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Physician-Nurse Collaboration and Patient Safety

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FORUM

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Collaboration Between Physicians and Nurses: Essential to Patient Safety

by Jeanette Clough, RN, MS, MHA

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Managing the complexity of modern health care delivery takes all of the resources and patience that leaders and caregivers can muster. In an environment already laden with risk, it is vital that all caregivers stay focused and that distractions are kept to a minimum. Collaboration between physicians and nurses is a fundamental element of a patient safety and risk management program. The ability of physicians and nurses to work together as a unified team is essential to improved outcomes, error and risk reduction, and optimum care.

Even though technology is designed to improve efficiency, a great deal of effort must go into collaboration: communication of even simple orders may become problematically complex, delay of a single procedure can lead to frustration and fault-finding, misunderstandings and miscommunications can all too easily create tensions among the team. When tensions and frustrations do build, then the environment becomes even more risky and is ripe for error. Mistakes occur, communication is compromised, trust erodes. In every care setting—hospital, clinic, or office—patients become more prone to error and risk if the team taking care of them is not working together as a collaborative unit.

Changing Roles of Physicians and Nurses

The years have brought changes to both the medical and nursing professions that have the potential to compromise collaboration and teamwork if not acknowledged and understood. For example, with the advent of clinical record technology, communication between caregivers is now much more likely to be electronic or telephonic rather than face-to-face. Orders are written, updated, and changed on-line perhaps without any verbal communication. Nurses who were formerly dependent on the attending physician for the particular pieces of a patient's history that aided in planning their care must now depend on a computer. Conversely, where the nurse had always been the round-the-clock source of patient information for physicians, it is now more likely that the physician consults the electronic record. To some, this technology transition has been painless; to others it has been difficult and burdensome. Even though technology was never meant to be a substitute for personal communication, there is no doubt that it has had an affect on the day-to-day physician-nurse interactions.

Likewise, images of a solo attending physician and a nurse at the patient's bedside are fading. The team has grown and become highly specialized. The attending is now joined in caring for a patient by the critical care intensivist, the hospitalist, a physician's assistant, and perhaps residents in training. Nurses

now need to collaborate with providers in many roles with different training, expertise, and focus. Fielding inquiries from such a variety of caregivers can sometimes make it unclear who is in charge.

Each profession, medicine and nursing, is experiencing unique pressures. Financial concerns, office and business management, and payer reimbursement bear down on the daily lives of practicing physicians. More and more, those who pay for health care are influencing decisions about care and length of stay. Office technology, coding, and third-party billing requirements are increasing in complexity—taking physicians' time away from their patients. Add to this the growing shortage of primary care physicians and the stage is set for frustration to spill over into interactions with nurses and other caregivers.

The nursing profession is under a different, but equal, set of pressures. A severe and prolonged drop in nursing school enrollment and graduating nurses created severe vacancy rates. Hospitals were forced to create new roles: patient care technicians and nurse extenders helped to fill the gap; permanent nursing positions were substituted with temps and per diem staff. Where the nurses once knew every physician on staff, and vice versa, that is no longer the norm. When many of the faces that physicians see in their own health care facility are unfamiliar, trusting relationships become more difficult to establish.

Leadership: Setting the Tone and Expectations

How do we lead to mitigate the risks these changes present? How do we create an environment that encourages and fosters collaboration and decreases the opportunity for tension, mistrust, and disrespect? There is no order one can give or magic wand one can wave to say that nurses and physicians must collaborate, but there are a number of building blocks that can be used to solidify nurse-physician collaboration that are worthy of review.

"It starts at the top" is certainly true when it comes to creating an environment that fosters collaboration and is focused on the patient. Organizational leaders—trustees, clinical chairs, and senior management—must all commit to a mission that prioritizes an organizational climate for collaborative care. Regularly communicating this message is vital, but backing it up with consistency is equally important. The actions and interactions of the most senior physician and nurse leaders will be carefully watched. Do they respect one another? Do *they* collaborate and work as a team? If senior leaders do not themselves embrace this kind of teamwork, then one can hardly expect the message of collaboration to be heard or heeded.

But it is not enough for only those leaders “at the top” to be committed to this goal. Champions must be developed at all levels of the organization and in all clinical departments. Each clinical chief and chair, along with each managing supervisor and department director, must follow suit and embrace the goal of creating a collaborative environment within his or her own sphere of practice. They must model it and provide opportunities for nurses and physicians to work together. It is their responsibility to identify people, problems, or barriers that are creating tension or otherwise making collaboration difficult. These may be systems or process issues, service problems, or ornery and difficult clinicians that need the attention and intervention of senior leaders. Everyone is accountable to foster collaboration and teamwork that contributes to better patient care. These expectations must be clearly written and consistently communicated.

Providing Resources and Opportunities

Do physicians and nurses have what they need to do their work? A lack of resources—material, human, or technical—increases the chances for frustration, discontent, and error. Functioning, up-to-date equipment, supportive information technology, and a well-trained, motivated workforce are essential to support nurses and physicians. Equally important is the workplace environment that values the contributions of physicians and nurses, and regularly looks for opportunities to recognize and celebrate the achievements of both groups.

Does your organization provide opportunities for nurses and physicians to lead and plan together, to further foster collaboration? Are nurses and physicians regularly given time to discuss cases, oversee quality, and set policy? Are physicians and nurses present and leading organizational committees that recommend organizational change, choose equipment and

The actions and interactions of the most senior physician and nurse leaders will be carefully watched. Do they respect one another? Do they collaborate and work as a team?

other capital purchases, and strategically plan? Finally, do nurses and physicians have opportunities to learn together, understand each others' challenges, and celebrate mutual success? These structural and cultural component parts are not expensive, speak volumes about the investment in physician and nursing staff, and provide enormous opportunities for nurse-physician collaboration.

Nurses and Physicians as CEOs

A clinical nursing background is a great foundation for being a health care CEO. Through my years as a practicing nurse, I developed a deep appreciation for the unique roles physicians and nurses have in patient care. Nursing is a physically and mentally challenging profession with round-the-clock accountability—and it requires a great deal of clinical education, patience, and compassion. In my leadership role, I find myself regularly referencing these clinical fundamentals.

My physician CEO colleagues share similar sentiments about their clinical background and experiences. Understanding the rigors of a medical education coupled with the overwhelming accountability for the patient's care is difficult to appreciate unless you have been in practice. Of course, it would be naïve to think that one's clinical background is all that is required to be a CEO. However, having the clinical perspective and witnessing the day-to-day interdependence of physicians and nurses certainly makes a difference in fostering organizational expectations and culture.

