Interdisciplinary Team Communication

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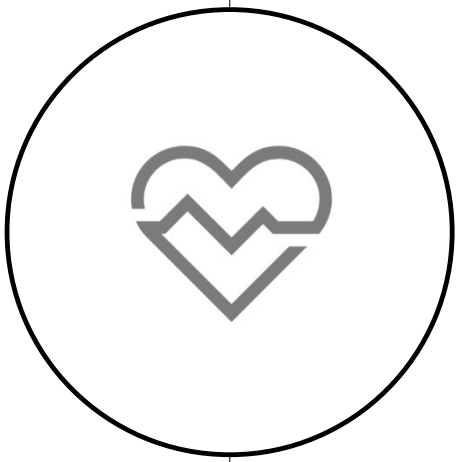
Objectives

- Define a therapeutic relationship
- List the 8 competencies of shared decision making
- Discuss the benefits of good interdisciplinary team communication
- Provide examples of how to be an effective communicator

A therapeutic relationship is…

- A partnership with our patients, formed to optimize the patient's medication experience
  - Involves the patient in drug therapy management decisions
  - A cornerstone of pharmaceutical care
  - Evolves over time



A therapeutic relationship is not…

- Friendliness
- Information overload
- Professional behavior
- Good rapport

Benefit of a therapeutic relationship

Patients who are better informed make better decisions and have better outcomes

Goal: Nurture the relationship through open dialogue to ensure that decisions are shared

Shared Decision Making

Shared decision making

What is informed shared decision making?

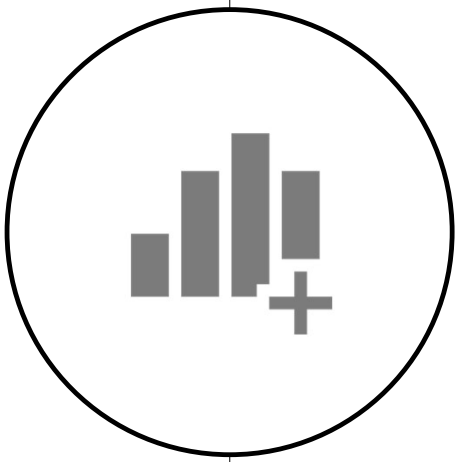
- Shared by health care provider and patient
- Considers risk and benefit
- Takes into account patient-specific characteristics

Who makes the shared decision?

- Patient
- Health care provider
- Family
- Staff

Shared Decision Making

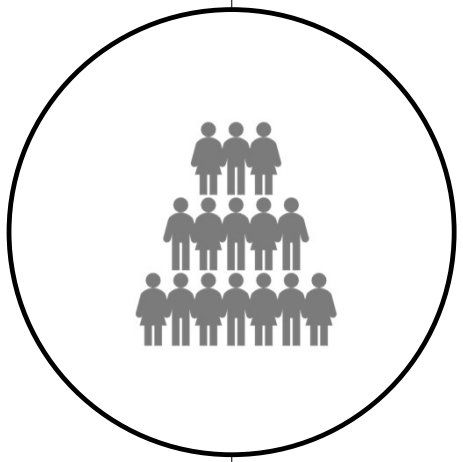
- Eight “steps” in shared decision making:
  - Develop a partnership
  - Establish the patient’s preference for information
  - Establish the patient’s preference for his/her role in decision making
  - Ascertain and respond to patient’s ideas, concerns and expectations
  - Identify choices and present evidence to the patient
  - Present evidence to the patient
  - Negotiate a decision and resolve conflict
  - Develop an action plan with follow-up



