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IMPROVING QUALITY AND EFFICIENT COMMUNICATION BETWEEN

PROVIDERS AND NURSING - A PSYCHIATRIC SBAR TOOL (PSYCH)

Karen Richards

University of San Francisco

Clinical Leadership Theme

The project presented focuses on the Clinical Nurse Leader (CNL) theme of *care environment management.* The CNL role function is Team Manager. In this role, the author will be identifying and leading a process of increasing the efficiency and quality of nurse and provider communication, utilizing a situation, background, assessment, and recommendation (SBAR) tool, modified for psychiatric services. The mnemonic for the tool is PSYCH which stands for **p**atient, **s**ituation, **y**our assessment, **c**ritical information, and **h**elp.

The process begins with specific client centered needs and staff providing care. The process ends with a decrease in phone times and an increase in reported quality of communication between providers and nursing within this microsystem. By working on the process, we expect the following to occur: (1) improved information flow between providers and nursing; (2) improved nurse and provider perceptions of the quality of communication; and (3) a decrease in the perception of medical errors as a result of ineffective communication.

Statement of the Problem

Effective communication is the cornerstone of providing safe and quality healthcare. However, nursing and providers often share information inequitably, as these disciplines are trained differently regarding communication. Providers are taught to be brief, accurate and focused while nurses are taught be descriptive and holistic. These differences have led to disparity in the sharing of valuable patient information, subsequently leading to increased frustration, inefficiency, and medical errors. Although interpersonal communication is a strong focus in the mental health arena, members of the profession are not as skillful in facilitating efficient and succinct communication among themselves. Additionally, the gap between providers and nursing remains a strong intimidation factor for many younger nurses going into

this field. These differences are inherent within the units of C and D at a thirty-seven bed, rural, not for profit, psychiatric hospital located in Colorado. As a consequence, several of the six aims of health care quality which are safe, effective, patient-centered, timely, efficient and equitable care as proposed by The Agency for Healthcare Research and Quality (AHRQ) (2016) and The Institute of Medicine (IOM) (2001) have been implemented poorly. Thus, the purpose of this project is to increase both efficiency and quality of communication during phone interactions between providers and nursing. In this way, quality of care for patients will also be improved.

Project Overview

The psychiatric facility in which this project takes place supports the mental health and addiction recovery needs of clients within twelve counties on Colorado's Western slope. The project is focused within the inpatient psychiatric units of buildings C and D. The goal of this project is to increase the quality of care provided to clients within these microsystems by increasing efficiency and perceived quality of communication between providers and nursing. When providers and nursing spend less time on phone calls, more time can be spent with patients and their care. Additionally, as these disciplines begin to utilize and adopt a standardized, consistent method of information exchange there is less opportunity for miscommunication and subsequent medical error. Accomplishment of these goals includes implementation of a standardized tool which nursing will utilize to disseminate information to providers. The Psychiatric SBAR tool (PSYCH) is a collaborative effort, resulting from provider and nursing input regarding succinctly and efficiently relaying pertinent patient information.

In order to reach the goal of improved patient care quality, by November 1, 2016, there will be a twenty percent decrease in provider and nursing phone times and a twenty percent increase in reported quality of communication among providers and nurses, within units

identified for the project. Comparison of pre intervention baseline data and post intervention data regarding provider/nurse phone times will be gathered via provider phone surveys. Additionally, comparison of pre and post intervention provider/nursing communication survey data will be compared to determine if the goal of an increase of twenty percent in perceived quality of communication will be realized.

Rationale

In order to assess the need for a project for increasing effective communication within the proposed microsystem, data analysis was obtained from several sources. Within the proposed facility the average occupancy rate ranges from eighty-five to ninety-five percent, with clients frequently having to wait for open beds in order to be admitted. The patient population ranges in ages from five years old to eighty-five with an average age of forty-five. Most prevalent diagnoses included Major Depressive Disorder, Post Traumatic Stress and Bipolar Disorder, Borderline Personality, Schizo-Affective Spectrum, and Attention Deficit Hyperactivity Disorder. Concurrent substance abuse is estimated in greater than eighty five percent of admissions and predominately associated with marijuana and methamphetamine abuse.

The microsystem analysis indicated educational levels of the staff range from high school to a single psychiatric mental health nurse practitioner with a doctorate, as well as one psychiatrist on call and no current medical director. Each registered nurse is responsible for up to eight psychiatric clients (independent of acuity level) and approximately seventy percent of nursing staff are new graduates.

