Communicating with Professional Colleagues

Year 3 Transition Block

June 2011
Actor & Tutor Notes

Introduction

Within the NHS today Clinical Care depends on the activities of a variety of multi-disciplinary and multi-professional teams. For those teams to be effective there must be an ethos of mutual understanding, respect and also accountability.

Health care professionals tend to train separately and develop their knowledge and skills around a set of core values, some of which are specific to their individual professional role and consequently may be fundamentally different. Within the clinical team, there will be a wide variety of attitudes, skills, expertise and experience which when brought together effectively can add much to the care of ill patients. Clinical care is challenging in the acute setting where pressure and stress on health care professionals can build up. This can be due to a combination of the volume of the work, but also because patients who are acutely ill can be difficult to diagnose, can become more unwell, quickly and unpredictably and can be fearful and anxious. With all this going on, many health care professionals find it difficult to admit their uncertainty, and there can be no doubt that this can lead to error and so, harm patients. However, the admission of uncertainty is a strength not a weakness, as it can lead to learning and so ensures that patients receive safe and effective care.

With all these complex agendas the need for clear and efficient communication in the acute situation is crucial, and relies on all health care professionals having not only mutual understanding and respect but demonstrating that in the method and the content of their communication with patients, their relatives and with each other.

Learning Outcomes;

At the end of the workshop the students should be able to;

- Identify the key characteristics of effective team based communication
- Describe the inter-relationship and differing roles and responsibilities within a health care team

- Describe behaviours that foster commitment and collaboration within the team
- Learn the principles of treating team colleagues with respect and creating an environment that supports learning from each other
- Utilise iSBAR in a variety of clinical and practical situations
- Develop a structure for hand-over that ensures patient safety
- Develop a structure for hand-over that ensures professional safety

The Session

The purpose of the session is to demonstrate within a fairly typical hospital setting a range of possible inter and intra-professional team based communications. The case is of an 87 year old lady who is admitted to an acute medical receiving unit because she is "off her legs"

After a short warm up session with the actor leading, on how to present oneself in a professional manner the session will be run as a series of role plays. The students will always take the part of the FY1. They will be asked to consider in advance:

What do you need to communicate here?
How will you do this?
What barriers to effective communication might there be here and how might these be overcome?

After an initial general discussion about what they have learned so far about Communicating with Professional Colleagues they will be given the role play scenarios, one by one.

They will then works in pairs or trios for 5 minutes to explore the topic and consider what the communication issues might be and how they might handle them. They should write this down (on flip charts if you wish). They will then discuss that briefly, collectively, with the tutor and then carry out the role play (one student, one actor and the rest watching) the tutor will then lead a de-brief as normal. They will then be given the next scenario, and repeat the whole process.

At the end the whole session they should reflect individually and together on lessons learned.

The Characters

FY1 Doctor	(all scenes)
GP	(Scene 1)
SPR	(Scene 2)
Patient's Daughter/son	(Scene 3)
Consultant	(Scene 4)
Hospital-at night nurse	(Scene 5)

(See appendix 2 for full details)

Scenario 1

GP phoning in to ask the receiving doctor to accept a patient for admission

Layout

Two chairs for the role play but arranged so student and actor are back to back and cannot see each other.

Background and Situation

The FY1 doctor knows there is only one bed left in the medical unit and has been told by the ward staff that the next patient to get the last bed had better be sick, as the consultant is fed up with "bed-blocking".

On other side, GP crouching down with mobile phone in hand whilst trying to write a referral letter and looking for info from the case sheet. (Occasionally shouts to unseen person in next room….it's OK Mrs McBride…I'll be back through in a minute etc)

GP call

"Hello I'm Dr Devine from Bridge of Tay. I have an 87 year old lady who is "off her legs" for you. I am hoping you might be able to find a bed for her. Name is Jeannie McBride, DoB – 02 02 20 1515.

I was asked to come in by next door neighbour who hadn't seen her for 24 hours, she got worried and let herself in with a key, then found Mrs McBride awake in bed but unable to get up.

Mrs McBride herself is alert and oriented but I think she's a bit confused as she isn't giving me any reason why she can't get up – she just isn't. Examination is pretty unremarkable. She has wet herself so I reckon she's probably got a UTI.

She can't really stay here as she's pretty much alone aside from her carer who pops in at teatime to help her out a bit."

Note – no mention of the husband; GP is not aware/not realised he is also in hospital.

If asked –

"She's got a history of type II diabetes and OA in both hips. She had a total hip done on the left two years ago and was in for four months with MRSA.