The nurse-physician partnership is a powerful one that has enormous capacity to serve the patient and the public. Fostering collaboration at the bedside as well as in the board room is an important part of a risk management program, creating a safer environment, and delivering patient-centered care. ■

Medical Malpractice Cases Involving Nurses (and Often Physicians)

by Jock Hoffman and Winnie Yu

Jock Hoffman is Editor of Forum. Winnie Yu is a Data Analyst for CRICO/RMF.

Since most patient care involves nursing, it would be accurate to say that the vast majority of medical malpractice cases “involve” nurses. In reality, nurses are named as defendants in significantly fewer cases than their physician colleagues, but they are far from immune. Of course, when measured against the overall volume of encounters, health care rarely involves anyone’s malpractice, or errors, or adverse outcomes. Thanks to highly trained, competent nurses and physicians working together, the vast majority of health care encounters conclude successfully.

But unfortunately, errors do occasionally occur, systems fail, and patients suffer injuries as a result. And when a plaintiff (the patient, family member, or estate) believes an injury was preventable, they look to be compensated for their loss. Generally, the onus is placed on the clinician responsible for the patient when the alleged error occurred, or on the person responsible for the error. Most often, that named defendant is a physician. Less often (but not infrequently) the plaintiff names a nurse. In settings with multi-disciplinary care teams, plaintiffs frequently name both physicians and nurses in the same malpractice case.

From 2002 to 2006, the number of nurses insured by CRICO increased 27 percent (from 13,400 to 17,000). Across the CRICO-insured institutions, an average of three malpractice cases per month either name a nurse defendant, or identify the Nursing service as responsible for the patient at the time of the allegedly negligent event. Among the significant details:

- nursing-related cases represent 16 percent of all CRICO cases and 21 percent of all CRICO incurred losses;
- of the 364 nursing-related cases filed from 1998–2007, 41 percent involved high-severity injuries (including 89 deaths);



- close to half of the nursing cases (45 percent) also named one or more physicians as defendants;
- the total incurred dollars (reserves or payments, and expenses) for cases involving nursing for the 10-year period was \$173 million;
- analysis of the cases that were closed during this same 10-year period shows that nursing-related events accounted for \$71 million in indemnity payments (average=\$441,000);
- safety and security (often slips/falls) topped the list of allegation types;
- the majority of the nursing cases alleged errors related to diagnosis or treatment;

Continued on page 3

CRICO Professional Liability Cases			Table 1
Cases Asserted 1998–2007	All CRICO	All cases involving nurses ^a	Cases in which a physician and a nurse were named
Total cases	2,342	364	163
Cases with high-severity injury ^b	986	149	117
Total incurred	\$849M	\$173M	\$127M
Average indemnity incurred	\$670,000	\$685,000	\$963,000
Cases Closed 1998–2007			
Total cases	2,338	339	150
Cases closed with indemnity payment	31%	47%	53%
Total indemnity payment	\$375M	\$71M	\$56M
Average indemnity payment	\$521,000	\$441,000	\$709,000
Cases closed with indemnity payment >\$1M	125 (5%)	21 (6%)	17 (11%)

a Claims and suits in which a nurse was named as a defendant or Nursing determined to be the service responsible for the patient at the time of the alleged event.

b The patient died, or suffered a permanent significant, major, or grave injury.

Failed Physician-Nurse Communication

by Gretchen Flack and Deborah LaValley, BSN, RN, CPHC

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A 48-year-old morbidly obese woman with sleep apnea, on antibiotics for acute bronchitis, suffered cardiac arrest the morning after uncomplicated eye surgery.

CASE STUDY

Key Lessons

- A patient's overall health status should be taken into consideration when scheduling non-urgent surgeries.
- Failure to make appropriate clinical provisions can lead to inadequate post-operative monitoring.
- Reporting key information about a patient's medical history from one provider to the next can guide important medical treatment decisions.

Clinical Sequence

A 48-year-old morbidly obese woman with diabetes and sleep apnea (treated with nightly nasal CPAP), required surgery for a detached retina. Two days before surgery, during her pre-operative evaluation with a locum tenens physician in her PCP's office, she reported a 3–4 day history of phlegm-producing cough and intermittent shortness of breath. Her EKG was within normal limits with no acute changes. The physician diagnosed her with acute bronchitis and prescribed antibiotics and a bronchodilator. He also sent the patient's pre-operative report to her surgeon, and discussed all relevant findings. Because the patient's procedure was scheduled as day surgery, the physician did not order post-op CPAP.

During the patient's pre-operative interview, the anesthesiologist noted the patient's acute bronchitis and sleep apnea. No respiratory assessment was documented.

Surgery was performed without complications. Given the patient's history of sleep apnea and the late afternoon surgery, her daughter requested that the patient be admitted overnight for observation.

- **6:30 p.m.** Stable, alert, and oriented, the patient was transferred to the floor. The floor nurse received the patient without a report or any mention of her sleep apnea.
- **7:00 p.m.** Shift change
- **8:00 p.m.** The patient—one of eight the incoming nurse was responsible for—complained of eye pain and was given Demerol (PO).
- **8:30 p.m.** The patient vomited and the nurse assumed that the pain medication had been expelled. Despite a clear order to contact the physician for uncontrolled eye pain, the nurse administered an antiemetic and another dose of Demerol (IM)—without notifying the physician.
- **9:30 p.m.** The patient again complained of inadequate pain control. The nurse contacted the physician, who ordered a different antiemetic and pain medication. After

receiving both medications and being encouraged to lie down, the patient appeared comfortable and began to fall asleep.

- **11:45 p.m.** Upon checking the patient and finding her to be lethargic with cool, moist skin, the nurse called the lab to draw her blood sugar. While waiting, the nurse gave the patient a glass of orange juice. Her blood sugar was 278 and she seemed more alert.
- **12:45 a.m.** The patient again appeared lethargic but arousable. The nurse, concerned for her patient, asked the charge nurse to assess her. He felt the pain medications had taken effect and the patient was sleeping comfortably; the physician was not contacted.
- **1:15 a.m.** The nurse found the patient without a pulse or respirations and called a code. The patient was resuscitated, but upon transfer to an ICU at a neighboring hospital, she was declared dead.

Allegation

The patient's daughter filed a suit against her mother's three anesthesiologists, the attending surgeon, the ophthalmology fellow, the nurse anesthetist, and the nurse caring for her the evening after her eye surgery. The suit alleged that 1) performing a non-emergent surgical procedure in the presence of an acute respiratory infection was negligent, and 2) that failing to note the patient's sleep apnea led to an improper post-op medication regimen and monitoring.

