200

30.7%...nurses leaving hospital as a result of disruptive physician behavior

24.0%...nurses revising schedules, changing departments to avoid contact with certain physicians
Great Nurses a Strong Draw

Percentage of Physicians Rating Clinical Nursing Skill as “Extremely Important” in Selecting a Hospital

n=531

Out of 47 factors, clinical skill ranked fourth-highest, even higher than hospital’s reputation for clinical excellence or access to latest-generation technology.
Root Causes of Sentinel Events 1995–2004

n = 3,197

Percentage of Sentinel Events Linked to Cause

- Communication
- Orientation/Training
- Patient Assessment
- Staffing
- Availability of Info
- Competency/Credentialing
- Procedural Compliance
- Environ. Safety/Security
- Leadership
- Continuum of Care
- Care Planning
- Organizational Culture

Over 60% of sentinel events reported to JCAHO attributed, at least in part, to poor communication

More Than Just Happiness
Nurse–Physician Collaboration = Improved Patient Care

Mortality per 100 Patients Before and After Implementation of Collaborative Rounds and Other Collaboration Initiatives

Concord Hospital Cardiac Surgery, July 1998–October 2001

Following collaboration initiatives, patient mortality rate decreases by 56%

* Other initiatives include a structured communications protocol and biweekly meetings to discuss rounds process, address system-level concerns.
Inverting Undesirable Outcomes

Relationship Between Nurse Autonomy/Nurse–Physician Collaboration and Negative Patient Outcomes

21 Units, 944-Bed Teaching Hospital

- Failure to Rescue: $r = 0.53$; $p < 0.05$
- Incidence of UTI: $r = 0.29$; $p < 0.05$
Disruptive Physician Behavior Still a Problem

Percentage of Survey Respondents Who Have Witnessed Disruptive Physician Behavior

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>74%</td>
</tr>
<tr>
<td>Nurses</td>
<td>86%</td>
</tr>
<tr>
<td>Administrators</td>
<td>75%</td>
</tr>
<tr>
<td>Physicians</td>
<td>49%</td>
</tr>
</tbody>
</table>

n = 1,509
An Unwelcome Focus on Nurses

Targets of Disruptive Physician Behavior
American College of Physician Executives Survey

- Patient: 14.2%
- Administrator: 14.5%
- Nurse or Physician Assistant: 56.5%
- Another Physician: 14.7%

n=1,554

Other clinicians most common target of physicians’ abuse
## Not Just Innocent Victims

Survey Respondents Who Have Witnessed Disruptive Nurse Behavior

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Nurses</th>
<th>Administrators</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>68%</td>
<td>72%</td>
<td>75%</td>
<td>47%</td>
</tr>
</tbody>
</table>

n=1,509
Nurses Bear Some Responsibility

**Poor Preparation**

No, I don’t have the test results.

**Unresponsiveness**

I can’t find a PCA machine for my patient.

That’s not my job.

**Complaints About Work Environment**

All these new graduates are incompetent!
# Hope for the Future?

*Current and Projected Trends Affecting Nurse–Physician Relations*

<table>
<thead>
<tr>
<th>Trend</th>
<th>Likely Influence on Nurse–Physician Relations</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growing Hospitalist Ranks</td>
<td>![Up Arrow]</td>
<td>Units with large numbers of hospitalists more fertile ground for collaboration; consistency of staffing builds trust</td>
</tr>
<tr>
<td>Reduced Resident Work Hours</td>
<td>![Double Arrow]</td>
<td>Inability to rely as heavily on residents may make physicians more reliant on nurses; shorter work hours reduce resident fatigue/stress, but may also increase nurse and attending workload/stress</td>
</tr>
<tr>
<td>Generational Shifts</td>
<td>![Double Arrow]</td>
<td>Younger nurses less tolerant of disruptive physician behavior; more interested in collaborative relationships with physicians; physician training increasingly technology-focused, less communication-focused</td>
</tr>
<tr>
<td>JCAHO Mandates</td>
<td>![Up Arrow]</td>
<td>Improving communication among caregivers a National Patient Safety Goal; additional related goals planned for future</td>
</tr>
<tr>
<td>Magnet Requirements</td>
<td>![Double Up Arrows]</td>
<td>Magnet application process provides impetus to launch collaboration initiatives</td>
</tr>
<tr>
<td>Increasing Interdisciplinary Education</td>
<td>![Up Arrow]</td>
<td>Joint health professions classes build trust, promote respect for and understanding of other disciplines; however, very few schools pursuing such initiatives</td>
</tr>
<tr>
<td>Projected Nursing Shortage</td>
<td>![Double Up Arrows]</td>
<td>As projected nursing shortage builds, hospitals will have to focus on improving collaboration to decrease nurse turnover and ensure quality and safety</td>
</tr>
</tbody>
</table>
## Forging a Better Nurse—