Per an impromptu survey and personal interviews of staff and providers, ineffective and inefficient communication is a major concern within this institution. Interviews with leadership support an emerging performance gap in effective communication among staff. Additionally,

results from a strengths, weaknesses, opportunities and threats (SWOT) analysis of the

organization reveal weaknesses demonstrated in poor systems, communication, and technology.

There are limitations both in staffing and monetary resources. The facility has no educational

department, nursing wages are low and there is no clinical ladder incentive program. Recent

severe budget cuts have resulted in a decrease in staffing, subsequently the turn over rate is

increasing among both nursing and providers. Threats include lack of providers and experienced

nursing labor within the local area. Furthermore, decreases in mental health state funding, the

recent presidential election outcome, increases in process drift, work arounds, and working in

silos threaten effective communication process and ultimately the quality of patient care.

Nevertheless, this analysis also shows strengths in a strong innovative CEO, supportive

philosophy of "growing our own" (LVN to Registered Nurse), client oriented staff, and a strong

working collaboration with the surrounding community. Opportunities are numerous, as

indicated by the organizational SWOT analysis (Appendix A).

A further root cause analysis demonstrated multiple factors adding to lengthy and poor

quality communication among providers and nursing. These included the young age and

inexperience of nursing staff, poor microsystem leadership, frequent interruptions, and escalating

and aggressive behaviors of the patients (Appendix B). Additionally, data obtained from

generating of a process map indicates multiple instances where ineffective communication may

contribute to poor quality patient care (Appendix C)

Data collected from a baseline communication survey indicated sixty-seven percent of

staff reported the occurrence of medical errors resulting from poor communication (Appendix

D). Additionally, twenty percent of respondents reported the quality of current communication

at 6/10 and thirteen percent at 7/10, whereas 10 represents the best quality of communication (Appendix E).

The implementation of a Psychiatric SBAR tool (PSYCH) has a limited expense deficit compared to the benefits of improving the efficient flow of the communication process within this microsystem. Total costs are estimated at $100.00 for printing of posters to update staff not directly involved with the process as well as key stakeholders. No cost expenditures would be incurred for education of the six-member team as the author is practicing as a student Clinical Nurse Leader (CNL) team leader and is not currently garnering a salary for her clinical rotation. Education is provided via frequent and impromptu elevator speeches, during work hours, so that participating team members are not paid for attending lengthy meetings. At the same time, the benefits of this project include increased interdisciplinary collaboration, decreased time spent away from patient care, decreased medical errors, increased productivity and efficiency of the workflow process, and ultimately improved patient care quality (Appendix F: Cost & Impact Analysis).

Support from primary stakeholders is critical in the success of this project. Data gathered from a stakeholder analysis indicated the need to engage and manage closely the Vice President, Director of Nursing, Family and Psychiatric Mental Health Nurse Practitioners, and patients as this group demonstrated the highest level of both interest and power within the facility. Those who were highly interested but had little influence in the organization consisted of nurses, ward clerks and mental health workers. It is important that these stakeholders are well informed in order to ensure continued interest and forward momentum of the project. Crisis team members, social workers and the nurses who had been with the hospital longest demonstrated low interest in change and will be monitored throughout the process. Those with high power and little

interest include some members of the leadership team as well as psychiatrists. It is essential that this group continue to be satisfied in order to decrease opposition and negativity (Appendix G: Stakeholder Analysis).

Methodology

Change can be perceived by some as a challenge and by others as an opportunity to implement creativity and enthusiasm in approaching a solution to a problem. These latter individuals are known as change agents. CNL's are change agents as well as advocates, educators and stewards within the front lines or "microsystems" of healthcare. As an emerging CNL the author is passionate regarding her responsibility for facilitating quality patient care and positively influencing those who view change as a stressful, fearful move away from the status quo.

In the process of integrating a Psychiatric SBAR tool (PSYCH) into the microsystem the author will be utilizing Lippitt's Phases of Change Theory as it aligns well with her democratic style of leadership. This theory emphasizes the role of the change agent in facilitating change within an organization. Supporting evidence indicates that the role of the CNL, with the inherent qualities of leadership, extroversion, and education is uniquely qualified to support and sustain change (Leathers, Spielfogel, Blakey, Christian, & Atkins, 2015). In the role of CNL, Team Manager, the author will be utilizing these qualities in the following phases in order to solidify the spread of the Psychiatric SBAR tool (Lippitt, Watson & Westley, 1958).