Disposition

After unfavorable expert reviews, the case was settled for more than \$1 million, allocated evenly among two physicians and one nurse.

Analysis

1. Defense experts agreed that the standard of care was not met when the physicians evaluating this patient did not consider postponing this non-urgent surgical procedure until her respiratory status had improved.

Potential risks to a patient's overall health should warrant more consideration when scheduling non-urgent surgeries. Rescheduling may be inconvenient for the patient and the surgical team, but a decision to proceed against the risk of unnecessary harm has to be defensible.

2. The anesthesiologist failed to perform a key element of the pre-operative physical examination.

Failure to complete (and document) a pre-operative physical assessment, including cardiac and respiratory status, could be perceived as a gap in diligence and is a hindrance to defending an allegation of malpractice.

Continued from page 1

- The nursing staff's lack of awareness regarding critical aspects of this patient's medical condition (e.g., history of sleep apnea, use of CPAP, and recent acute bronchitis) ultimately impeded the care she received.

Risk is reduced for a patient transferring from one location or service to another when a report noting key information about his or her medical history is provided to the receiving caregiver. Such information can guide decisions, e.g., the regulation of medications provided to the patient, rooming the patient closer to the nurses' station (allowing for more frequent observation), or flagging the need for special care.

- The patient's casual admission for overnight post-op observation appears to have been subject to numerous (errant) assumptions. Her uncontrolled pain was not promptly reported to her physician and she received narcotics in excess of those originally ordered.

Casual admissions to holding facilities can be dangerous in the absence of specific notes/orders regarding any pre-existing health conditions. Likewise, the nursing staff can minimize the risk of an adverse event by monitoring each patient through continual clinical assessment and reporting any deterioration in his or her condition. Failure to recognize the (sometimes subtle) significance of the physician's orders (e.g., when to contact him or her) places patients at unnecessary risk for an adverse event.

- The orders written for this patient were too narrow to cover the realm of possible clinical needs of someone with a history of multiple health problems. Most critically, the postoperative orders did not adequately address monitoring the patient's respiratory status

Care plans should go with the patient across care sites and feature prominent clinical risk issues, in order to keep providers aware of complicating factors that increase risk to the patient. Multiple providers and disciplines must maintain awareness and ensure monitoring of serious clinical risks before, during, and after treatment. Electronic order entry and medical record systems with decision support tools that flag concerns and highlight significant aspects of a patient's problem list (and also prompt recommended actions) offer promise—where available. ■

- 45 percent of incurred losses (i.e., dollars) associated with nursing cases, stems from obstetrics-related cases naming a nurse midwife, RN, or both;
- in the recent five-year period (2002–2007), nurse practitioners and nurse midwives saw a significant jump in the number of cases in which they were named as defendants;
- more than half (57 percent) of the NP cases were diagnosis-related; 89 percent alleged inadequate clinical judgment (e.g., failure to order tests, failure to obtain a consult);
- 21 CRICO cases naming 29 certified nurse midwives (and 24 physicians) account for \$27.6 million in incurred losses.

Cases in which both a physician and a nurse are named compose 45 percent of the nursing cases. More than half of those cases closed with an indemnity payment, a significantly higher percentage than the average for all CRICO cases (31 percent). The average payment for nursing cases in which a physician was also named is 61 percent higher than those without a physician defendant.

As several contributors to this issue of Forum point out, the once-sharp delineation of roles and responsibilities for nurses and physicians continues to blur. When they clash, the only potential winner is the plaintiff's attorney. But when physicians and nurses work together to develop best practices to help them provide safe, high quality care, their patients benefit and the clinicians (nurses and physicians) greatly reduce their risk of being "involved" in a malpractice case. ■

Total Defendants	N=1,132
Institution/Organization	321
Physician	387
Nurse	373
Registered Nurse	297
Nurse Practitioner	41
Certified Nurse Midwife	29
Licensed Practical Nurse	3
Nurse Assistant	2
CRNA	1
Top Allegations	N=364
Safety and security	81
Medical treatment	59
Obstetrics-related	46
Diagnosis-related	46
Surgical treatment	36
Medication-related	33
Patient monitoring	27
Top Risk Management Issues	N=1,334*
Failure to ensure patient safety	23% of cases
Miscommunication among providers	21% of cases
Inadequate patient monitoring	17% of cases
Policy/protocol not followed	12% of cases
Mismanagement of labor and delivery	12% of cases
Inadequate staff training	9% of cases
Never Events	
Patient death associated with a fall	10
Retained foreign object after surgery/procedure	16†

*More than one risk management issue may be assigned to each case.

†Only three since 2003.

Building a Foundation for Nurse-Physician Collaboration

by Jeanette Ives Erickson, RN, MS, FAAN, and Joyce C. Clifford, RN, PhD, FAAN

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Today's health care delivery system challenges all of us to provide care that is patient-centered, efficient, effective, safe, timely, and easily accessible.¹ To meet this challenge, quality and safety become everyone's business. Lindeke and Sieckert (2005) demonstrate that maximizing nurse-physician collaboration holds promise for improving patient care and creating satisfying work roles. Indeed, we now know that we need to maximize *all interactions* that occur within a multi-disciplinary health care team.²

Evolution of Nurse-Physician Relationships

Anyone involved in either the direct delivery of patient care or the development of systems and work environments supporting that effort understands that an essential element in achieving successful outcomes for patients is the effectiveness of physician-nurse communication and collaboration. While the "doctor-nurse game" Stein described in 1967 remains an issue for some, the relationships that once were considered totally hierarchical (i.e., the "captain of the ship" model) are no longer predominate or acceptable practices for either discipline.³

For some, nursing may still be viewed (and, thus, understood) through the tasks nurses carry out on behalf of the patient or family. But the professionalization of nursing practice that began, in large part, in the 1970s ushered nursing's switch from a skill and task model of caring to one that incorporates an increasing emphasis on knowledge and critical thinking. The traditional model—nurses only following orders in a deferential relationship with physicians—has long since been replaced in *most* contemporary organizations and in *most* nurse-physician relationships.

In 1986, Steele called for a change in the way health care is delivered.

"Without a doubt, patients are better served through a union of nurses and doctors working collaboratively. The mutual goals of doctors and nurses providing quality patient care are achievable if the major providers of patient care work together to formulate that care. Neither nursing nor medicine can 'do it all' today, as the patient demands for health care are too broad in scope, the curative techniques are too complex, and no one specialist (medical or nursing) can be expected to generate all the potential possibilities for delivering health care today. Efficient and reasonable efforts for the delivery of care can be accomplished between the doctor and the nurse working together."⁴

When we began to recognize that truly caring and competent practice relies upon strong collaboration among physicians and nurses (as well as with other health professionals), we also initiated improved relationships between physicians and nurses. That, in turn, served to strengthen the collaboration required for improved quality and safer patient outcomes.

