TRAINING RESIDENTS AND NURSES AS PATIENT-CENTERED CARE TEAMS

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SAFETY

ACGME and JCAH: better team-work to enhance safety

– 70% fatal & serious errors from poor communication among team members

Medical ward rounds important? Nurses rarely attend
CARE TEAMS

What’s involved: use PCC skills with each other → effective communication

Team formation successful in acute areas (ICU, trauma)

No one has tried on medical wards to increase teamwork of nurses and doctors

We developed a program to do this
Step 1: CONSOLIDATING PATIENTS ON ONE WARD

Previously: patients on 10-12 different wards -- 600 bed community hospital

Many discussions with Medical Director → one 32-bed ward where ~2/3 of patients now come = crucial first-step
Step 2: TRAINING INDIVIDUAL NURSES & RESIDENTS

OBJECTIVES

Skills:
• Evidence-based PCC method (5 steps, 21 substeps)
• Clinical skills for common psychosocial ward problems; e.g., depression, opiate use

Attitudes:
• Self-direction and collaborative agenda-setting
• Personal awareness, including emotional issues that interfere with teamwork
TRAINING NURSES IN PCC

Authors train 3 nurse leaders: two 3-hr PCC seminars → 4 hrs bedside teaching → 4 hrs on how to teach PCC

Nurse leaders train 35 staff nurses: 4-hr seminars (groups of 4-8) → one-on-one bedside training in PCC (4 hrs for each staff nurse)

Maintenance:
• nurse dyads self-critique weekly
• nurse leaders critique monthly
TRAINING RESIDENTS IN PCC

Existing one-month full-time psychosocial rotation


Mental Health Management Skills

Quarterly videotaped review of PCC skills – implementation stage
NURSES & RESIDENTS

• Provided textbook and DVD describing basic PCC method

• Worked with national consultant (Richard Frankel) during 2 visits and follow-up video conferences

• One nurse leader and one staff nurse attended AACH June 2009 meeting
TEACHING METHODS

Didactic -- <10% of time (e.g., 5 step PCC model; treating depression; opiate misuse)

Experiential

• Role playing
• Critiques: taped & observed interactions -- real patients
• Address personal awareness at each critique and role play → many issues
Step 3: TEAM-BUILDING
Trust and Respect

Faculty, Nursing Leadership, and Medical Director = Model for later work

Develop objectives: improved patient satisfaction, teaching, care, and nurse-doctor communication – as trust and respect develop

Negotiate details of consolidated ward

Faculty and ward nursing leaders

– Issues: non-acute ward; many residents
– Negotiation of details as trust and respect develop
– Negotiated following approach
INFORMAL NURSE & RESIDENT INTERACTIONS

1. Grand opening of ward
2. Name tags; prominent pictures with names
3. Use same conference room
4. Common eraser-board: messages, call, etc.
5. Introduce self; use first names; “thank you”
6. Watch body language
7. Make explicit who does what and when
8. Joint softball team for the ward
FORMAL NURSE AND RESIDENT INTERACTIONS

1. Nurses attend morning report for their pts
2. Senior resident, charge nurse, & CM – daily (review problems)
3. Joint chart review before rounds (problems, plans)
4. Nurses join ward rounds when their patients involved, including bedside
5. Resident conducts chart rounds with evening shift nurses
6. Resident attends LOS conference 2/week
7. Nurses join conferences for their patients (family, near-miss, etc.) and express ideas & concerns
8. Awards: outstanding nurse and resident
BIOPSYCHOSOCIAL CONFERENCE

• Bi-weekly residents’ a.m. report – authors, faculty attending, nurse leaders, and nurse involved with patient attend

• Objective:
  – skills to handle difficult psychosocial issues (depression, opiates)
  – associated personal awareness issues
  – support for those involved with patients

• Senior resident plans, prepares referenced handout, and leads discussion

• Patient interviewed in conference room
ATTENDING FACULTY

All from GIM Division

Incorporate their initial input and ongoing feedback with regular review quarterly

Key role: model interactions; monitor residents; teach residents
RESEARCH DESIGN

RCT with post-test only evaluation
   80 randomly allocated ‘no-doc’ admissions to our ward (T) and 80 to other services (C)
   Powered to achieve effect size 0.4 on primary endpoint (patient satisfaction)

Also conducting:
   1) Formative evaluation
   2) Summative evaluation of impact on nurses and residents (pre/post): interactional & teamwork measures, satisfaction, self-efficacy

Data evaluation just beginning
PRELIMINARY FINDINGS

• PCC principles key to requisite administrative interactions – joint ownership, respect, and trust
• Nurses learn quickly, contribute significantly, and are interested in teamwork
• Resident equally enthused in working with nurses – and having all patients in one place
DISCUSSION

Unique teaching: training nurses and residents to work as a team on a medical ward, after training them in requisite PCC skills

Data in acute units support but none in this area – rigorous evaluation pending

Very positive feedback from administration, nursing, residents, and faculty
DISCUSSION : A Caveat

Not as easy as training in PCC individually and giving guidelines for working together

**Fundamental issue**: long in-grained nurse-doctor relationship patterns = zero sum game where nurse always loses

Ongoing relational process: developing genuine trust & respect, overcoming institutionalized biases, & overcoming personal biases

Progresses slowly, but it does progress if you stick with it -- Much daily behind-the-scenes work
CONCLUSION

Much research supports *training individuals* in PCC

= “necessary but not sufficient”

To maximize *care, satisfaction, and safety*, we must *expand teaching efforts to address teamwork*