1. Diagnose the problem

2. Assess motivation and capacity for change

3. Assess change agent's motivation and resources

4. Select a progressive change objective

5. Choose an appropriate role of the change agent

6. Maintain the change

7. Terminate the helping relationship

The project has begun in the proposed microsystem with the objective of instituting a standardized communication tool to improve quality of care. This is demonstrated by decreasing provider/nursing phone times by twenty percent and increasing reported quality of care by twenty percent by November 1, 2016. In a twenty-four-hour period staffing includes approximately 2 family nurse practitioners (FNP's), 1-2 psychiatric mental health nurse practioners (PMHNP's), 1 psychiatrist (on call), 1-unit ward clerks, 2 - 5 mental health workers (MHW's), 1 – 2 therapists, 3 unit nurses, and 1 traveling nurse. A team of 3 volunteer providers (PMHNP's) and 3 volunteer nurses has been compiled to facilitate the project.

Baseline data has been gathered by using a communication survey tool, designed by the author (Appendix H). This initial data will be compared to post intervention data utilizing the same survey in order to establish the accomplishment of increasing quality of care. A second source of baseline data indicates sixty-seven percent of respondents perceive there have been medical errors resulting from lack of communication between team members. A third source of baseline data has been gathered from the communication team using a phone survey tool, designed by the author in collaboration with the three volunteer providers (Appendix I). Results indicate the current average length of a provider/nursing phone call is 3-5 minutes.

Education has been provided regarding the use of the intervention, goals and timeline of the process. The Psychiatric SBAR tool (PSYCH) is being developed by the process team. This data will be compared to baseline information to assess the achievement of decreasing provider/nurse phone times by twenty percent. After the three-week data collection period, the

tool will be reviewed for possible changes. Due to the time limitation of the project a second

Plan-Do-Study-Act (PDSA) cycle will not be instituted.

The results will be posted throughout the unit to facilitate continued support and

motivation (Appendix J). Additionally, a meeting will be scheduled with leadership to provide

results of the intervention further solidifying the opportunity for continued support and

momentum towards the ultimate goal of organizational wide use of the Psychiatric SBAR tool

(PSYCH).

The author predicts the final phases of the project, which include maintaining the change

and gradually terminating from the project as the tool becomes part of the microsystem culture,

will not be able to be implemented as effectively as she would have hoped secondary to time

constraints. However, she expects to achieve the goals of (1) decreasing provider/nursing phone

call times by twenty percent; and (2) increasing perceptions of the quality of communication by

twenty percent by November 1, 2016. These expectations will be determined by comparing the

pre and post intervention communication survey and provider phone time survey information.

The current assembled team is extremely motivated to work on the issue of miscommunication

among the disciplines and will provide a driving force to facilitate the process beyond the end

date. Should the tool improve the workflow process and interdisciplinary coordination, others

will see the positive effect in their own work process and will willingly come forward to become

a part of the change process. As the culture shifts towards acceptance of the tool, more

champions will continue to arise to further facilitate use of the intervention throughout the

organization.

Data Source/Literature Review

The proposed project is supported by multiple studies and literature regarding communication and quality care. For example, the six aims put forth by the Institute of Medicine (2001) in the report *Crossing the Quality Chasm,* and by The Agency for Healthcare Research and Quality (2016) encourage the current healthcare system to strive to begin shifting towards systems which truly provide high quality patient care. These six aims are safe, effective, patient-centered, timely, efficient and equitable care proposed to breach the "chasm" currently created between quality healthcare and what is being provided to patients today.

In addition, ineffective communication has led to costly and fatal consequences within the current healthcare system. In the landmark study presented by The Institute of Medicine (1999) strong data for preventing death and injury resulting from the high incidence of medical errors in the current healthcare system was presented. The report proposes the need for dramatic and system wide changes in order to improve patient safety within the United States. The report was instrumental in providing increased focus on review and funding for implementation of new systems, technologies and approaches to improve the safety and quality of healthcare systems. Other literature further supports the use of a standardized tool to facilitate quality care. In a study conducted by DeMeester, Verspy, Monsieurs and Van Bogaert (2013) sixteen hospital ward nurses were trained to use an SBAR tool to communicate with physicians in cases of deteriorating patients. After introduction of the tool, increases in perceptions of effective communication and collaboration and decreases in unplanned ICU admissions resulted. Additionally, there was a significant decrease in unexpected deaths. This study provides strong evidence supporting the effectiveness of implementing an SBAR tool within hospital wards (DeMeester et al., 2013).