### Revitalizing the Nurse–Physician

<table>
<thead>
<tr>
<th>Creating Leadership Alliances</th>
<th>Addressing Unacceptable Behavior</th>
<th>Building Joint</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tactic #1</strong></td>
<td><strong>Tactic #2</strong></td>
<td><strong>Tactic #3</strong></td>
</tr>
<tr>
<td>Nursing–Medical Leadership Linkage</td>
<td>All-Staff Conduct Policy</td>
<td>Complaint Feedback Loops</td>
</tr>
</tbody>
</table>

Nursing and physician leaders—starting with the CNO and CMO and continuing down through the nurse manager and physician leader—establish proactive, visible partnerships; goal to promote standards of conduct, build relationships, and nurture clinical collaboration.

Hospital establishes clear conduct policy for all staff and physicians, uniformly applies consequences regardless of offender’s status; goal to hold all disciplines to same expectations.

CNO and medical leadership work together to ensure that all complaints from nurses or physicians receive formal response; goal to build trust in organization, and across disciplines, by demonstrating that all concerns are heard, investigated, and appropriately addressed.

Hospital provides new graduate nurses with tools, training, and support to prepare them for physician interactions; goal to increase new nurses’ confidence around physicians, minimize physician complaints about nursing staff’s being under-prepared for conversations.

Nurses and physicians commit to clear standards of responsiveness and preparedness; goal to preempt negative interactions by addressing common points of friction up front.
## Physician Partnership

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Establishing Clinical Collaboration</th>
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</thead>
<tbody>
<tr>
<td><strong>Trust</strong></td>
<td><strong>Offering Shared Learning Opportunities</strong></td>
</tr>
<tr>
<td>Tactic #6 Nursing-Driven Physician Education</td>
<td>Tactic #9 Hospital-Wide Communication Improvement Campaign</td>
</tr>
<tr>
<td>Nurse leaders educate physicians about nurse retention and nursing department operations; goal to help physicians understand their role in establishing and maintaining a positive work environment, as well as correct misimpressions about the hospital's nursing organization</td>
<td>Nursing and medical leadership collaborate to establish hospital-wide committee comprising physicians, nursing management, and frontline staff; goal to address concerns on both sides, as well as improve hospital-wide nurse-physician collaboration</td>
</tr>
<tr>
<td><strong>Tactic #8</strong> Interprofessional Health Care Education</td>
<td><strong>Practicing in Partnership</strong></td>
</tr>
<tr>
<td>Hospitals support schools of nursing, medicine, and other health professions in establishing opportunities for students across disciplines to learn together; goal to build future cadre of clinicians already accustomed to working collaboratively to improve care quality</td>
<td>Physicians and nurses conduct joint rounds, develop unit-specific education sessions to share respective clinical expertise; goal to minimize conflict over practice decisions, improve communication, and elevate care quality</td>
</tr>
<tr>
<td><strong>Tactic #7</strong> Hospital-Wide Nurse–Physician Committee</td>
<td><strong>Tactic #10</strong> Clinical Expertise Sharing</td>
</tr>
<tr>
<td>Nursing and physician leaders collaborate to establish hospital-wide committee comprising physicians, nursing management, and frontline staff; goal to address concerns on both sides, as well as improve hospital-wide nurse-physician collaboration</td>
<td>Hospital sponsors unit-based clinical practice committees comprising nurses, physicians, and other disciplines; goal to establish evidence-based practices and elevate clinical quality through discussion of recurring unit issues, recent patient cases</td>
</tr>
<tr>
<td><strong>Tactic #11</strong> Unit-Based Interdisciplinary Committees</td>
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</tbody>
</table>
**Revitalizing the Nurse–Physician Relationship**

**Creating Leadership Alliances**

**Tactic #1**
Nursing–Medical Leadership Linkage

Hospital establishes clear conduct policy for all staff and physicians, uniformly applies consequences regardless of offender's status; goal to hold all disciplines to same expectations

**Tactic #2**
All-Staff Conduct Policy

CNO and medical leadership work together to ensure that all complaints from nurses or physicians receive formal response; goal to build trust in organization, and across disciplines, by demonstrating that all concerns are heard, investigated, and appropriately addressed

**Addressing Unacceptable Behavior**

**Tactic #3**
Complaint Feedback Loops

Hospital provides new graduate nurses with tools, training, and support to prepare them for physician interactions; goal to increase nurses' confidence around physicians, minimize physician complaints about nursing staff's being under-prepared for conversations

**Tactic #4**
New Graduate Communication Coaching

Nurses and physicians commit to clear standards of responsiveness and preparedness; goal to preempt negative interactions by addressing common points of friction up front

**Building Joint Trust**

**Tactic #5**
Nurse–Physician Service Contracts

Nurse leaders educate physicians about nurse retention and nursing department operations; goal to help physicians understand their role in establishing and maintaining a positive work environment, as well as correct misperceptions about the hospital's nursing organization

**Tactic #6**
Nursing-Driven Physician Education

Nursing and physician leaders collaborate to establish hospital-wide committee comprising physicians, nursing management, and frontline staff; goal to address concerns on both sides, as well as improve hospital-wide nurse-physician collaboration

**Tactic #7**
Hospital-Wide Nurse–Physician Committee
Institute's reputation for care excellence increases patient volumes, but new facility still under construction.