She's on Metformin 500mg bd, diclofenac MR 75mg bd and omeprazole 20mg od. I don't think she's got any allergies"

Points to draw out:

- *Respect your colleagues who have pressures of their own*
- *Negotiate reasonably while trying to convey/explain why your case is urgent*
- *Negotiate reasonably while trying to convey the pressures you are under around beds*
- *Appreciate the GP is not able to talk freely as patient is within earshot*
- *Don't lose your temper and be courteous at all times*

Additional Resources;

- Refer to SBAR approach in Primary Care http://www.institute.nhs.uk/images//documents/SaferCare/SBAR/Cards/Primary_Care_SBARv4.pdf

- Comparison can be drawn to hospital request for senior colleague opinion: http://www.patientsafetyalliance.scot.nhs.uk/docs/sbarguide.pdf

See Appendix 1 for details of what to tell the students prior to each scenario.

Scenario 2

Old lady now in ward and the junior doctor needs to speak to their specialist registrar about what they think should be done/needs done etc. (This to be done face to face)

Background for the student

You've just finished clerking in Mrs McBride, but haven't taken any blood or ordered any tests yet. (Although the nurse has done a dipstick, protein ++, blood trace, no leucocytes)

She is conversing and pleasantly compliant, she's tired and lethargic. She is complaining of a little nausea when she moves but otherwise nothing specific. She does smell of stale urine.

PMH/DH – As above. SH – only that from GP.

On examination she has dry mucous membranes, is apyrexial, P88 reg, BP 118/77, HS normal, Chest - AE good, vesicular BS and nil added.
Abdo examination – quite tender in LIF – seems like 'fullness' but no specific mass. PR – normal stool and rectum. Bowel sounds a bit sluggish.
Neuro exam – NAD except you havn't been able to get her to stand.

Layout and Situation

FY1 doctor standing at desk.

SPR is walking past with hands full of case notes on way to dictate some letters from the clinic. The FY1 doctor says as he/she passes…."can I have a quick word"

The FY1 doctor explains he/she is worried about Mrs McBride as he/she can find nothing very specific….she is tired and lethargic, can't stand up unsupported and says she feels nauseated when she tries.
The SPR can ask for more info e.g. drug history and the FY1 doctor has to rummage in the notes etc.

"What drugs is she on? What about past history? What about family history?"

The SPR gives instructions etc but is rushing and does a quick check back to see if the FY1 doctor has heard what he said – if the FY1 doctor is vague the SPR becomes irritated and even terser. When checking back the second time if the FY1 doctor still hasn't got it, then leave it there.

Instructions

> "Do her bloods – make sure she's got an amylase, culture her blood and urine. Erect chest and abdo plain film. ECG. Stick up a bag of fluid to keep her tied over. Let me know what the results are. I'll go and lay a hand on her tummy."

Points to draw out:

- *It is important to admit when you don't know what to do; trying to muddle through will get you into trouble. If you don't know, ask!*
- *How to ask for help i.e. have all the information to hand including all the charts, be clear about what you want i.e. are you looking for advice or do you want your senior to attend and see the patient themselves*
- *How to pass on information, requests etc*
- *The importance of writing things down*

Scenario 3

Mrs McBride is getting a bit worse but no test results back yet so still all very puzzling and daughter/son wants to speak to junior doctor.

Layout and Situation

At the desk again in office, this time writing up notes and the relative comes in very shyly and says

"Sorry to bother you but I wanted to speak to you about my parents"

The FY1 Doctor has to find out what it is the daughter wants and may expect it is to be an update on the clinical condition, but he only wants to make sure the FY1 doctor knows his father was in the ward downstairs having had a stroke and may not survive. As soon as possible he wondered if someone could arrange for his mother to visit his father. She has to go collect her kids from school but will be back in the evening.

Points to draw out:

- *It is part of a doctor's role to communicate with relatives who may be anxious upset or concerned.*
- *Relatives do understand that there at times information can be limited and restricted to a range of possibilities and options about what might happen*
- *Delaying communicating with relatives can lead to more stress and more challenging interviews as a result*
- *Recording information that may be revealed later or through a family member is vital so that all members of the team can have access to that information.*

Additional Resources

- Refer to GMC guidance on "Confidentiality" and section on Confidentiality guidance: Sharing information with a patient's partner, carers, relatives or friends.
  http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality_64_66_sharing_information.asp

Scenario 4

The FY1 Doctor has been called back to see the patient as the registrar had suggested that if Mrs McBride's' abdominal pain worsened he/she should get a surgical opinion. The staff nurse said when she phoned that the surgical SPR has just gone into theatre and that the FY1 doctor will need to phone the Consultant surgeon at home and that the consultant Mr/Ms Gallagher hates to be interrupted at teatime when he/she has just got home.