Increased education of nurses, organizational support for their contributions to the overall quality of patient care, and increasing involvement of the patient and family in the care process, has also led to better collaboration between physicians and nurses—as well as a greater willingness to confront each other with important issues of care. Consider, for example, the current patient safety movement. Nurses have always been at the "sharp end" of assuring that patient safety occurs, but their role in patient safety was not fully appreciated. Today we see a new level of focus on this aspect of the nurse's practice and an increase in collaborative efforts between nurses and physicians, placing both in a more effective position to serve the patient and family well.

Leading the Way to Safer Care

Assuring success in patient safety efforts (collaboration and quality care in general) is dependent upon an institution's leaders and their commitment to facilitating the outcomes desired. The Institute of Medicine, as well as the Joint Commission, have identified nursing leadership as a critical element in institutional effectiveness. Over the past few decades, nursing has joined its physician counterpart as an important component of institutional leadership with new titles such as Vice President for Patient Care Services or Clinical Operations. The critical nature of leading a clinical discipline is now well recognized, with Chief Nursing Officers (CNOs) bringing accountability to the forefront.⁵ In many organizations today, the CNO and the

	2000	2001	2002	2003	2005	2006
Nurse/Physician Relationships (Scale: 1=non-collaborative, 4=collaborative)	2.8	2.8	3.0	3.1	3.1	3.0
Agree or Strongly Agree that there is a lot of teamwork between MGH nurses and doctors.	69%	66%	73%	79%	81%	82%
Agree or Strongly Agree that MGH physicians and nurses have good working relationships.	76%	76%	83%	84%	86%	86%

No survey was conducted during 2004

cmo (Chief Medical Officer) are equal members of the senior leadership team and together hold responsibility for the quality of care and for the effective nurses-physicians relationships necessary to establish and maintain reliably safe care centers.

Measuring nurse-physician relationships heightens attention to this important interface. Since 1997, at Massachusetts General Hospital (MGH), clinicians have completed a survey every 12–18 months on their perceptions of the professional practice environment.⁶ The survey assesses eight organizational characteristics: autonomy, clinician-physician relations, control over practice, communication, teamwork and leadership, conflict management, internal work motivation, and cultural sensitivity. Table 1 illustrates the tracking of nurses' perceptions of nurse-physician relationships (i.e., relations with physicians that facilitate exchange of important clinical information) from 2000–2006. Nurses' perceptions of collaborative relationships with physicians improved over time as a result of focused educational programs designed to develop conflict resolution and negotiation skills. In addition, these scores are presented to a variety of audiences including the Chiefs Council, composed of physician chiefs of service throughout MGH, thereby including their voice in developing interventions to enhance collaborative working relationships moving forward. ■

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ABOUT FORUM

FORUM provides in-depth analyses of specific medical malpractice cases and issues along with practical loss prevention advice and case abstracts.

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Lessons from Settled Malpractice Cases Involving Failed Physician-Nurse Communication

by Claudia A. Hunter, Esq.

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Inadequate communication and documentation are often at the heart of events that prompt a medical malpractice lawsuit. When the miscommunication is between a physician and a nurse, it can give rise to conflicts of interest significant enough to alter the defense of the case. When the evidence to be presented at trial will make the presentation of a unified defense difficult (if not impossible), cases that would otherwise be defensible have to be settled, usually with both the physician and the nurse contributing to the settlement amount. The following examples are based on CRICO malpractice cases that were settled with payment.

Case 1: Who Knew What When?

An internal medicine physician treats patients who are in a rehabilitation/nursing facility. When the patient is transferred from the local hospital, the transfer papers include a discharge summary written by a physician, and nursing notes. The rehabilitation facility physician does not read the nursing notes; she only reads the discharge summary. No mention is made of any skin breakdown in the discharge summary; an ulcer is mentioned in the nursing notes. Because the patient is uncomfortable and in a brace, the rehabilitation facility physician does not turn the patient over to check her back and buttock area. On the initial physical evaluation form filled out by the rehabilitation facility physician, she checks off the box regarding full physical examination, including *having* examined the patient's skin.

The nurse assigned to this patient reads the nursing notes and knows this patient is developing a decubitus ulcer (which she has little experience treating). There is no communication between the physician and the nurse regarding the ulcer. The rehabilitation facility physician's office is called for medication (for the ulcer) and the nurse writes in the chart that the physician authorized the medication by verbal order. The nurse also records in the chart that the family, the dietician, and the physician are aware of the ulcer and its treatment. The wound continues to worsen. The rehabilitation facility physician learns the patient has an infection; the source is unknown to her. Because the infection is not responding to broad range antibiotics, the patient is hospitalized, and subsequently dies from septicemia.

Lessons

Do not create a record of events that did not take place; if part of an examination is incomplete, document what was not done and why. Defense counsel cannot defend a false medical record. This negative inference will taint the jury's overall impression of the defendant physician no matter how earnestly he or she tries to explain the circumstances.

Physicians are obliged to read nursing notes and talk with the nursing staff. At trial, the evidence would be that the physician sees a patient maybe once a day, but nurses are covering a patient 24 hours a day. Who better to ask and learn from than the 24-hour-a-day caregivers? Defense counsel does not want a jury to believe that the physician cannot be "bothered" to speak with and learn from the nursing staff.

Physicians should review office practices regarding dispensing of medications by verbal order without the physician's knowledge, no matter how "routine" the medications are that have been requested. A verbal order means the physician has authorized the medication request and he or she will be charged with that responsibility and knowledge. At trial, the nurse would have to testify that she had notified the physician—the proof being the verbal order for the prescription medications. In this case, the physician denies having been informed of the patient's condition despite the order. It is the jury that, ultimately, determines credibility; if this case went to trial, one, or both, of the defendants would lose.

Case 2: Counting on Each Other

Following surgery, the surgeon packs a neck wound and does not tell the nurse how many pieces of gauze were used. (The surgery was done emergently and late at night. The proper packing material was not available and gauze, if used, should have been counted and the count recorded.) The surgeon writes an order for dressing changes. The patient is seen post-operatively by other members of the physician's practice group, not the operating surgeon. The nursing staff unpacks and repacks the wound as ordered, without knowledge of how many pieces of gauze were initially used in the operating room to pack the wound. No count is kept by the nursing staff of the number of gauze pieces removed nor of the number used to repack the wound.