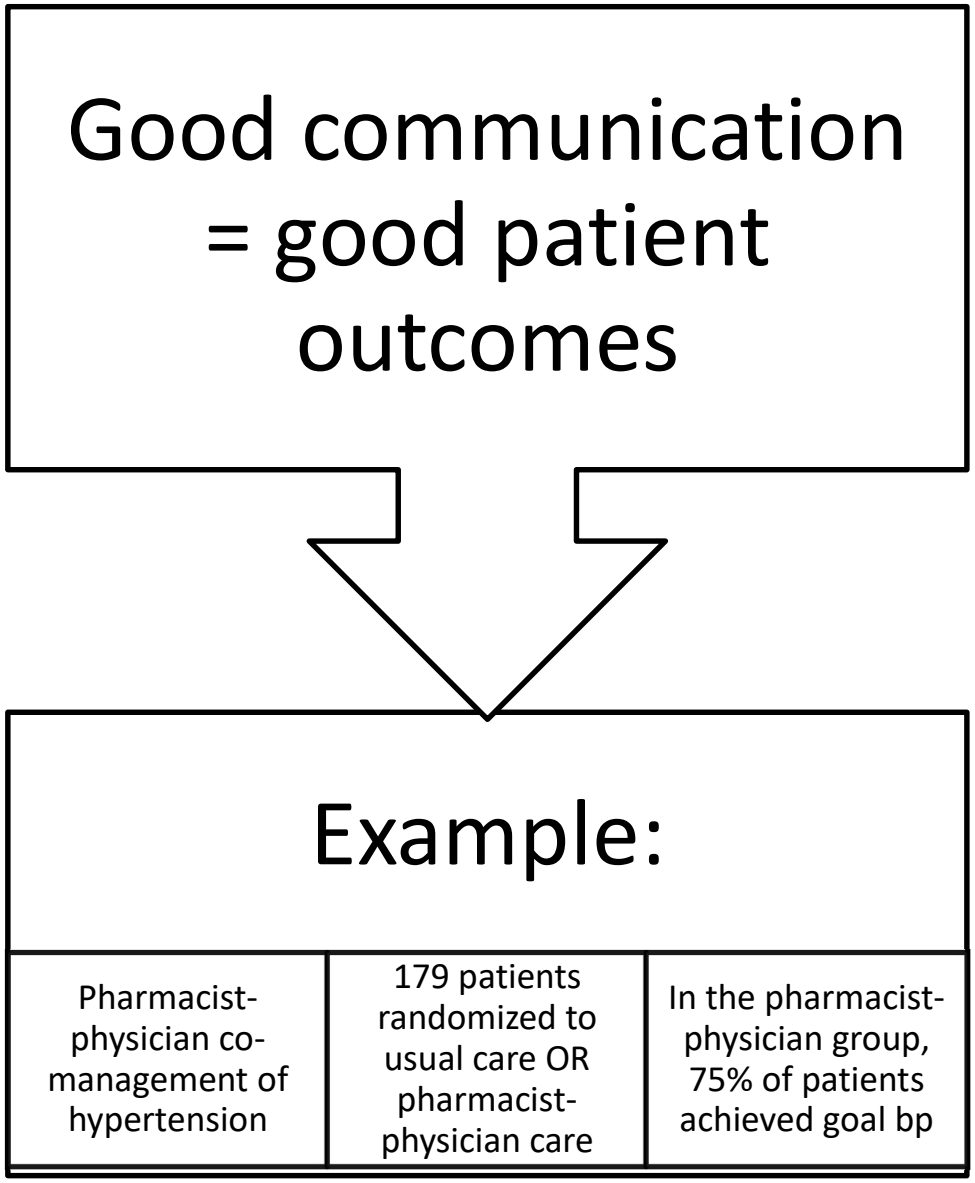
Interdisciplinary teams

- To be successful, team members must….
  - Be competent in their own discipline
  - Be respectful of others' roles and perspectives
  - Possess skills that facilitate effective group dynamics, team performance and…