Nurses and physicians debate ideas, priorities for allocation of space and resources to accommodate as many patients as possible.

Nurses and physicians come to consensus, present mutually acceptable plan to CEO for approval.

Tactic #1: Nursing–Medical Leadership Linkage

Planning Collaboratively for Volume Growth

Dana-Farber Cancer Institute, Boston, Massachusetts
Tactic #2: All-Staff Conduct Policy

Interdisciplinary Committee Develops Staff-Wide Conduct Policy
OSF Saint Francis Hospital, Peoria, Illinois

Elements of Conduct Policy

- Applies to all physicians and hospital staff
- Specifies both acceptable and unacceptable behaviors
- Includes procedures for investigating and resolving complaints
- Supported by CEO, who has terminated physician privileges as necessary

Standards of Professional Relations
Policy
Saint Francis Medical Center ("Hospital") is committed to providing a work environment that supports the philosophy of teamwork, collaboration, and professional growth. Hospital employees, physicians, contracted staff and vendors will utilize behaviors and interpersonal communication styles that demonstrate courtesy, dignity, and respect in all interactions including e-mail and telephone.
Calling All Angels

The OSF Saint Francis Medical Center / Children’s Hospital of Illinois
Outstanding Physician and House Staff Angel Award

Nomination Form

This award is designed to recognize OSF SFMC / CHOI Attending Physicians and House Staff (residents) who exhibit outstanding service to patients, families, visitors and/or co-workers. While it is every physician’s responsibility to foster a customer-focused environment and have a positive attitude, individuals worthy of the Outstanding Physician and House Staff Angel Award nomination consistently extend themselves beyond their normal work responsibilities and contribute to the overall Mission of the hospital. Nominees need not be limited to those with direct patient contact. The Outstanding Physician and House Staff Angel Award is given to individuals who exemplify the unique ability to foster outstanding professional relationships with all levels of hospital staff and co-workers.

Criteria

Nominees must exemplify outstanding behavior in the following organization-wide competencies:
(Please rank 1–3 with 3 being the highest)

1) Communication
   • Shows common courtesy in all co-worker interactions 1 2 3
   • Responds to co-workers questions / concerns in a timely fashion 1 2 3
   • Listens attentively to all team members’ concerns 1 2 3
   • Always addresses team members in a positive manner 1 2 3
   • Recognizes and acknowledges individual expertise of all team members 1 2 3
   • Shares knowledge willingly 1 2 3

2) Teamwork
   • Partners effectively with all members of the team to accomplish goals 1 2 3
   • Places team responsibilities above individual interests 1 2 3
   • Effectively works with diverse groups of employees 1 2 3
   • Shares knowledge and provides feedback to others 1 2 3
   • Is receptive and responsive to others’ ideas and opinions 1 2 3
   • Encourages teamwork and builds team skills in self and others 1 2 3

3) Service Principles
   • Treats the people we serve with respect and courtesy at all times 1 2 3
   • Demonstrates pride in our personal appearance and the appearance of our facility 1 2 3
   • Respects the privacy and confidentiality needs of the people we serve 1 2 3
   • Anticipates the wants and needs of the people we serve 1 2 3
   • Acts to reverse negative service situations as quickly as possible using “Acknowledge, Accept and Amend” 1 2 3
   • Works to actively listen to and communicate with the people we serve 1 2 3
   • Demonstrates a sense of ownership and pride toward our work, recognizing that it is a reflection of OSF SFMC/CHOI and ourselves 1 2 3
Physician Feedback
Leads to Concrete Improvements
St. John’s Regional Medical Center, Oxnard, California

Surgeon frustrated by lack of PCA machine following procedure
Rather than getting upset, surgeon calls physician complaint line to report problem
In response to several such complaints, hospital convenes committee to examine problem
Hospital spends $50,000 on new equipment, changes maintenance procedures to make more units available
June, 2005

Dear Dr.:

With regard to your complaint, control #1386, our records show that an evaluation of your concerns has been completed and the results were reported to you. *(Attached is a copy of the response)*

The evaluation of your satisfaction is an integral part of monitoring our complaint process. Please answer the following questions and return this form to Medical Staff Services (by mail or fax to 981-4402) within two weeks:

1. Were you satisfied with the complaint process?  
   - Yes [ ]  
   - No [ ]

2. Did you receive a resolution report?  
   - Yes [ ]  
   - No [ ]

3. a. If there was a RESOLUTION, please rate it by circling the appropriate letter:

   - Highly Satisfactory  
   - Very Satisfactory  
   - Satisfactory  
   - Somewhat Satisfactory  
   - Unsatisfactory

   High A  
   Very B  
   Satis C  
   Some D  
   Unsatisf E

b. If there was NO RESOLUTION, please rate the explanation by circling the appropriate letter:

   - Highly Satisfactory  
   - Very Satisfactory  
   - Satisfactory  
   - Somewhat Satisfactory  
   - Unsatisfactory

   High A  
   Very B  
   Satis C  
   Some D  
   Unsatisf E

Comments:

Date: [ ]  
Signature: [ ]

Thank you for participating in this quality management process. We recognize you as a valued customer and partner as we strive to continuously improve the delivery of health care to our patients.
Tactic #4: New Graduate Communication Coaching

Preparing New Graduates for Physician Calls
INTEGRIS Baptist Medical Center, Oklahoma City, Oklahoma

New graduate nurses often unprepared when calling the physician

Nursing team managers coach new graduate nurses through first calls with physicians; new graduates read back orders

Nursing department develops list of information to have prior to calling the physician

Physicians develop greater trust in new graduate nurses and the entire nursing team
Tactic #5: Nurse–Physician Service Contracts

Aligning Physician, Nurse, and Patient Expectations
St. John’s Regional Medical Center, Oxnard, California

**Nursing’s Commitment to Our Physicians and Patients**
The nurses at SJRMC and SJPVH are committed to:

- Reviewing physicians’ orders within 30 minutes
- Noting routine orders within one hour, and STAT orders within 15 minutes
- Implementing routine orders within one hour, STAT orders within 15 minutes, and NOW orders within 30 minutes (assuming medication supplies are available)
- Reading physicians’ orders, H&P, progress or interdisciplinary notes, lab results, and tests

**Nurses promise to review all progress notes, lab results, and other relevant communications**

**Nurses commit to carry out physician orders within specified timeframes, depending on urgency**
Setting the Record Straight
INTEGRIS Baptist Medical Center, Oklahoma City, Oklahoma

CNO catalogues physician misperceptions, complaints

Clinical director presents correct information at nurse–physician liaison committee meeting

Information also presented in physician newsletter

Armed with accurate data, select physicians become champions of hospital’s nursing organization

Actually, our RN turnover is quite low.
SPREADING THE NEWS ABOUT NURSING

PHYSICIAN UPDATE
News for Physicians about INTEGRIS Health
Vol. VII No. VII July 2005

A Word from Bruce Lawrence
Part three of this series related to INTEGRIS’ Metropolitan Facilities Ten Year Strategic Plan addresses our third strategy. Strategy C: Provide quality of care and service that exceeds our patients’ expectations.
This strategy is the heart of all we do. Improving clinical outcomes, using appropriate clinical information systems to support clinicians or developing minimum customer service standards across metropolitan facilities – these tactics ensure we become the role model for care delivery in our region.
We continue to focus on what our patients tell us regarding their care and will work closely with our clinicians to make improvements. Convenience, communication and consideration are three primary issues of concern. We will compare our outcomes to best practices across the nation and will focus on improving culture.
In the communication piece that will be mailed to our physicians, board members and staff, we address the environmental factors shaping our industry’s future. Delivery of care changes, consumerism, competition and work force issues will impact us as we work toward providing quality of care and service that exceeds our patients’ expectations. We look forward to this journey and encourage your participation.
C. Bruce Lawrence, president and COO, INTEGRISmetro facilities

INTEGRIS Baptist Re-launches Magnet Journey
INTEGRIS Baptist nursing team has pursued Magnet status for several years. The Magnet Nursing Services Recognition program is a national recognition for health care organizations demonstrating
sustained excellence in nursing:
• Management, philosophy and practices of nursing services
• Adherence to national standards for improving the quality of patient care
• Nursing leadership in supporting professional practice and continued staff competencies.
Only 143 hospitals nationwide have achieved this status.
On May 19 and 20, the Nursing Leadership team met with an American Nurse Credentialing Center (ANCC) consultant to work with the Magnet Operational steering committee to conduct a gap analysis. A review of all 14 forces of Magnetism was completed. These areas included:
• Quality of nursing leadership
• Organizational structures
• Management style
• Personnel policies and programs
• Professional practice care models
• Quality of care
• Quality-improvement initiatives
• Consultation and resources
• Nurse autonomy
• Community and the health care organization
• Nurses as teachers
• Image of nursing
• Interdisciplinary relationships
• Professional development.
The consultation helped the team identify opportunities for improvement and focus. The Magnet Operational steering committee has established an aggressive timeline for gathering all the interpretive evidence required.
The goal is to submit all the required documents to the ANCC by Jan. 31. Once the documents are reviewed and approved, a site visit will be scheduled.