Weeks following surgery, the patient's complaints of pain are attributed to the chronicity of the patient's underlying medical condition and a slow recovery from surgery. The patient and the family become dissatisfied with the surgeon and seek a second opinion. The wound is re-explored and a piece of gauze is removed. It cannot be determined whether the gauze that was removed had been placed by the surgeon and not removed by the nursing staff, or whether the retained gauze had been placed and left by the nursing staff during subsequent dressing changes. The physician says wound dressing changes are a nursing responsibility; the nursing staff says their dressing changes were appropriate and the surgeon placed the gauze deep in the wound where it could not be visualized. Further,

they assert they did not know the number of pieces of gauze the surgeon originally used to pack the wound, as the surgeon did not record a count in the record.

Lesson

The bottom line is that a patient will be compensated for a retained foreign body and a jury could find all defendants liable because of finger pointing and the mutual lack of documentation and failure to communicate.

Case 3:

The patient (diabetic with no history of chest pain) is admitted for cataract extraction. The day after admission, the patient complains of chest pain. An EKG is read as showing no ischemic changes and no changes from a baseline EKG performed one year prior. The nurse writes in the chart that cardiac enzymes are to be drawn to rule out a myocardial infarction. There is no corresponding physician order, verbal or written, for cardiac enzymes and none is drawn. The patient continues to complain of chest pain and is given nitroglycerin. There is no documentation in the record of a physician having ordered nitroglycerin and no documentation of nitroglycerin in the medication administration record. There is no documentation in the record of the physician's evaluation of this patient for chest pain. The patient undergoes surgery and is discharged the next day. Four days later, the patient arrests at home and sustains anoxic encephalopathy.

The physician is charged with failure to order appropriate diagnostic testing and failure to examine the patient, as there is no documentation of such an examination. If the case went to trial, the nurse would testify that the physician gave either a verbal or telephone order for the administration of nitroglycerin after evaluating the patient. Without an order, the nurse is being charged with practicing beyond the scope of her license. The physician would testify that there was no notification from the nursing staff of the patient having any continuing cardiac complaints.

Lessons

In Case 1, it was recommended that a physician not document that an examination was performed when one never took place. In this case scenario, it is recommended that a physician document an examination, if one is performed, and the results of that examination. Remember: not written, not done. At trial, it is unlikely that a jury is going to believe a physician who tries to testify about a memory of an examination and the findings of the evaluation years after the event.

In this case, the physician claims the nursing staff did not inform her of the patient's ongoing cardiac complaints. The nurse would testify that the physician was informed of the patient's complaints, examined the patient, and gave an order for nitroglycerin. The case could be defensible had there been appropriate communication and documentation by both defendants; however with having neither, the case settles with contribution from both the physician and the nurse. ■



Triggers: Rapid Response at Beth Israel Deaconess Medical Center

by Patricia Folcarelli, RN, PhD, and Michael Howell, MD, MPH

Ms. Folcarelli is Director of Patient Safety, Silverman Institute for Health Care Quality and Safety, at Beth Israel Deaconess Medical Center (BIDMC), Boston. Dr. Howell is Director of Critical Care Quality for BIDMC's Silverman Institute for Healthcare Quality and Safety.

The nurse's view: When working as a clinical staff nurse on a general med-surg unit on the evening or night shift, I would often need to exercise my clinical judgment about a change in a patient's status. Imagine this scenario: it is 2:00 a.m. and one of my patients developed a respiratory rate of 32. After my initial assessment of the situation, I needed to decide whether or not to call the physician. When the physician returned my call, he or she needed to decide whether or not to actually come to the bedside to evaluate the patient or just make recommendations over the phone. Some of the physician's decision might have been based on how well I described the clinical condition, how worried I sounded, or how well the physician knew me and trusted my assessment skills.

The physician's view: When working as an intern on the wards at night, I relied on the assessment skills of the nurses and really hoped they always knew when to call. Imagine this scenario: it is 2:15 a.m. and I'd just admitted a worrisome sick patient. If he was with a nurse I knew well, then I was very comfortable. But, if he had a nurse I had not worked with much before, then I was nervous. In fact, with these kinds of patients (cared for by nurses I was unsure of), I would always try to sneak by in the middle of the night to double check, because I just wasn't certain that I would get a call if something changed. Of course, when I did get those calls, I had several decisions to make: Go and see him? Just make recommendations over the phone? Call my supervising resident? (sometimes) Call the attending? (rarely).

In 2005, the Institute for Healthcare Improvement launched the 100K Lives Campaign.¹ One of the recommended practices was that institutions develop rapid response teams to provide earlier intervention to the decompensating patient.² For 2008, the Joint Commission hospital accreditation standards include a new National Patient Safety goal which calls for improved recognition and response to changes in a patient's condition.³ Understanding that studies have yielded conflicting results—and less resource-intensive practices have not been tested—BIDMC approached these recommendations by launching the clinically resource neutral Triggers Rapid Response process for attending to decompensating patients.

BIDMC started by identifying a standard set of “triggers” (see Figure 1).⁴⁻⁵ When a non-ICU patient meets the trigger criteria, the result is a standard communication from the nurse to the intern or resident caring for the patient, e.g., “Mr. S has triggered with a BP of 82/50.” The intern or resident, and a senior nurse (clinical supervisor or clinical nurse specialist) then must come to the bedside to see the patient. If the trigger is a respiratory event, a respiratory therapist also comes to the bedside. Once the evaluation is complete, the intern or resident informs the attending that his or her patient has “triggered,” then they discuss the plan of care.

To assist in this new process, BIDMC's Information Systems department created a “Trigger” multidisciplinary event note. Nurses can generate a Trigger event note by a single click in BIDMC's CPOE system. The note pulls a list of the active medications, recent lab results, advance directive status, and allergies so that when the team responds to the bedside, it has this key information at hand without needing to scan through the record. This event note provides the documentation of the interventions and helps to capture the truly multidisciplinary discussion of the plan of care for that patient with all team members. It has also provided access to day-to-day data on activity of the triggers program, helping team members track and follow up on the patients who trigger and to review the

response and the interventions that occurred. Clinicians can also review the care of patients who require resuscitation to see if a trigger was called prior to a cardiac arrest or ICU transfer. Knowing which patients did or did not trigger prior to an event has allowed BIDMC to learn more about its systems of care and to identify areas of practice where educational reinforcement was needed.