Background for students

Med reg has seen Mrs McBride, was concerned and asked FY1 to r/v Mrs McBride at 5pm. If abdo pain not settled then for surgical review. In meantime, some results are back

Hb	12.2		
WCC	13.2	**N**	9.5
Plt	378		
CRP	47		
	Na	134	
	K	4.7	
	U	15.7	
	Cr	126	
	LFT	Normal	
	TFT	Normal	
	Amy	Normal	
Chest Film AP Erect	Looks OK. No air under diaphragm		
Abdo Film	Looks ok, (you think)		

On checking Mrs McBride she is still looking dry, she is still a little confused and is now having more pain from her belly. Abdominal examination suggests LIF tenderness with rebound and guarding.

Layout and Situation

FY1 doctor at desk on phone, on one side of the screen.

On other side of the screen, Consultant in jeans etc drying hands on dishtowel to answer phone whilst telling kids (in room next door) to be quiet and to finish their tea as their bath is run.

Points to draw out

- *How to give information in a structured manner (SBAR)*
- *The importance of knowing where you can get help*
- *How to convey to someone on the end of the phone that the patient is critically ill*
- *With senior staff;*
    - *Be assertive (be direct, appropriate and responsible)*
    - *If you want a senior colleague to come and see the patient say so straight away*
    - *Have all the information to hand*
    - *Be clear and concise*
    - *Repeat whatever you think necessary to ensure the consultant understands your concerns*
    - *Don't delay; if you have concerns it is better to ask too early for help than too late!*

Scenario 5

FY1 doctor now going off shift and has to hand over sick old lady to "hospital at night"

Background for students

Mrs McBride has been reviewed by the surgical registrar (Consultant got a message to him in theatre). He/she does not think she has a surgical problem and has said so in the notes. The remarks are written with a fountain pen and are very brief. The surgeon suggests the most likely diagnosis is UTI. Please call again if concerned.

Layout and Situation

FY1 doctor and HAN nurse standing in corridor. FY1 doctor gives information about Mrs McBride (iSBAR) HAN nurse is rushed as there is a lot going on and seems pre-occupied with mobile phone keeping on ringing/bleep going off etc. At one point repeats information back that he/she has just been told, but gets it wrong.

Points to draw out

- *How to pass on information in structured manner*
- *The need to check that the messages are understood*
- *The need to repeat information when necessary*
- *That even though a colleague is rushed it is important not to allow that pressurised to restrict the time s pend giving important information*

Additional Resources

- Safe Handover; Guidance from the Working Time Directive Working Party. The Royal College of Surgeons of England
  March 2007
  http://www.healthcareworkforce.nhs.uk/index.php?option=com_docman&task=doc_details&gid=1282&Itemid=

Mairi Scott and Rob Jarvis
May 2011

Session timing

10.00 – 10.30	**Introduction to the session including** • Actor warm up "Presentation Skills"	**Tutor** **Actor**
10.30 – 10.45	**General Discussion** • Team Communication Issues	**Tutor**

10.46 – 12.45	**Series of Trio Discussion, Role Play and Debrief (for all 5 scenes)**
	• Trio Discussion (5 mins)
	  ○ What barriers to effective communication might there be here?
	  ○ How might these be overcome?
	
	• Role Play (10 mins)
	
	• Debrief (5 mins)	

12.45 – 1.00	**Reflection and Summing Up**	

Additional Notes for the Tutors

- As the groups get more comfortable it may not be necessary to split up into trios for the pre-role play discussion
- Only hand out the next scenario after the previous one is finished
- If you get through the roles quickly, then consider asking more than one student to try it out differently (and request the actor to play it differently)

Appendix 1

What to tell students before each scene

Scene 1

You are an FY1 covering for the FY2 responsible for admitting patients to acute medicine in Ward 15. The ward is nearly full. Neither the FY2, nor the Consultant is going to be happy with 'bed-blocking' admissions.

Please take this call from a GP. It is likely that they would like to admit a patient, however, they may just want some advice.

Scene 2

You've just finished clerking in Mrs McBride, but haven't taken any blood or ordered any tests yet. (Although the nurse has done a dipstick, protein ++, blood trace, no leucocytes.)

She is conversing and pleasantly compliant, she's tired and lethargic. She is complaining of a little nausea when she moves but otherwise nothing specific. She does smell of stale urine.

PMH/DH – As above. SH – only that from GP.

On examination she has dry mucous membranes, is apyrexial, P88 reg, BP 118/77, HS normal, Chest - AE good, vesicular BS and nil added.