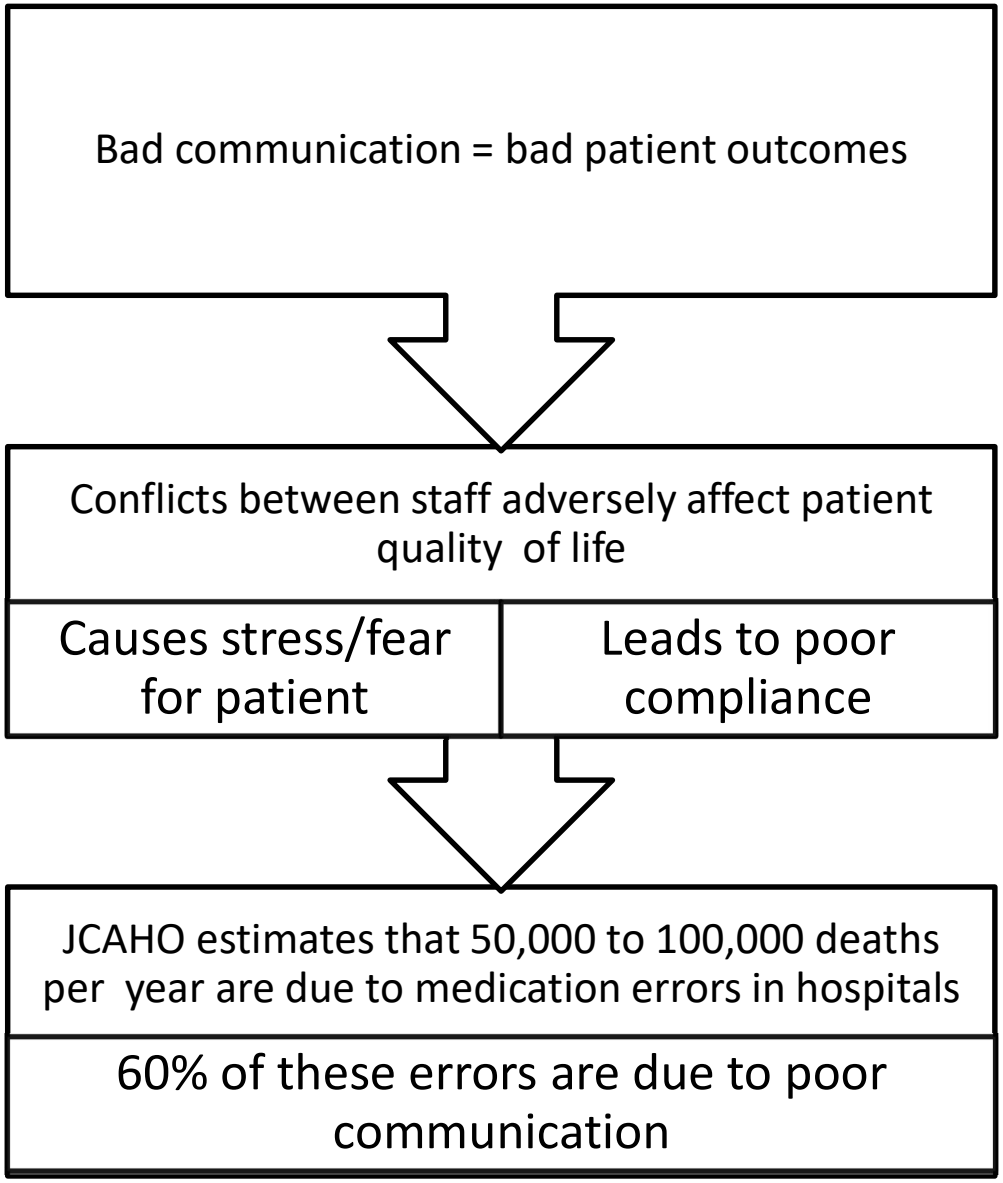
shared decision making



Communication



Communication



Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

The majority of events have multiple root causes
(Please refer to subcategories listed on slides 5-7)

2013 (N=887)		2014 (N=764)		2015 (N=936)	
Human Factors	635	Human Factors	547	Human Factors	999
Communication	563	Leadership	517	Leadership	849
Leadership	547	Communication	489	Communication	744
Assessment	505	Assessment	392	Assessment	545
Information Management	155	Physical Environment	115	Physical Environment	202
Physical Environment	138	Information Management	72	Health information technology-related	125
Care Planning	103	Care Planning	72	Care Planning	75
Continuum of Care	97	Health Information Technology-related	59	Operative Care	62
Medication Use	77	Operative Care	58	Medication Use	60
Operative Care	76	Continuum of Care	57	Information Management	52

https://www.jointcommission.org

Background

- Medical errors are common
- Sizable number of patients in six countries report medical errors
  - Medical mistake
  - Wrong medication or dose
  - Incorrect test results
  - Delays in getting test results
- There are many factors that typically contribute to a medical error
- Many errors are PREVENTABLE

Source: C. Schoen et al., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005): W5-509–W5-525. Data from the 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults.