One example of this was in management of oxygen therapy for medical and surgical patients. In several instances, BIDMC discovered that nurses would increase the oxygen delivery by turning up a nasal cannula delivery from 2L to 4L to 6L without calling a “trigger” because the oxygen saturation was remaining above 90. Retrospective review of several of these instances over time led to adding a new, more specific trigger criteria in 2007 and also led to enhanced nursing and physician education about oxygen management.

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Triggers
The acute, new development of any of these constitutes a Trigger:
<ul style="list-style-type: none">■ heart rate <40 or >130■ blood pressure decrease to <90■ respiratory rate <8 or >30■ Sa O₂ <90% with oxygen therapy■ any need for non-rebreather O₂■ urinary output <50 cc in 4 hours■ acute change in consciousness■ marked nurse concern
The Trigger team includes:
<ul style="list-style-type: none">■ the patient's house officer■ the patient's nurse■ the floor's designated senior nurse■ the floor's unit coordinator (if staffed)■ respiratory therapy (if needed)■ other providers as needed

How to Encourage Collaboration in the OR

by Jo Shapiro, MD

Dr. Shapiro is Chief, Division of Otolaryngology, at Boston's Brigham and Women's Hospital, and Senior Associate Director, Graduate Medical Education, for Partners Healthcare.

In recent years, I have developed a successful operating room (OR) briefing technique that promotes and prompts good rapport and efficient communication among all of the team for a given procedure. Our success with this process has prompted questions about why and how we do it. Certainly our model is just one of many, but I'm pleased to share. Depending on your personal communication style, initiating OR briefings may seem very basic or very unnatural. The constant is that you need a plan for what you want from the pre-op briefing, and some specific techniques to accomplish your goals.

Generally, I wait until the patient is intubated to begin the briefing. That way, we can get everyone's full attention because everyone is usually in the room, and there is a relative lull in the intensity of the work. We literally gather around the patient, so the patient is in the center. I ask everyone in turn to say his/her first and last name and what his/her role in the case is, e.g., Jo Shapiro, attending surgeon; Sue Smith, attending anesthesiologist; so-and-so, student; etc. Many of us know each other already, but not 100 percent of the people know each other 100 percent of the time. Students come and go, residents change, nurses change, surgeons change, etc. By knowing everybody's name and role, we begin to build (or reinforce) a sense of teamwork.

We start with the standard time out or "safety pause" in which we confirm the patient's name and what procedure we will be performing, including laterality. This lets us establish a shared mental model so that we all know what we are going to do in the case. It sounds basic, but because surgery is complicated, because one case might not be the same as another, because there might be a variation in the technique, the briefing helps make sure everybody is on the same page. That, in turn, will help the nurses and the physicians know what instruments might be needed so that people can do less of the scurrying around ad-hoc work that they end up doing if you don't brief them. Because the nurses, of course, want to be competent, they want to know what's coming: the surgeon's entire plan, the instruments he or she will need, etc. Without that, nurses are running in and out of rooms just to find things. With everyone on the same page and knowing in advance what might be needed, the nurses' process is more efficient and engenders fewer risks.

We discuss anything that may be different about this procedure from the usual, as well as any concerns any team member has regarding the particular patient. For example, the resident may remind us that the patient is wearing a magnet for pacing, and we need to avoid monopolar cautery.

I then ask that we all use the OR equivalent of read backs; when somebody asks for something, he or she should verbally repeat the request: "4-0 chromic please. 4-0 chromic." That prevents

errors or delays due to requests being misinterpreted or just not heard. So for example, if we ask for a particular instrument, the circulating nurse may say, "Muscle biopsy clamp. I need to go to another room to get that," rather than just disappearing, leaving the surgeon to wonder whether the request was even heard in the first place.

Anybody Any Time

Next, I say, "This is a team effort and everybody's input is valuable. If there is anything that you do not understand or that you think is of concern, I want you to call it out. We need to hear from anybody at any time if you have concerns."

Unless prompted and encouraged, some team members may hold on to information, or not give it to the right person, because of the hierarchical cultural barriers to speaking out. And in our hospitals, if you don't explicitly welcome input, you probably won't get it. And, if the team leader doesn't mean it—if he or she really doesn't want input from other people and is saying she does proforma—that quickly becomes known and renders the words ineffective. Or, if you say it and then when someone does give input you don't act on it, or you ignore it, or you belittle it, then the sense of inclusion and trust is over, it's absolutely over.

Much of this communication process can be uncomfortable or unfamiliar. For example, not all anesthesiologists are used to telling you what's going on when the patient is having problems. We are not acculturated to have them tell us, "We're having a problem with the blood pressure right now." I didn't train to say, "Listen, we've lost more blood here than I thought we would. I just want to let you know." Even though everybody would say that's good medicine, it is not habitual. Since I started these briefings, it has become more of a habit for our teams—I have noticed more clinicians routinely briefing each other during the case, more routinely updating each other as to how the patient is doing, and that's really helpful.

Flattening the Hierarchy...Temporarily

While the briefing process does not ask anyone to perform clinical tasks they are not trained for, we are challenging some established behaviors and (bad) habits. The pushback I get from physicians is that they are afraid that what we are advocating is no hierarchy at all, any time. What I hear is, "I'm not comfortable with anyone just telling me what to do or disrespecting my orders. I cannot have people constantly questioning me because I don't have the time to sit and explain it."

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So What Have We Accomplished?

Better Outcomes: BIDMC looked at the risk of full-code patients dying outside of an ICU—what the literature generally calls “unexpected mortality” or “non-ICU, non-DNR mortality.” Since beginning the triggers program in 2005, unexpected mortality at the BIDMC has fallen by more than 50 percent, even after adjustment for age, case mix, and comorbidities.

A New Verb in Clinical Language: The Triggers Rapid Response process has helped to enhance collaborative communication by standardizing the expectations for response when a patient becomes unstable. The criteria and the naming of the program with the “trigger” phrase provides rule-based communication that eliminates ambiguity in the expected response. Over the past two years, the triggers program has become a part of the day-to-day work in the care of BIDMC’s non-ICU patients. In interdisciplinary rounds, it is now common to hear “Mr. S triggered at 1300 for a low blood pressure.” BIDMC now has a new verb!

We are particularly proud of the decision to use the existing primary care team to respond to the bedside; the patient is best served by an initial response by the physician who knows him or her.⁶ This level of response also fits with BIDMC’s teaching mission. And finally (and not insignificantly), this level of response did not require the addition of staff resources.

So if we think back to that long ago night shift on our medical surgical unit...