Abdo examination – quite tender in LIF – seems like 'fullness' but no specific mass. PR – normal stool and rectum. Bowel sounds a bit sluggish.

Neuro exam – NAD except you havn't been able to get her to stand.

Please ask your busy SpR what to do next.

Scene 3

You are writing up your notes for Mrs McBride. A nurse tells you that Mrs McBride's daughter/son wishes to speak with you.

Scene 4

Med reg has seen Mrs McBride, was concerned and asked FY1 to r/v Mrs McBride at 5pm. If abdo pain not settled then for surgical review. In meantime, some results are back

Hb	12.2		
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Chest Film PA Erect	Looks OK. No air under diaphragm		
Abdo Film	Looks ok, (you think)		

On checking Mrs McBride she is still looking dry, she is still a little confused and is now having more pain from her belly. Abdominal examination suggests LIF tenderness with rebound and guarding.

Please ask for a surgical review.

Scene 5

Mrs McBride has been reviewed by the surgical registrar (Consultant got a message to him in theatre). He/she does not think she has a surgical problem and has said so in the notes. The remarks are written with a fountain pen and are very brief. The surgeon suggests the most likely diagnosis is UTI. Please call again if concerned.

It is now 10pm and the end of your shift. Mrs McBride has had some more fluid and is still tired and feels rotten, but with no great change. Please hand over Mrs McBride to Hospital at Night nurse.

Appendix 2

FY 1 Doctor
(For info)

Foundation Year 1 doctors (formerly junior house officers) have only recently qualified and are working in a supervised capacity. Although they have qualified from medical school this is their early experience of being responsible for real patients. They do this in a supervised way and they have at Induction been told what the operating systems for their hospital unit will be.

GP
Dr Gail/Gavin Devine (Any age)

The GP is fully trained and has spent some years as a junior doctor, and knows they hate to have patients like this old lady sent in, ("bed-blockers"). He/she however is certain this patient needs to come in and although he/she doesn't have an exact diagnosis he knows she is ill.

He/she is pretty competent and tolerant of the junior doctors' troubles but not to the point where he/she tolerates any silly arguments. After all, the GP is much more experienced than some young doctor just out of medical school. He/she is also in a hurry as he/she has left the surgery to do this extra house call and knows that there is a queue forming back there!

Young doctors come and go so fast as well and each one needs their hand held for weeks before they are less of a liability, never mind any use! And the fact that they get paid a whole lot more than he/she does just adds to the irritation of it all.

SPR
Bill/Belinda Malcolm (Age, around 30)

The specialist registrar has chosen medicine as a career and is enjoying it, mostly. He/she is studying really hard for advanced exams and so is quite focused on exact diagnosis of the clinical problem and less interested in the soft stuff about communicating etc.

He/she thinks FY1 doctors are a mixed bunch. Some are not cut out to be consultants for sure and might as well end up as GP's. There are so many of them working shifts these days he/she doesn't really think it's worth getting to know them anyway, good or bad!

Patient's daughter/son
Mary/Martin Williams (Age, at least 40)

Mary/Martin is a caring and loving daughter/son who is really worried about her/his parents. They have always been so supportive, and the kids adore their grand-parents. Her/his father has had a stroke, s/he hates the thought of him being paralysed or even worse, unable to communicate, and now mum is ill and no-one seems to know why.

The kids are young and have busy lives, (scouts/football practice etc) and partner works shifts, and so can't always be there to look after them if s/he is up at the hospital.

S/he knows the doctors and nurses are busy, but if they would just spend a few minutes listening and explain things it would make planning life so much easier, let alone a whole lot less worrying and alarming.

Consultant
Mark/Marion Gallagher (Age 45)

Mark/Marion has just got home and was met by partner being really cross as s/he was late and he knew s/he had to go out to her drama group dress rehearsal early. S/he was late because he had been in theatre all afternoon, having been called in by the gynaecology team as they had unfortunately had to ask him to deal with an "unexpected" ruptured bowel. S/he had missed lunch.

S/he has not yet eaten, (partner is an unenthusiastic cook who only feeds the kids and one of them has a cold and is a bit miserable and grumpy). S/he was hoping to get a quiet night once he got the kids to bed and watch the football on TV.

S/he thinks junior doctors nowadays are over protected and don't get enough hands on experience due to the European Working Time Directive (which restricts how many hours junior doctors can work).

Hospital at Night (HAN) Nurse
Harry/Hilary Lang (Age at least 26)

He/she is fairly new to this post but really enjoys it. The extension of the nurse's role is challenging and gives him/her additional responsibility which he/she likes. He/she does, however, like to be given concise information and finds some young doctors to be just hopeless at this. He/she wonders what on earth they get taught these days at medical school!