importance of Timely Micro Sample Transport
Microbiology samples are placed
onto plated media and incubated for hours before being available for microbiologist inspection. Timely transport from the floor ensures the viability of infectious agents, but it also provides additional sample incubation time. Specimens that arrive late in the day may not be grown sufficiently to allow the work to progress as much as possible the following day.
Your efforts are appreciated to ensure prompt collection and transport of samples as early in the day as possible.
Call Debbie Loyton, 609-2095, for more information.

New Medical Plan Network – OHN
On Jan. 1, the Oklahoma Health Network (ONH) was expanded to include
an Oklahoma hospital employees/dependents statewide, including INTEGRIS employees.
OHN is a managed care network being developed in cooperation with VHA Oklahoma/Arkansas.
As you are aware, hospitals are not exempt from the challenges of escalating employee benefit costs. Last year, health care expenses for INTEGRIS employees grew by more than 15 percent, compounded every year. In order to ensure quality health care for our employees at affordable prices, INTEGRIS continues to search for opportunities to improve both service and costs. The development of the OHN, along with other coordinated services offered through VHA Oklahoma/Arkansas, including third party claims administration, disease management, 24-hour management, 24-hour nurse advice line, and wellness programs, allows us to reduce benefit administration costs while increasing the levels of services offered to employees.
Next year, INTEGRIS will use

Article in physician newsletter highlights nursing department’s Magnet journey

Detailed overview explains Magnet program to build physician buy-in
Tactic #7: Hospital-Wide Nurse–Physician Committee

Creating a Nurse–Physician Liaison Committee

Del. E. Webb Memorial Hospital, Sun City, Arizona

To bolster nurse–physician relations, CNO outlines structure for nurse–physician liaison committee, to include 10 staff nurses and 10 physicians.

CNO invites highly collaborative physicians recommended by CEO and vice president of physician services to join committee.

Nursing leaders asked to nominate staff nurses who are skilled, assertive communicators.

When launched in 2006, committee will elect nurse–physician co-chairs, tackle issues such as collaborative rounding protocols and reporting procedures.

Summer 2005
Fall 2005
Spring 2006
Establishing
Clinical Collaboration

Offering Shared Learning Opportunities

Tactic #9
Communication Improvement Campaign

Nursing and medical leadership collaborate to improve interdisciplinary communication using guidelines such as SBAR; goal to ensure effective and efficient information transfer

Tactic #10
Clinical Expertise Sharing

Physicians and nurses conduct joint rounds, develop unit-specific education sessions to share respective clinical expertise; goal to minimize conflict over practice decisions, improve communication, and elevate care quality

Tactic #11
Unit-Based Interdisciplinary Committees

Hospital sponsors unit-based clinical practice committees comprising nurses, physicians, and other disciplines; goal to establish evidence-based practices and elevate clinical quality through discussion of recurring unit issues, recent patient cases

Practicing in Partnership

Tactic #8
Interprofessional Health Care Education

Hospitals support schools of nursing, medicine, and other health professions in establishing opportunities for students across disciplines to learn together; goal to build future cadre of clinicians already accustomed to working collaboratively to improve care quality
Interprofessional Course Promotes Collaborative Learning
University of Tennessee, Memphis, Tennessee

**Interprofessional Health Practice (IP 844)**

**Course Description**
- Interprofessional Health Practice (IP 844) provides a framework for all health professional students to discover the benefits of a practice that actively engages all health professions.
- The course will focus on the role and scope of practice of various health professions, how teams function and the benefits of teamwork, and effective patterns of communication and collaboration among health care team members.

**The Course in Phases**

**Phase I: The Health Professions**
- Web-based, self-paced
- Roles of various health professions
- Becoming a health care professional
- Pre- and post-test used for student evaluation

**Phase II: Team Building & Maintenance**
- General team-building principles
- Benefits of IP health practice
- IOM and research readings

**Phase III: Applied IP Activities**
- Learning and working together
- Sharing experiences
### Getting Interprofessional Teamwork on Schedule