We no longer rely on the nurse to decide if a call is necessary, knowing that there are other factors that might influence the decision to call for help. We no longer rely on the intern or resident to decide whether the attending should be called, since there are other factors that might influence the decision to notify the attending physician of a change in the patient’s status. We have standardized the rules and, in doing so, we have developed a new collaborative process for communication. ■

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That fear—that we’re slowing things down with indiscriminate interruptions—can prevent some physicians from seeing that we are not talking about equal responsibility. The attending surgeon still makes the decisions even if the team disagrees, but we have to improve information transfer. Especially during periods of extreme stress or emergency, we need to flatten the hierarchy—temporarily—and then be able to immediately reconstitute it.

I also do a debriefing, essentially as a teaching tool, as we are closing. I say, “What do you think went well? What would anyone do differently?” When I first began talking about this to a national audience, somebody said “Well, I’d hope you wouldn’t be disclosing any adverse event in front of the team.” But that misses the point. Who am I trying to keep it secret from? They were all there and know what happened; what better time to talk about it and learn from it? Of course there are times when it is more appropriate to say “This might have been upsetting, it was upsetting to me, and if any of you feel that you want to talk about it afterwards, we should.” But, generally, I want to take advantage of the learning opportunity while it’s fresh in everyone’s minds.

I am very lucky in that my division at BWH (Otolaryngology) has a mutually respectful relationship with our nurses, who are all talented and dedicated. But, like virtually every health care setting, we may at times work with people who are not usually involved with our particular procedures; there are sometimes staffing and training issues that may leave nurses not knowing exactly what they are supposed to be doing. That is, obviously, unfair to the patient as well as the nurses and physicians. But that is a systems problem, not an “incompetent nurse” problem (nor an incompetent anybody problem). A system that puts someone in a position of having to do something he or she isn’t trained to do is a system that needs fixing. It’s a huge issue that we all have to deal with—including those who are most vocal in complaining about it.

A second concern that, perhaps, gets less attention is when anyone fails to maintain respectful relationships with physician trainees. When I do see unprofessional behavior, often what I see are individuals looking for fault in other individuals—rather than trying to help each other or improve a failed system. Finger pointing is rarely helpful, and we need to address it.

The nature of health care is changing dramatically. Roles and responsibilities are shifting, modeling and mentoring are less emphasized, and we could all use a healthy dose of training around professionalism within the whole health care team. ■

Let's Talk: Building Better Physician-Nurse Collaboration

by Alexander R. Carbo, MD and Patricia Folcarelli, RN, PhD

Dr. Carbo is a hospitalist at Beth Israel Deaconess Medical Center (BIDMC), in Boston. Ms. Folcarelli is BIDMC's Director of Patient Safety.

Successful teamwork, in any setting, is dependent on strong collaborative relationships. In health care, collaborative relationships are the cornerstone of safe, patient-centered care. On the other hand, collaboration has been defined as “cooperating traitorously with an enemy.”¹ This definition may not describe nurse-physician collaboration in your institution, but developing and maintaining strong relationships among clinicians *is* challenging.

The clinical team commonly includes the patient, family, physicians, nurses, pharmacists, therapists, and a host of other providers. The nurse-physician interaction—in particular, communication and collaboration between these two groups—has been identified as a major factor contributing to patient outcomes and quality patient care.² Positive nurse-physician relationships have also been recognized as important components of professional practice in “magnet” hospitals.³ And in other studies, nurses who report favorable and effective teamwork in their areas rate the quality of care higher, express greater job satisfaction, and are less prone to professional burnout.⁴

Successful collaboration, in any setting, depends on effective communication, and is contingent on all parties being available for and receptive toward one another.⁵ Collaboration in health care requires nurses and physicians to cooperate, share responsibilities for solving problems, and to jointly formulate and carry out patient care plans.⁶ All of that calls for open communication and mutual responsibility.⁷ Collaboration also hinges on mutual respect for both the perspective and the knowledge held by each discipline and a shared concern for quality patient care.³

Getting Back to Face-to-Face

Effective communication begins with physicians and nurses actually speaking to one another. This may sound like a trivial concept, but in the age of cell phones, e-mail, and computerized provider order entry, in which patient orders can be communicated from a remote location, face-to-face interactions regarding patient care are becoming less standard.⁸ Remote communication can lead to miscommunication: delayed initiation and execution of orders, and cracks in the coordination of care.⁸

Even when providers are physically proximate, communication between nurses and physicians does not necessarily occur with great regularity. In a study looking at the causes of error in six different intensive care units, “nurses and physicians conferred with each other in only two percent of the activities” carried out each day in the unit.⁹ When they did talk to each

other, however, it did not always improve care, as the study found that “verbal exchanges between physicians and nurses were recorded in 37 percent of errors.”⁹ Clearly there is much room for improvement in the frequency and quality of nurse-physician communication. Assuming that the frequency can be increased, the content and style of their interactions deserves careful examination.

In broad terms, physicians tend to focus on measurable and factual understanding of the patient's disease or condition, while nurses are trained to focus on the narrative—the patient's experience and response to treatment.⁷ A physician who is unaware of or who disregards that disparity may perceive “nurses' work as less relevant than their own primary work concern—the disease itself and its treatment.”⁷

To further complicate matters, individual characteristics: expertise, autonomy, and responsibility, are easier to develop, maintain, and reward than collaborative behaviors such as interdependence, deliberation, or dialogue.² Physicians clearly “perceive themselves as the primary decision makers in health care [who] feel free to change treatment plans without consultation.”⁷ Against this backdrop, nurses consistently rate physician communication lower than that of colleagues.

But all hope is not lost. When queried, every physician can relate occasions when they relied on the knowledge and experience of a nurse as guidance toward the proper decision. The strength of a collaborative environment is having those occasions more common than rare.

How

The key to further improving collaboration between nurses and physicians is shared education with a focus on teamwork and communication.² Results of this approach can be seen in the MedTeams project¹⁰ and in Pronovost's daily goals checklist in the ICU.¹¹ In both cases, communication and collaboration were improved, with subsequent reduction in errors. On a much smaller scale, BIDMC has initiated a series of simulation-based activities involving nurses and physicians, with an eye toward improving collaboration. The simulation lab provides opportunities for nurses and physicians to safely experiment in situations where skills related to differential diagnosis, as well as skills related to effectively communicating, can be strengthened. Simulation of a bedside emergency (e.g., acute dyspnea) with nurses and physicians—followed by a debrief about both the clinical decision making and the communication among the team members—is a powerful and effective experience.

