Legal Issues

By William C. Wilson, Esq.

Can We Talk? Structured Paths to Better Communication

Susan was a 65-year-old woman who had been living independently with no acute deficits, and who was independent in all her activities of daily living. Then she had a stroke, resulting in hemiparesis on her left side. After a lengthy stay at an acute facility, she was admitted to a skilled nursing facility for rehabilitation. Susan's first month at the SNF was mostly uneventful. Her weekly weights were stable, she attended therapy, and her mobility and independence with her activities of daily living seemed to be improving. Because her weekly weights were stable, the SNF stopped the weekly weigh-ins, per their policy, after 4 weeks. The attending physician saw Susan twice in the first month with no adverse observations noted.

Susan's second month, per the chart notes, also was mostly uneventful. However, the chart noted several behavior changes, such as increased refusal to attend therapy, refusal to eat or finish her meals, and social withdrawal. Susan's family encouraged her to eat, but Susan refused, saying she was not hungry. By the end of the second month, Susan had lost 17 pounds. Her physician was notified of the extreme weight loss and ordered Reglan, a new diet, and a restorative nurse assistant (RNA) dining program. Three days later, Susan was found unresponsive 1 hour after being assessed by a staff member, who found her vitals to be normal and her responsiveness to be normal. The attending physician saw Susan once during the second month and did not note any concerns about Susan's weight loss.

Susan's family sued the SNF, claiming she had starved to death. The chart indicated that Susan was eating her meals, but was taking in less in the second month than in the first. In the Minimum Data Set (MDS), she was noted to be 119 pounds, but according to the licensed nurses' notes, she weighed 17 pounds less than what was reported on the MDS. The attending physician examined Susan 6 days prior to her death and was only concerned with nausea and vomiting, potentially due to gastroparesis. Reglan was prescribed. The physician's progress note did not contain any mention of weight loss.

Susan's case appeared to be one of communication breakdown between the nursing staff and the physician and possibly observational failure by the SNF staff. The chart notes did not appear to follow any set pattern of communication between the physician and the staff. When the clinician was notified of an issue or change of condition, the note simply stated "physician notified." There was no further elaboration in the chart as to the details of the notification and the outcome of the contact with the clinician. Once the legal team became involved, it was sheer speculation as to what occurred between the nursing staff and the clinician when the "physician notified" note appeared in the chart. This vague charting does not help, and potentially hurts, a defense.

Physicians or their nurse practitioners are required to make rounds on their patients at a minimum of once every 30 days for the first 90 days and at least every 60 days thereafter. If a clinician rounds are on a resident only once a month, good communication between staff and the clinician is even more important than if they are regularly speaking to each other face-to-face. Communication channels are a two-way street. Staff must be prepared to report on residents, and physicians must be willing to listen. Studies have shown that effective nurse-physician communication has led to increased satisfaction for nurses and increased patient safety.

Barriers to Communication: Behaviors

In 2008, the Joint Commission's National Patient Safety Goals described nurses' perceptions of nurse-physician communication in the long-term care setting. The nurses identified several barriers to effective nurse-physician communication, such as: (1) lack of physician openness to communication, (2) logistic challenges, (3) lack of professionalism, and (4) language barriers. Feeling hurried by the physician was the most frequent barrier. The nurses also reported frustrations with communication because of physician interruptions before the nurses finished reporting on a patient or because of the physician's failure to return calls. The physician's failure to call back in a timely manner affected communication quality because a long gap between the call and the call back limited nurses' preparedness for the call.

Inadequate preparation on the part of the nurses led to physician frustration, which led to ineffective communication. The nurses also described the challenges of working with covering physicians who were not familiar with any particular patient.

The nurses knew that being prepared for a call to the physician was important for good communication. The report recommended that nurses communicate clearly, explain the reason for the call and state clearly what is needed from the physician.

Barriers to Communication: Nonstructured Techniques

A barrier to communication is a lack of structured communication techniques between physicians and nurses. Some standardized approaches to communication are the American Medical Director Association's Protocols for Physician Notification, which structures and informs the content of key clinical information necessary for reporting various clinical scenarios.

Another structured communication technique is SBAR (Situation, Background, Assessment, and Recommendation), which distills content into a quick format that works within tight time constraints. With this technique, nurses are trained to report in narrative form, providing many more details than may be necessary for a telephone call to a physician. Physicians are trained to communicate in bullet point form, and to provide only necessary information. SBAR creates a shared mental model that ensures the message sender and message receiver are on the same page in terms of how information is conveyed.

A third structured communication technique is the CHAT method. CHAT stands for (1) Chief Complaint, Context, Code Status; (2) History; (3) Assessment/exam; and (4) Talk with the physician/agree on a plan. This technique was developed specifically for use in long-term care for improving and standardizing communication in after-hours telephone calls to on-call physicians.

Focus groups in a study (J Am Geriatr Soc 2008;56:1080-6) were convened to discuss the dissatisfaction between nurses and on-call physicians. Nurses reported they were frequently unable to predict the questions an on-call physician would ask. To find certain information, the nurse would have to interrupt the call, consult the chart, or return to the patient. Both nurses and physicians agreed this was a waste of time and delayed care. Nurses also reported difficulty in raising the on-call physician's level of concern about a patient. After implementation of the CHAT method, nurses reported increased satisfaction. Concurrently, the on-call physicians were more likely to transfer the patient to the emergency department or come to the facility to evaluate the patient.

Best Practices

Ideally, a standardized method of communication should be adopted and implemented in every facility to streamline and enhance communication between nursing staff and physicians. But in the absence of a standardized method of communication, physicians should:

- Provide timely call-backs.
- Listen to the nurse.
- Ask for relevant information.
- Acknowledge a high level of concern on the part of the reporting nurse.

Effective communication is only as good as its foundation, which is accurate and effective observation. In Susan's case, her medical care may have been hindered by a failure on the foundational level because the chart did not reflect a significant weight change until it was too late. However, the chart also was significant for the lack of communication between the nurses and the physician. It appeared that the nursing staff and the physician were operating in two separate universes – neither of which was observing, reporting, or communicating.

Standardized communication may not have prevented Susan's death, however, it may have prolonged her life or at least initiated a transfer to an acute care facility for further observation prior to her death.

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dementia has to do with people who are not undergoing acute medical treatment. That's a very different situation from hip fractures and other acute problems in the elderly. Unfortunately, the evidence for one situation has been transposed onto a different situation, so a lot of hospitalists hesitate to initiate tube feeds," she said.

In patients who waited more than a day to get fed, "there was a lag time to even getting a nutrition consult. Nobody really quite noticed that they weren't getting nutrition." That's consistent "with what I've seen throughout my hospitalist career, and not just in hip fractures," Dr. Wallace said. "We get very worked up about the medical issues, and we simply don't attend to nutrition. We sometimes think somebody else is taking care of it," she said.

The ages were statistically the same between the two groups, and there was a fairly even distribution of comorbidities, she noted.

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