*Schedule at a Glance*

**Interprofessional Teamwork for Patient-Centered Care**

**Fall 2005**

All in-class sessions are Tuesdays from 8:00–9:45am

<table>
<thead>
<tr>
<th>Session</th>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9/13</td>
<td>8:00–9:45</td>
<td>Introduction to the course Introduction to the professions</td>
</tr>
<tr>
<td>2</td>
<td>9/20</td>
<td>8:00–9:45</td>
<td>Teams and team concepts</td>
</tr>
<tr>
<td>3</td>
<td>9/27</td>
<td>8:00–9:45</td>
<td>Interprofessional healthcare teams: The end-of-life care example</td>
</tr>
<tr>
<td>4</td>
<td>10/3</td>
<td>8:00–9:45</td>
<td>Effective Communication I and appropriate assertion</td>
</tr>
<tr>
<td>5</td>
<td>10/10</td>
<td>8:00–9:45</td>
<td>Effective Communication II and situational awareness</td>
</tr>
<tr>
<td>6</td>
<td>10/17</td>
<td>8:00–9:45</td>
<td>Self, peer, and team assessment in patient-centered care</td>
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Communication occupies a prominent place in course curriculum

First session introduces students to peers’ professions
Tactic #9: Communication Improvement Campaign

SBAR Training Spreads Via Shared Governance
Queen’s Medical Center, Honolulu, Hawaii

CNO disturbed by sentinel events, physician complaints resulting from poor communication

SBAR training implemented as pilot program on 32-bed medicine unit with 50% new graduate nurses; physician satisfaction scores rise

Hospital uses shared governance unit councils to roll out project across entire hospital

Clinical Nurse IIs and IVs lead implementation throughout hospital, receiving clinical ladder credit for their role
“Instant Replay” Improves Nurse–Physician Communication
Providence St. Vincent Medical Center, Portland, Oregon

I really should have given Dr. Peters more background on how the patient presented when she arrived on the unit.

You also could have made a clearer recommendation about the IV.

I should have asked for more of that background information myself before agreeing to the plan of care.

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**SAMPLE SCENARIOS**

**SUPPORT COMMUNICATION**

**WHEN CALLING A PHYSICIAN**

*Check with the charge nurse to review the call and be prepared.*

1. Identify yourself, have patient chart with you.
2. Use the SBAR technique to guide the call.

S: Situation—What is going on with the patient. State urgency/seriousness of situation.

B: Background—Clinical history of the patient, labs, and current medications, vital signs, diagnostic studies.

A: Assessment—What do you think the problem is? Be specific, e.g., a change in cardiac, neurological, pulmonary status or bleeding.

R: Recommendation—What do I need to correct it—what orders do I need to manage this?

**Example:**

**Situation**—Dr. Jones, I’m Jane, the nurse for Mr. Smith. He is in serious respiratory distress.

**Background**—Mr. Smith is a 66-year-old with severe COPD. He had a needle biopsy this afternoon. He has been increasingly SOB the last 30 minutes, with decreasing saturations.

**Assessment**—His breath sounds are very diminished on the right. I think he has a pneumothorax.

**Recommendation**—He needs a chest x-ray and evaluation by a physician.

3. Read back orders, obtain parameters for callback if patient does not respond to interventions.

**EXAMPLES OF POSSIBLE PROBLEMS—INFORMATION TO HAVE**

<table>
<thead>
<tr>
<th>RESPIRATORY</th>
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<tbody>
<tr>
<td>Respiratory distress, change in oxygen delivery method—increasing need for oxygen.</td>
</tr>
<tr>
<td>Progressive dyspnea</td>
</tr>
<tr>
<td>RR &lt; 8 min. or &gt; 30 min.</td>
</tr>
<tr>
<td>1. O2 saturation / % oxygen</td>
</tr>
<tr>
<td>2. Lung sounds</td>
</tr>
<tr>
<td>3. Mental status</td>
</tr>
<tr>
<td>4. Effort of breathing/accessory muscle use</td>
</tr>
<tr>
<td>5. R.T. assessment/intervention/ response</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CIRCULATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in systolic BP—high or low</td>
</tr>
<tr>
<td>1. Current vitals</td>
</tr>
<tr>
<td>2. Mental status</td>
</tr>
<tr>
<td>3. Skin temperature</td>
</tr>
<tr>
<td>4. I/O</td>
</tr>
<tr>
<td>5. Medications—current list &amp; received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEUROLOGICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased responsiveness/change in LOC</td>
</tr>
<tr>
<td>Orientation</td>
</tr>
<tr>
<td>Cognition</td>
</tr>
<tr>
<td>Repeat or prolonged seizure</td>
</tr>
<tr>
<td>Delirium</td>
</tr>
<tr>
<td>1. Vital signs</td>
</tr>
<tr>
<td>2. Current neurological assessment—current LOC</td>
</tr>
<tr>
<td>3. Medications—check when last medicated with narcotics, anti-anxiety agents, anti-psychotics</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FEVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current temperature</td>
</tr>
<tr>
<td>1. Post 24-hr temperatures—fever trend</td>
</tr>
<tr>
<td>2. WBC / CBC</td>
</tr>
<tr>
<td>3. Culture reports</td>
</tr>
<tr>
<td>4. Potential sites of infection—wound—aspiration</td>
</tr>
<tr>
<td>5. Indwelling lines, tubes, catheters</td>
</tr>
<tr>
<td>6. Antibiotics—current list</td>
</tr>
</tbody>
</table>
When calling Docs:

1) Have I seen and assessed this patient myself before I call?
2) Have I reviewed the patient’s active orders?
3) Do I have at hand:
   • The chart
   • List of current meds, IV fluids, and labs
   • most recent vital signs
   • If reporting lab work, date and time this test was done and results of previous tests for comparison
   • Code status
4) Have I read the most recent MD progress notes and notes from the previous shift’s staff?
5) Is there a need to discuss this call with my supervisor?
6) When ready to call, remember to identify:
   • Self, unit, patient, room #
   • The admitting diagnosis and date of admission
   • Briefly, the problem, what it is, when it happened or started, and how severe it is
7) What do I expect to happen as a result of this call?
8) Document whom you spoke to, time of call and summary of conversation

---

### SBAR report to physician about critical situation

<table>
<thead>
<tr>
<th>S (Situation)</th>
<th>&lt;patient name and location&gt;.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;code status&gt;.</td>
</tr>
<tr>
<td></td>
<td>I am afraid the patient is going to arrest.</td>
</tr>
<tr>
<td></td>
<td>Blood pressure <strong>/</strong>_, Pulse ____, Respiration ____ and Temperature ____</td>
</tr>
<tr>
<td></td>
<td>Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual.</td>
</tr>
<tr>
<td></td>
<td>Pulse because it is over 140 or less than 50.</td>
</tr>
<tr>
<td></td>
<td>Respiration because it is less than 5 or over 40.</td>
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<tr>
<td></td>
<td>Temperature because it is less than 96 or over 104.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B (Background)</th>
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</thead>
<tbody>
<tr>
<td>Alert and oriented to person, place, and time</td>
</tr>
<tr>
<td>Confused and cooperative or non-cooperative</td>
</tr>
<tr>
<td>Agitated or combative</td>
</tr>
<tr>
<td>Lethargic but conscious and able to swallow</td>
</tr>
<tr>
<td>Suppurative and not talking clearly and possibly not able to swallow</td>
</tr>
<tr>
<td>Comatose. Eyes closed. Not responding to stimulation.</td>
</tr>
<tr>
<td>The patient has been on ____ (l/min) or (%) oxygen for ____ minutes (hours)</td>
</tr>
<tr>
<td>The oximeter is reading ____ %</td>
</tr>
<tr>
<td>The oximeter does not detect a good pulse and is giving erratic readings.</td>
</tr>
<tr>
<td>Warm and dry</td>
</tr>
<tr>
<td>Diaphoretic</td>
</tr>
<tr>
<td>Pale</td>
</tr>
<tr>
<td>Extremities are cold</td>
</tr>
<tr>
<td>Mottled</td>
</tr>
<tr>
<td>Extremities are warm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A (Assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
</tr>
<tr>
<td>Infection</td>
</tr>
<tr>
<td>Neurologic</td>
</tr>
<tr>
<td>Respiratory ____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R (Recommendation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;say what you would like to see done&gt;</td>
</tr>
<tr>
<td>Transfer the patient to critical care.</td>
</tr>
<tr>
<td>Come to see the patient at this time.</td>
</tr>
<tr>
<td>Talk to the patient or family about code status.</td>
</tr>
<tr>
<td>Ask the on-call family practice resident to see the patient now.</td>
</tr>
<tr>
<td>Ask for a consultant to see the patient now.</td>
</tr>
<tr>
<td>Do you need any tests like CXR, ABG, EKG, CBC, or BMP?</td>
</tr>
<tr>
<td>Others!</td>
</tr>
<tr>
<td>How often do you want vital signs?</td>
</tr>
<tr>
<td>How long do you expect this problem will last?</td>
</tr>
<tr>
<td>If the patient does not get better, when would you want us to call again?</td>
</tr>
</tbody>
</table>
**Tactic #10: Clinical Expertise Sharing**

**Case-Based Education Sessions**

**Strengthen Collaboration**

University Hospital, Cincinnati, Ohio

- Physician teaches session on workups for pulmonary embolism; presents case and calls on residents to talk through diagnosis.
- Approximately 20-30 nurses and physicians attend; breakfast is served and nurses receive clinical ladder credit for participation.
- Nurses learn why physicians request different workups for different patients; physicians learn more about specifics of workups and what questions nurses are likely to ask.
Reforming a Service
Line-Based Practice Committee
St. Joseph Regional Medical Center, Milwaukee, Wisconsin

**Step 1:** Perinatal director and CNS inherit nearly defunct practice committee and decide to revamp membership and purpose.