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Implementing a Nursing Peer Review Process

by Valerie J. Hunt, PhD, RN

Ms. Hunt is Senior Vice President, Patient Care Services, for North Shore Medical Center, in Massachusetts

Successful collaboration between nurses and physicians has a positive impact on nursing and physician satisfaction, can reduce errors, and assists in the achievement of quality clinical outcomes for the patient.¹⁻² Unfortunately, for many organizations, the culture of collaboration does not extend into the examination of adverse events and health care errors.

In 2006, as part of an effort to further enhance physician-nurse collaboration across its health care delivery system, North Shore Medical Center (NSMC) embarked on a new peer review process to have its Nursing Division examine clinical cases which had previously been discussed at NSMC's Patient Care Assessment (PCA) Committee from the medical (i.e., physician) perspective.

While the PCA Committee's case reviews had long provided an opportunity to identify nursing issues and system problems related to the cases discussed, its mission (and time constraints) limited the opportunity for an in-depth, thoughtful examination of nursing practice, recognition of practice patterns, and determination of nursing action steps to mitigate patient problems. Thus, by creating a nursing peer review forum, NSMC more comprehensively addresses the nursing and systems issues related to clinical cases with compromised or adverse outcomes. That process, in turn, enables nursing to be better prepared for collaboration with physicians during the PCA forum.

Nursing Peer Review Sessions

The Nursing Peer Review Committee comprises nursing representation from management, education, clinical practice, performance improvement, and patient safety. Cases are usually referred to the Committee by nurses, but may also be referred by physicians, performance improvement personnel, or customer service representatives. The nursing peer review process begins with a review of the clinical case conducted by a nurse leader who includes input from staff and others as appropriate. When a case is reviewed and presented by a staff nurse, the nurse manager, educator, or clinical nurse specialist provides coaching and consultation. The consultation is also a mechanism for a second level review of the case.

The case review opens with a narrative description of the occurrence clearly identifying any actual or potential nursing problems, followed by a nursing history and assessment. The hospital course consists of a detailed chronology of events and the related timeline. Next, a preliminary assessment is documented; this identifies the factors contributing to the outcome and any adverse events for the patient. An action plan includes steps taken to address or mitigate patient problems. The writ-

Figure 1

Nursing Peer Review	
Peer Review Session	
Narrative Description (statement of occurrence/actual, or potential problem)	
<ul style="list-style-type: none">■ Nursing history and assessment■ Hospital course (includes chronology/timeline)■ Preliminary assessment (factors contributing to outcome)■ Action plan	
Post Review Session	
Discussion Points from Nursing Peer Review	
<ul style="list-style-type: none">■ Nursing peer review additions to action plan■ Severity Index Score:<ul style="list-style-type: none">0: Acceptable standard of care1: Minor variation from standard of care2: Major variation from standard of care	

Figure 2

Tips/Strategies in Implementation of Nursing Peer Review Process	
<ol style="list-style-type: none">1. Include representatives from nursing education, nursing practice, performance improvement, patient safety, nursing management, and nursing research on the committee.2. Establish a non-punitive, "just culture" environment in which members are encouraged to actively participate.3. Use evidence-based practice, review of the literature, and national benchmarks to guide case discussions and practice changes.4. Provide coaching and second level review to nurses analyzing and presenting cases.5. Document themes/patterns detected in patient cases.6. Establish a database of nursing problems identified and action steps/recommendations taken to address problems.	

ten report of the case analysis is presented to the full Nursing Peer Review Committee (which meets monthly and typically reviews two or three cases per 90-minute session).

Upon completion of the presentation, committee members discuss the case, with discussion points documented in the meeting minutes and recorded in the second part of the case review format. Also included are any additional steps or recommendations to the action plan from the Committee. For each case, the Committee determines and records a single severity index score, which is used to guide action plan priorities (see Figure 1).

From the minutes of the meeting and the individual case summary reports, a nursing database has been compiled of all clinical cases presented. This database contains the nursing practice issues identified and a summary of system improvements and nursing actions taken. For the Nursing Division, the database provides documentation of the comprehensive work completed on professional practice issues and serves as a guide to set future direction for improvements in nursing practice and team collaboration.

In establishing the Nursing Peer Review Committee, careful attention was paid to establishing a non-punitive, “just culture” environment in which nurses were encouraged to openly participate in the disclosure of nursing practice issues and system failures. NSMC’s Director of Patient Safety helped the Committee develop a format and process for case review and the severity score index, and she provided education on the just culture environment and the peer review process. Early on, the group established the guideline for case reviews to include review of recent literature, examination of research studies, review of national standards, and benchmarks as appropriate. This focus on relevant data and evidence-based practice provided a framework to review cases, examine practice patterns, and propose positive practice and system changes. The framework also resulted in stronger collaboration with physician colleagues on the review of clinical cases and the determination of system improvements. Clinical improvements on care transitions and handoffs, as well as effective team communication, have been particular areas of focus.

The Nursing Peer Review Committee model at NSMC has created a system for professional nurses to examine their practice, actively disclose practice and system issues, and collaboratively create action plans with their physician colleagues. Ultimately, this proactive review of practice and outcomes will result in reduction of error, mitigation of patient risk, and the creation of a safer, quality environment of patient care. ■

The author acknowledges the many positive contributions made by associate chief nurses Judy Schneider, RN, MS; MaryBeth DiFilippo, RN, MS; and Martha Page, RN, MS, Director of Patient Safety, to NSMC’s Nursing Peer Review Model.

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Another strategy for improving collaboration is to provide “cross-disciplinary shadowing opportunities for physicians and nurses. These experiences can help to improve mutual understanding of roles and enable both groups to better envision collaborative practice.”² In the past, BIDMC had a “nurse for a day” program for resident and attending physicians to spend observing and participating in the work. Many physicians expressed the sentiment that they wished they had been given that opportunity in medical school. Today, many of the Harvard Medical School students spend a day or half-day “shadowing” a nurse on one of BIDMC’s units. The theory—born out in practice—is that it is much easier to collaborate with a team member if each participant clearly understands his or her colleague’s perspective. One of the goals of the HMS–BIDMC shadowing experience is to help ensure that the students have successful transitions to their internships.

Last, mutual respect among professions is modeled by the senior clinical leadership within an organization. Organizations that model collaboration at the highest leadership levels are likely to engender successful teamwork in all areas. These collaborative environments are the cornerstone of safe, patient-centered care. ■

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Additional Reading

by Judith Jaffe, MSLIS

Ms. Jaffe is Knowledge Manager for CRICO/RMF.

The following additional resources related to nursing patient safety issues were selected from the PubMed (Medline) database of indexed biomedical literature published from 2000 through March 2008. Links are provided to abstracts and full text, where available.

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