Background

- Poor or ineffective communication is a
- common cause of medical and medication errors
- Communication is key
- Functioning healthcare team
- Patient safety

Communication Failures

Can lead to breakdown in:

- Sharing information with team
- Requesting information from team members
- Include patients and families in care plan

Examples of missed communication:

- Poor documentation – nonspecific, incomplete
- Failure to get input from patients

Effective Communication

Complete

- Communicate all relevant information
- Avoid excessive details

Clear

- Convey information in an easy to understand manner
- Use standard terminology

Brief – communicate concisely

Timely – offer and request information in appropriate timeframe

Barriers to good communication

- Differences in training/experience/culture
- Time
- Environment
- Stress
- Method: Telephone, pager, electronic medical record, email, fax
- Location

Communication Challenges

- Communication styles
- Conflict
- Distractions
- Language barrier
- Physical proximity
- Personalities
- Shift change
- Workload

SBAR

S = Situation – what is going on with patient?

B = Background – what is the clinical background?

A = Assessment –what do I think the problem is?

R = Recommendation –what is my recommendation?

SBAR Example

Introduction	•Hello Dr. Jones, I am (your name) the pharmacist at university Pharmacy. •I'm calling about your patient Ima smith
Situation – What is going on with the patient?	•The patient is a 69 YO female with T2DM. She came in to pick up her prescription for glyburide today and was complaining of several episodes of low blood sugar.
Background – What is the clinical background or context?	•She has noticed frequent episodes of hypoglycemia in the middle of the night since her glyburide was increased from 5 mg to 10mg twice daily. She is also taking metformin 1000 mg twice daily with meals.
Assessment – What do you think the problem is?	•Considering her frequent low blood sugars, she may need a dose reduction in the evening glyburide.
Recommendation – What is my recommendation?	•I would suggest decreasing the PM dose of glyburide back to 5 mg and monitor AM blood glucose and follow-up with your office as soon as she can. Do you agree?

SBAR in Clinical Pharmacy

Communicate with providers for medication- and patient-related concerns

Examples

- Recognize a drug allergy and suggest therapeutic alternative
- Recognize duplications of therapy
- Recognize contraindications of therapy
- Report adverse drug events with prescribed therapy
- Convey concern over potential drug interactions or inappropriate dosing/indication

Check-backs

Closed-loop communication strategy to verify and validate information exchanged

Example

- During an emergency situation, the physician calls out an order to give 1mg epinephrine IV. Another team member says, “Got it. 1 mg epinephrine IV.” The physician completes the loop by saying, “Correct.”

Check-backs in Clinical Pharmacy

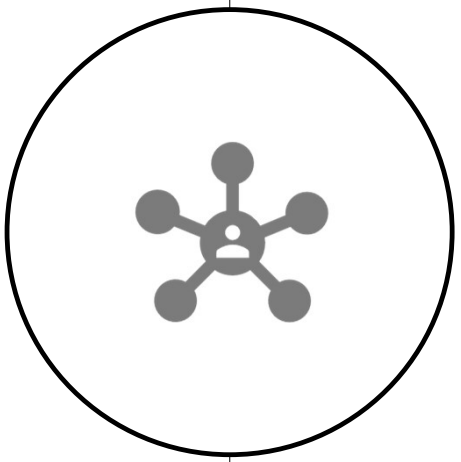
- Verbal prescription orders
- Phone refill requests
- Verification of missing dose
- Verification of suspected ADR
- Confirmation of drug information request
- Confirmation of clinical consult

Remember…

- Positive Attitude
- Have Alternatives
- Assertiveness NOT Aggression
- Research
- Manners
- Edit and Check
- Respect

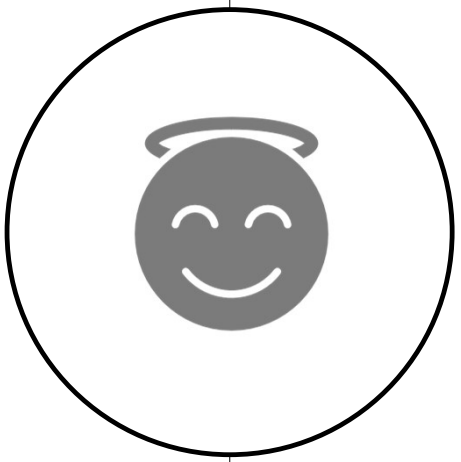
Structured Communication

- What is structured communication?
  - Reduces ambiguity and increases efficiency
  - Creates a shared expectation between two healthcare providers
- Standardized or “structured” communication is a Joint Commission Patient Safety Goal for inpatient settings



Positive Attitude

- It is 4:30PM on Friday. You are looking forward to getting the weekend started – when a provider knocks on your door with a question about a patient.



