Incident 4 – Staff Communication

A staff nurse called the on-call doctor to assess a ward patient with a rash and confusion.

The on-call trainee doctor was attending a primary angioplasty patient, and knew the patient had a rash and had been prescribed treatment as required, and also knew the patient had had their night time confusion assessed.

After 20 minutes, when the doctor did not attend, the nurse submitted a Datix report highlighting the delayed arrival of the on-call doctor.

The nurse felt the doctor had arrogantly dismissed her concerns. The doctor felt aggrieved that the incident had not been escalated to senior nursing staff and anxious that it had been reported through the Datix system.

The doctor in training discussed this with their educational supervisor and considered the challenges of working in the pressurised complex NHS system and the resultant need for clear communication.

The trainee now gives clearer communications to other team members to explain the rationale for decision making, having considered the importance of good communication as part of the human factors affecting patient safety.

A. Reflection for appraisal based on AoMRC Template

Outline skills, activity or event

Datix report from staff nurse highlighting delayed arrival to ward on call doctor when contacted to assess a patient with rash and confusion.

(Background of discussion with ES - I was attending a primary angioplasty patient. The ward patient was known to have a rash and have appropriate treatment prescribed on prn chart, and also known to have night time confusion which had been assessed previously. Meeting with my supervisor we discussed the background of this in detail and considered individual, local and organisational (system) factors at play (new nurse, unfamiliar with patient who did not escalate to senior nursing staff first as per hospital protocol and made Datix report 20 minutes after the call was made to me).

What is **the most important thing you have learned** from this experience?

Several learning points:

1. Need to provide clear feedback to ward team regarding other patients who require more urgent care in hospital, and prior knowledge of the patient of concern (who had already been assessed for the same problems with a plan in place).
2. Advise staff to escalate via other senior staff within hospital system.
3. Raise system issue (should have contacted senior nurse on call if concerned, and importance of handover).

How has this influenced your practice?

I will make sure that I communicate clearly with staff when on night shift to explain my priority list. I will explain my prioritisation to staff based on my knowledge of the patients.

Looking forward, **what are your next steps**?

I will work with my colleagues and supervisors to engage with the multi-professional team to look at handover and communication out of hours, using a quality improvement methodology to test changes and monitor using a run chart.

Summary of discussion with Educational Supervisor or Appraiser.
Meeting with my supervisor we discussed the background of this in detail and considered individual, local and organisational (system) factors at play (new nurse, unfamiliar with patient who did not escalate to senior nursing staff first as per hospital protocol and made Datix report 20 minutes after the call was made to me).

B. <u>Reflection based on Schon…</u>
Schon, D.A. (1983) *The Reflective Practitioner: How professionals think in action* New York: Basic books

The effective reflective practitioner is able to recognise and explore confusing or unique (positive or negative) events that occur during practice.

The ineffective practitioner is confined to repetitive and routine practice, neglecting opportunities to think about what he or she is doing.

Reflection-in-action – thinking ahead, analysing, experiencing, critically responding (in the moment)

What were you thinking at the time?

I was busy with an urgent case and answered the call explaining I could not attend as was focusing on the patient in front of me.

What was influencing that thinking?

I was aware of the background of the patient I had been called about and had prioritised based on this and the communication on the telephone. I was confident in my assessment and prioritisation.

Reflection-on-action – thinking through subsequent to the situation, discussing, reflective journal

What is your thinking about the event now? Having time to think, discuss, review information etc

Initially I was annoyed that the report had been made, as I worried that it would be perceived negatively by my supervisor. Having had a discussion with them I am happier, as I realise that I could have explained more rationale and reassured the nurse who called and encouraged her to escalate by another route. I also understand that being explicit about my actions and supportive by clearly stating alternative pathways is very valuable.

C. Reflection - The what, why, how approach

What do you want to reflect on?

This should contain enough information to allow you to recall the event.

Datix report from staff nurse highlighting delayed arrival to ward of on-call doctor when contacted to assess a patient with rash and confusion.

Why do you want to reflect on it?

What do you hope to get out of this reflection – how will it help you

I want to think about how I can incorporate my learning from the Datix report into my professional development and improve the system as a whole.

How did you and will you learn from this?

How will this affect your practice and make you a better doctor.

I realised that there were a number of ways I could have improved my communication within the event, and also use this experience to engage my peers and supervisors to improve multi-professional working. I will ensure that I always respond clearly to staff when speaking to them on the telephone, by explaining what I am doing currently that takes priority and giving them an alternative plan (e.g. contact senior nurse).

How have you been affected by this?

What are your overall conclusions from this episode. How do you feel about the reflection?

It was upsetting to read the Datix report and have to discuss it with my supervisor. I felt better after the discussion as it became clear that whilst I could have approached the problem differently, it was a multifactorial issue and demonstrated that there are systemic issues that I can now engage with. Knowing that I have learnt from this shows that I am able to apply the human factors training I have undertaken to real-life situations.