**Step 2:** Expanded group begins by considering non-controversial change from Betadine to soap and water prep.

**Step 3:** Committee later moves to more significant topics such as standardized order sets, oxytocin policy, and use of fundal pressure.

**Step 4:** As nurses and physicians learn to share their perspectives in a consensus-oriented manner, interdisciplinary respect grows.
OB Practice Meeting Agenda

Date: Thursday, September 15, 2005
0800–0900

Always ask yourself—“What’s best for the patient/family?”

1. Reflection
2. Service moment
3. Review purpose of OB Practice committee
   Our purpose is to bring together all disciplines providing care to perinatal patients with the purpose of making best-practice clinical decisions. We embrace the perinatal philosophy of care, and remember that the patient and family are at the center of all we do.
4. Perinatal death orders
5. Oxytocin policy changes
6. Postpartum orders
   Vital signs
   CMV for < 30 weeks
7. Scheduled cases
   Cesareans
   Inductions
   Letter/instructions to patients
8. AIUM certification for ultrasounds
9. New Covenant NST policy
10. Other add-ons as needed

Next meeting: Thursday, October 20, 2005 from 0800–0900

Co-Chairs: Perinatal Clinical Nurse Specialist, Perinatal Director
# Forging a Better Nurse—

## Revitalizing the Nurse–Physician

<table>
<thead>
<tr>
<th>Creating Leadership Alliances</th>
<th>Addressing Unacceptable Behavior</th>
<th>Building Joint</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tactic #1</strong></td>
<td><strong>Tactic #2</strong></td>
<td><strong>Tactic #3</strong></td>
</tr>
<tr>
<td>Nursing–Medical Leadership Linkage</td>
<td>All-Staff Conduct Policy</td>
<td>Complaint Feedback Loops</td>
</tr>
</tbody>
</table>

Nursing and physician leaders—starting with the CNO and CMO and continuing down through the nurse manager and physician leader—establish proactive, visible partnerships; goal to promote standards of conduct, build relationships, and nurture clinical collaboration.

Hospital establishes clear conduct policy for all staff and physicians, uniformly applies consequences regardless of offender’s status; goal to hold all disciplines to same expectations.

CNO and medical leadership work together to ensure that all complaints from nurses or physicians receive formal response; goal to build trust in organization, and across disciplines, by demonstrating that all concerns are heard, investigated, and appropriately addressed.

Hospital provides new graduate nurses with tools, training, and support to prepare them for physician interactions; goal to increase new nurses’ confidence around physicians, minimize physician complaints about nursing staff’s being under-prepared for conversations.

Nurses and physicians commit to clear standards of responsiveness and preparedness; goal to preempt negative interactions by addressing common points of friction up front.
**Physician Partnership**

**Relationship**

### Trust

**Tactic #6**
Nursing-Driven Physician Education

Nurse leaders educate physicians about nurse retention and nursing department operations; goal to help physicians understand their role in establishing and maintaining a positive work environment, as well as correct misimpressions about the hospital’s nursing organization.

**Tactic #7**
Hospital-Wide Nurse–Physician Committee

Nursing and physician leaders collaborate to establish hospital-wide committee comprising physicians, nursing management, and frontline staff; goal to address concerns on both sides, as well as improve hospital-wide nurse–physician collaboration.

**Tactic #8**
Interprofessional Health Care Education

Hospitals support schools of nursing, medicine, and other health professions in establishing opportunities for students across disciplines to learn together; goal to build future cadre of clinicians already accustomed to working collaboratively to improve care quality.

**Establishing Clinical Collaboration**

### Offering Shared Learning Opportunities

**Tactic #9**
Communication Improvement Campaign

Nursing and medical leadership collaborate to improve interdisciplinary communication using guidelines such as SBAR; goal to ensure effective and efficient information transfer.

**Tactic #10**
Clinical Expertise Sharing

Physicians and nurses conduct joint rounds, develop unit-specific education sessions to share respective clinical expertise; goal to minimize conflict over practice decisions, improve communication, and elevate care quality.

**Tactic #11**
Unit-Based Interdisciplinary Committees

Hospital sponsors unit-based clinical practice committees comprising nurses, physicians, and other disciplines; goal to establish evidence-based practices and elevate clinical quality through discussion of recurring unit issues, recent patient cases.

### Practicing in Partnership

Physicians and nurses conduct joint rounds, develop unit-specific education sessions to share respective clinical expertise; goal to minimize conflict over practice decisions, improve communication, and elevate care quality.

Hospital sponsors unit-based clinical practice committees comprising nurses, physicians, and other disciplines; goal to establish evidence-based practices and elevate clinical quality through discussion of recurring unit issues, recent patient cases.