Can We Talk? Structured Paths to Better Communication

Susan was a 65-year-old woman who had been living independent-ly 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 physi-cian saw Susan twice in the first month with no adverse observations noted.

Susan’s second month, per the chart notes, was also mostly uneventful. However, the chart noted several behavior changes, such as increased refusal to attend therapy, refusal to eat or fin-ish 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 medication ordered for good 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 communica-tion are the American Medical Director Association’s Protocols for Physician Notification, which structures and informs the content of key clinical infor-mation 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 neces-sary 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, which stands for (1) Chief Complaint, Context, Code Status; (2) History; (3) Assessment/ examination; and (4) Talk with the physician/agree on a plan. This technique was developed specifically for use in long-term care for improving and standard-izing 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 dis-cuss 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 phy-sicians 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 commu-nication should be adopted and imple-mented in every facility to streamline and enhance communication between nursing staff and physicians. 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 accu-rate 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 sig-nificant 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 observ-ing, 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 facil-ity for further observation prior to her death.

William C. Wilson is a partner in the law firm Wilson Getty LLP, which represents all types of long-term care facilities against civil claims. He also represents facilities in administrative hearings and advises long-term care clients on risk management and corporate compliance. This column is not to be substituted for legal advice.

Legal Issues

M. Alexander Otto is with the Seattle bureau of Frontline Medical News.