D. What happened, what did you do, what have you learnt, what next?

What's the issue you reflected on?
An incident/situation/feeling that gave you cause for reflection
Datix report from staff nurse highlighting delayed arrival to ward of on-call doctor when contacted to assess a patient with rash and confusion.

What made you stop and think?
I was upset to have been part of a Datix report; on speaking to my educational supervisor about the incident I realised that working within a complex system can be challenging and understanding how communication is organised is a key aspect of learning.

There are many ways to reflect - how did you do it?
I discussed this with my supervisor and discussed the themes that came up within the event.

What did you do?
I reviewed the communication methods for on call work including handover, escalation routes and protocols then created a plan with my peers for improving processes, using QI methodology.

Tell us what you took away or learned from this experience?
I could have been clearer in explaining that I was with a high priority patient and given the nurse an alternative route for escalation via the senior nurse.
The incident emphasised the importance of teamwork and robust, standardised communication – and the need for doctors to work with others to improve the system from within.

How did it change your thinking or practice?
I took away the importance of good communication, ensuring the team are aware of appropriate management of escalation and clarity regarding my situation.

What have been the effects of your changes?
Has it improved your practice and outcomes?
Over the next four months, we will examine handover and escalation processes and create a run chart with key measures such as a) proportion of team members at handover, and b) number of calls on shift that could have been escalated to senior nurse as initial step (in line with organisational guidance). We will then plan a series of interventions (email communication, attending team meetings, daily reminders) to improve these measures.

The trust is considering running some in situ simulation exercises at small scale to test how well the escalation protocol works in the hospital. This will test knowledge of the team and also be a learning exercise for myself.

E. <u>Reflection based on Rolfe et al…</u>
Adapted from Rolfe, G. Freshwater, D & Jasper, M. (2001) Critical reflection for nursing and the helping professions: a user's guide Basingstoke: Palgrave Macmillan

What? – (a description of the event)

What happened? What did I do? What did others do? What did I feel? What was I trying to achieve? What were the results? What was good or bad about the experience?

I was attending to an urgent case and was called by a ward nurse regarding a less urgent problem. The fact that I did not attend was then reported via the Datix system. I then had to discuss this with my supervisor.

The nurse who called explained her concerns, and I fed back that I did not feel this was urgent and would come when necessary. I was concerned about the more urgent problem in front of me. I wanted to prioritise well and manage the situation. The nurse remained concerned and reported the issue. I was upset about this but after discussion with my supervisor have learnt from the issues that were highlighted from the event and understand how I could have mitigated the issue with better communication skills.

So, what? – (An analysis of the event)

So, what is the importance of this? So, what more do I need to know about this? So, what have I learned about this? So, what does this imply for me?

Communication is the cornerstone of good systems-based clinical management. It is covered in the Trust human factors training and the event I am reflecting on covers the themes of hierarchy, silo/professional role working, being explicit in feedback, having and expressing a clear plan and checking understanding, knowing the system and processes well.

Now what? (Proposes a way forwards following the event)

Now what could I do? Now what should I do? Now what would be the best thing to do? Now what will I do differently next time?

I will re-read the communication part of the human factors handout and consider how I approach communication in future. I will ask others for a check of understanding and take time to be clear with people when plans, roles and responsibilities are being discussed.

Template: Reflection based on Gibbs reflective cycle…

Gibbs, G. (1988) *Learning by doing. A guide to teaching and learning methods*. Oxford Polytechnic: Oxford

Description – what happened?

I was asked to see a patient when on call, who I felt was stable, and was a lower priority than the patient I was managing when I was contacted. The nurse who contacted me then reported this issue via the Trust system.

Feelings – what were you thinking and feeling?

At the time I was busy on call and focusing on the unstable patient, when I was contacted about the report I was annoyed and a little upset and worried about the perception of my supervisor. I felt reassured by my supervisor's approach to the discussion and feedback to me, which he also summarised in a short email. I felt that I had learnt from the incident and that the opportunity to reflect with my supervisor was the key way that I achieved this learning.

Evaluation – what was good and bad about the experience? What went well and what went badly?

It was good to consider a system issue from all perspectives. It was "bad" that I had to speak to my supervisor about it, and it upset me (for a short period).

My supervisor was very supportive, and I was able to reflect on the event and consider my actions and how I might do things differently in future.

Analysis – what sense can you make of the situation?

The incident has underlined for me how important it is to communicate clearly, appropriately and efficiently. I have understood the need to consider all perspectives – the patient, the nurse and mine – within a complex system. The ability to reflect and learn is powerful and I hope will make me a better doctor.

Conclusion – what else could you have done?

Checked understanding, given an alternative pathway of escalation, clearly explained my decision making.

Action plan – if it arose again, what would you do?

Clearly feedback on a concern with a “SMART” plan of action to support my colleague in delivering patient care.