Positive attitude

- There is a problem with a medication order placed by a physician; the directions do not match the dose. Since you are the pharmacist on duty, it is your job to call for clarification.

Have Alternatives

- There is a 65 y.o. female patient admitted to your service after hip replacement. During rounds, an issue regarding her pain management is mentioned. The team asks you for a recommendation.

Have alternatives

- A new physician at the hospital where you work orders valsartan, an angiotensin receptor blocker, for a patient's blood pressure. This medication is not on the formulary.

Assertiveness not aggression

- A patient who has an allergy to penicillin comes to the pharmacy window with a prescription for amoxicillin. You call the provider to discuss the situation.

Assertiveness not aggression

- A nurse who is responsible for transcribing a patient's medications on to the MAR at the nursing home makes an error. Instead of recording torsemide, as written on the prescription, she records furosemide.

Research

- Before making a drug, therapy recommendation make sure you know the full story:
  - Diagnoses
  - Allergies
  - Medication List (including OTCs)
  - Labs

Research

- A patient with high blood pressure at the nursing home is sent to the hospital for evaluation. When she is discharged back to the nursing home, you notice in the discharge summary that a troponin level was ordered during her hospital stay.

Manners

- After making a drug therapy recommendation to a patient's primary care provider, she tells you, "I am not familiar with that medication, so I am not going to use it."

Manners

- A social worker is frustrated with the pharmacy department. She was hoping that a patient could get some assistance with filling his pill boxes, but the pharmacist she spoke to said that this was illegal for pharmacy to do (which happens to be untrue).

Edit and Check

Before writing *anything* in the patient's chart, be sure that your information is correct!

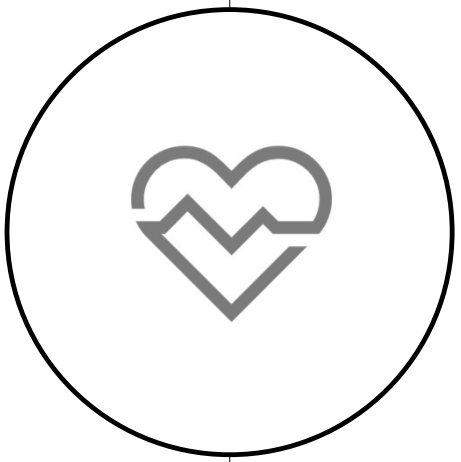
When making a recommendation, check two references to ensure that your answer is correct:

- Micromedex/Pharmacotherapy
- Clinical Pharmacology
- PubMed

Ensure that the recommendation you're making is conducive to the patient you're treating

Respect

- A patient of yours, whose blood pressure you manage, is seen in the cardiology clinic. As you research this patient in preparation for clinic, you see a note written by the cardiologist in the electronic medical chart. It turns out that the cardiologist has stopped the medications you started, in favor of something else.



Respect

- You are an outpatient pharmacist, working on a Saturday, at a pharmacy that is not your own. The technician is sitting in the back reading a magazine, and although you have asked for help, he will not come fill the prescriptions that you just entered.

Remember Three Things:

- Hear no evil, see no evil, speak no evil

Things to avoid

- The blame game
- A power struggle
- Conflict
  - “Didn’t you know…”
  - “That’s not safe…”
  - “Are you sure….”
- Gossip
- Excuses
- Loose ends

If things are going bad…

- Keep your cool!
- Focus on the patient
- Listen
- Compromise
- Agree to disagree
- Follow up

When things go well…

Trust develops &
Opportunity follows

The team is happy

You're happy

The patient is happy

Take home Points

- Patient care occurs in teams
- Good team communication = good patient outcomes
- Each member of the team has something to contribute
- These contributions are important in making decisions
- Shared decision making enhances team and patient relationships
- Hear no evil, see no evil, speak no evil (& do no evil)
- PHARMER

Take Home Points

- Communication failures are a leading factor in medical errors
- Effective communication is complete, clear, brief, and timely
- Communication barriers include communication styles, hierarchy, distractions, and workload
- Using structured communication techniques like SBAR and check-back can prevent communication errors in clinical pharmacy