Within the microsystem of the proposed site for the Psychiatric SBAR tool (PSYCH) a cause and effect diagram provided information leading to several sources of ineffective communication which are similar to results found in a study conducted by Foronda, MacWilliams, and McArthur (2016). Their study presents several barriers to effective communication, including lack of confidence, lack of experience, complexity and distracting nature of the current healthcare system. Add to this, the differences in communication styles of nurses and physicians, and perceived differences in hierarchy between these disciplines which in turn leads to an increase in miscommunication and resulting sentinel events. The study is a good resource to support the use of standardized communication tools and education in addressing ineffective communication between physicians and nurses. Mahoney, Ellis, Garland, Palyo and Greene (2012) utilized the standardized tool known as TeamSTEPPS from the Agency of Healthcare Research and Quality within the Menninger Clinic. Mental health teams were able to improve their interdisciplinary team's effectiveness both in communication and mutual trust. The TeamSTEPPS communication strategies include SBAR, check backs and an emphasis on brief, clear and timely information exchanges to facilitate effective communication. Their research is helpful in outlining the steps involved in the TeamSTEPPS process, including sustainment of the progress achieved as a result of increasing effective communication. In Randmaa, Martensson, Engstrom and Swenne (2014) prospective intervention study was conducted within two anesthetic clinics located within two Swedish hospitals. After the introduction of an SBAR tool, significant improvements among licensed practical nurses, registered nurses, and physicians were seen in the areas of improved communication accuracy, decreased incident reports secondary to communication errors, and increased perception of a culture of safety.

The goal of decreasing provider and nursing phone times by using a standardized tool is being further supported by the Joint Commission (2012) which addresses the effects of ineffective communication resulting in delays in treatment, inappropriate treatment and increased lengths of hospital stays. The tool uses the SHARE mnemonic which stands for standardize critical content, hardwire within your systems, allow opportunity to ask questions, reinforce quality and measurement and educate and coach. The Joint Commission release provides a simple and useful tool for obtaining the goal of efficient and effective communication within a healthcare system resulting in improved quality of patient care.

Timeline

The project began in late August and the team has currently developed the Psychiatric SBAR tool (PSYCH). The project has been adversely affected by the resignation from the hospital of two of the providers. Two new providers have been engaged, however, this has affected the timeline for the PDSA cycle and subsequent data collection (Appendix K: Timeline).

Expected Results

Midway through the process, the author anticipated that the project would continue to move forward and accomplish the goals presented by November 1, 2016. This goal was accomplished; however, meeting with leadership and follow-up education will need to be determined secondary to time constraints. As a result of this study several conclusions have already arisen. For example, the saying "you can lead a horse to water, but you can't make him drink" is a pertinent comment in response to those individuals who are resistant to change. The theory of the first follower and the power of group consensus combined with resulting momentum is what will ultimately sustain this intervention within the microsystem.

Nursing Relevance

Through interviews and information collected from quality management, increases in inaccurate transcription of orders related to inappropriate care are rising throughout the organization. The Vice President of the hospital states the hospital has grown at an unprecedented rate in order to meet the increased demand for care from psychiatric clients throughout the surrounding twelve counties. Unfortunately, the supporting systems have not progressed as quickly.

The supportive data for using a standardized tool to improve the quality of care is prolific. By successfully instituting a simple tool, such as a Psychiatric SBAR (PSYCH), the goals of the proposed organization to envision health and wellness in our communities by rebuilding lives, inspiring hope by providing exceptional mental health and addiction recovery care, and strengthening the health and vitality of our communities can easily be achieved.

With this in mind, as the author has progressed through the project, her role as CNL and the importance of effective communication on quality care has become even clearer. It has been an enlightening experience to motivate and support others in the organization both through the project and by providing education and role modeling regarding the CNL role within this microsystem. Leading by example, others will be inspired to implement projects facilitating quality of care and an interdisciplinary team approach. Consequently, resulting in all individuals throughout the facility being positively affected, and thereby positively influencing the overall health and well being of both the patient and themselves.

Summary Report

The objectives of this project were to decrease by twenty percent nursing and provider phone times and to increase reported quality of communication by twenty percent, by November 1, 2016, among the providers and nurses within the units identified for the project.