The first few hours of the shift is always chaotic with so many ill patients being handed over. He/she has his/her own system of remembering but it does need him/her to be able to concentrate on one patient at a time and no matter how much he/she has tried to get that to happen it never seems to work! Mostly it's because people are so impatient and instead of waiting for him/her to get round to them in an organised and prioritised manner they interpret and hassle him/her because they want to get away!

Background Notes for Students
(Adapted from University of Aberdeen Communication Skills Course)

A Team Approach Multi-Disciplinary Multi-Professional Use the expertise of others...take advice Never be afraid to ask for help Admitting uncertainty is strength, not weakness COMMUNICATE	**The Team Approach** Critical Care depends on a **multi-disciplinary** and **multi-professional** team. Indeed, one of the purposes of the course is to promote **mutual understanding**, and **respect**, among this team. Health professionals tend to train separately and work according to different sets of **rules** and **assumptions**. Throughout the team, however, there is **expertise** and **experience** that can be used to guide the care of the critically ill. Accordingly, it is **always** a good idea to ask for **advice** from colleagues if you are uncertain. Many staff, particularly doctors, find it **difficult** to admit uncertainty, to patients, colleagues, seniors (and themselves?). This undoubtedly has contributed too **many** instances of patient harm over the years. The admission of uncertainty is **strength**, not weakness.
	Think! Where have you seen clinical teams working best? **What factors made the team effective?**
	Effective communication in emergencies *The less haste, the more speed* It is easy to dismiss the importance of communication between staff in the acute situation. When a patient needs things done and done quickly, practical measures should and do take priority. However the way we communicate around these measures can become crucial when dealing with very ill patients, where a misunderstanding can cause crucial delays in treatment or worse. Consequently effective and efficient communication is of particular importance in an emergency.

	Think! What are the barriers to effective communication in the emergency situation? List some here…
	……. ……. ……. ……. ……. ……. ……. …….
Communicate Effectively Poor communication is a constant threat to patient safety Respect everyone in the team Basic courtesy helps you get what you want Say what you want - don't be vague Write your instructions clearly, and show others where you have written them Always document clinical findings and decisions - even in retrospect What you write is important	Here are some important aspects of communication in the emergency situation: **Take control** If a situation arises where you are required to be the lead person it is important to take charge and clarify the roles of those involved. You might want to check the names of other staff and say "OK Eileen, can you check the BP and set up for an IV infusion". Using people's names or making it clear to whom you are speaking by using eye contact will ensure that person knows you want them to act on your instruction and will enable all to work more efficiently. **Keep it simple** Time is of the essence so take your time and get your instructions right first time. Don't rush so much that you fail to provide all the necessary detail. Nursing staff are likely to be more familiar with the acute situation than a junior doctor but they aren't psychic. **Check** Check that the message is understood. In the acute situation a few seconds taken to check, will save unnecessary delays caused by confusion or misunderstandings, which commonly occur when people are under pressure. **Repeat** Repeat the request if necessary. Remember when people are stressed they don't absorb information as well so repetition may be necessary, again this may save time later.

	Watch your body language Remember your anxiety can come across as aggression. When we are anxious we function at a more primitive level, this means that non-verbal communication becomes more critical. Anxiety misinterpreted as aggression can result in disagreements which can waste precious time. Equally remember that the same is true for your colleagues, they may appear irritated or difficult but are probably just anxious too. Think about people you know that are good in emergencies, they often look calm and relaxed, this tends to have a calming effect on those around them and helps everyone to work more efficiently. Acting calmly even when you don't feel it can also help you feel more in control!
Involving Senior Staff Be assertive – say what you want First say what assistance you want Have all the information to hand Be concise Repeat the request if necessary DON'T DELAY	# Involving Senior Staff Getting the help you want can sometimes be a difficult business. Senior colleagues may be busy and distracted. You may not know them very well and feel quite intimidated. They may not know **you**. There are several useful principles to remember when requesting senior help: **Be assertive** Say what you want and why you want it. Assertiveness is about being direct, appropriate, and taking responsibility. If you are not happy with the response you get, say so – diplomatically! **First say what assistance you want** If you wish the senior colleague to come and see the patient, say so at the beginning. **Have all the information to hand** Have the notes, charts and results in front of you – don't have to go away back to the bedside to get the vital signs chart! **Be concise** Think about what you are going to say before you pick up the phone – a coherent, concise request is much more likely to get you what you want. **Repeat the request if necessary** None of us take in every part of what we are told – the same goes for senior colleagues – repeat the request if necessary. **DON'T DELAY** If you think you maybe should get senior help – you should, NOW.