The need for implementing a standardized communication tool became evident after initiating a microsystem analysis and conducting an impromptu survey of leadership and staff members. Initial baseline data and was gathered via two originally designed surveys. The first survey was oriented towards obtaining data regarding perceived quality of communication among team members and was distributed among staff within the proposed microsystem. Initially, the communication survey generated the following results (1) twenty percent of staff reported the quality of communication at a 6/10 on a scale where one indicated the worst quality communication and ten indicated the best; (2) sixty percent of respondents reported there had been errors in patient care due to miscommunication or lack of communication among team members. A second original survey was developed to gather data on phone times between providers and nursing. Initial phone survey results indicated the average length of calls between these disciplines was 3-5 minutes. An initial microsystem assessment provided results as follows (1) occupancy rate ranges from eighty to nine five percent; (2) nurse to psychiatric patient ratios are one to eight, irrespective of patient acuity; (3) approximately seventy percent of nursing staff are new graduates; (4.) most prevalent diagnoses include Major Depressive Disorder, Post Traumatic Stress, and Bipolar Disorder, Borderline Personality, Schizo-Affective Spectrum, and Attention Deficit Hyperactivity Disorder; and (5) concurrent substance abuse is estimated in greater than eighty five percent of admissions and is predominantly associated with marijuana and methamphetamine abuse. Additionally, an impromptu survey of leadership and personal

interviews of staff further supported the need for a standardized communication tool within this hospital setting.

In developing a tool for inpatient psychiatric use, the template for SBAR (situation, background, assessment and recommendation) was used as a guide (Institute for Healthcare Improvement, nd). The tool (Appendix L) was developed in collaboration with the communication team using the mnemonic PSYCH. Additional information was provided on the back of the tool to provide further incentive for utilization of the tool (Appendix M).

Following frequent, elevator in-services to the communication team, placement of the tool in all nursing Kardex's, and education of the staff with posters and elevator briefings, the tool was implemented over a three week period. Three providers gathered data using the phone survey template. The communication survey was again distributed to staff to gather post tool data on perceived quality of communication. Provider and nurse phone times decreased to approximately 1 to 2 minutes, a reduction of thirty to forty percent. Communication survey results indicated a slight increase in the quality of communication (Appendix N), as well as increased reporting of perceived errors resulting from poor communication (Appendix O). Additionally, post tool posters were placed throughout the microsystem to inform the units of the outcome of the project (Appendix P).

To further the sustainability of the process, a meeting will be scheduled to present the project results to leadership and integrate the tool throughout the organization. A proposal to incorporate the tool into a policy and procedure as well as development of a computerized learning module to present to new employees during orientation will be presented. Upon approval, phone stickers with the PSYCH mnemonic and tear off pads with the pre printed tool

will be placed throughout the facility. Lastly, review of the process will be at six months and twelve months from the start of institutional approval and the results posted for stakeholders.

Conclusion

Provider phone times were markedly affected by the standardized communication form, demonstrating a positive correlation between the use of the Psychiatric SBAR tool (PSYCH). Although the increase in the reported quality of communication was less than forecasted, the results were promising (Appendix N). With the addition of added time several factors of the process could have been further addressed. For example, incorporating a larger sample population such as the inclusion of three units, including admissions. Also, a drill down of the information gathered through the communication survey may have provided a clearer picture of which disciplines were more likely to experience poor communication. Lastly, by reviewing charting, verbal orders and patient care delivery and outcomes, a closer look at the relationship between perceived medical errors and ineffective communication could have been further evaluated. For example, was the increase in reported medical errors from increased awareness or an actual increase in errors from poor communication?

The importance of recruiting unit champions was clearly evident as the project progressed. The volunteer communication team was a solid driver in both facilitating the tool and strengthening continued enthusiasm for effective communication. There will always be those who are hesitant, even resistant to change, which further emphasizes the importance of creating an initial sense of urgency along with influential unit champions and continued leadership support. Interestingly, one of the most challenging aspects of the project was educating stake holders regarding the role of the Clinical Nurse Leader (CNL). In this rural facility, the new role of CNL is literally unheard of. As a result, the author generated an

infographic (Appendix Q) which was distributed throughout the facility to all disciplines including hospital and corporate leadership to assist with education. Ultimately, it was by working on the front lines, increasing trust, demonstrating the competencies of the CNL and networking with both leadership and those "at the tip of the arrow" that the author was most successful in increasing awareness of this role and the importance of continually improving the quality of healthcare.

The author is extremely grateful for the opportunity to provide a glimpse of what a CNL can do within a unit's microsystem. This would not have been possible without the support and hard work of all the stakeholders involved, including strong leadership support from D. Sharpe, Director of Nursing. Particularly, the author would like to thank her mentor, H. Covington, PhD PMHNP, who has unwaveringly supported the author throughout her practicums and who has come to appreciate and champion the CNL role within this organization. Additionally, the authors gratitude extends to the providers and unit champions who demonstrated an unyielding desire to improve patient care quality despite all obstacles. The author is honored and excited to be given such a unique opportunity to work with this organization. Furthermore, she is thankful for each and every one of her instructors throughout this journey, all of which have been truly motivating and inspirational which has allowed her to grow not only as a CNL, but as an enlightened human being.

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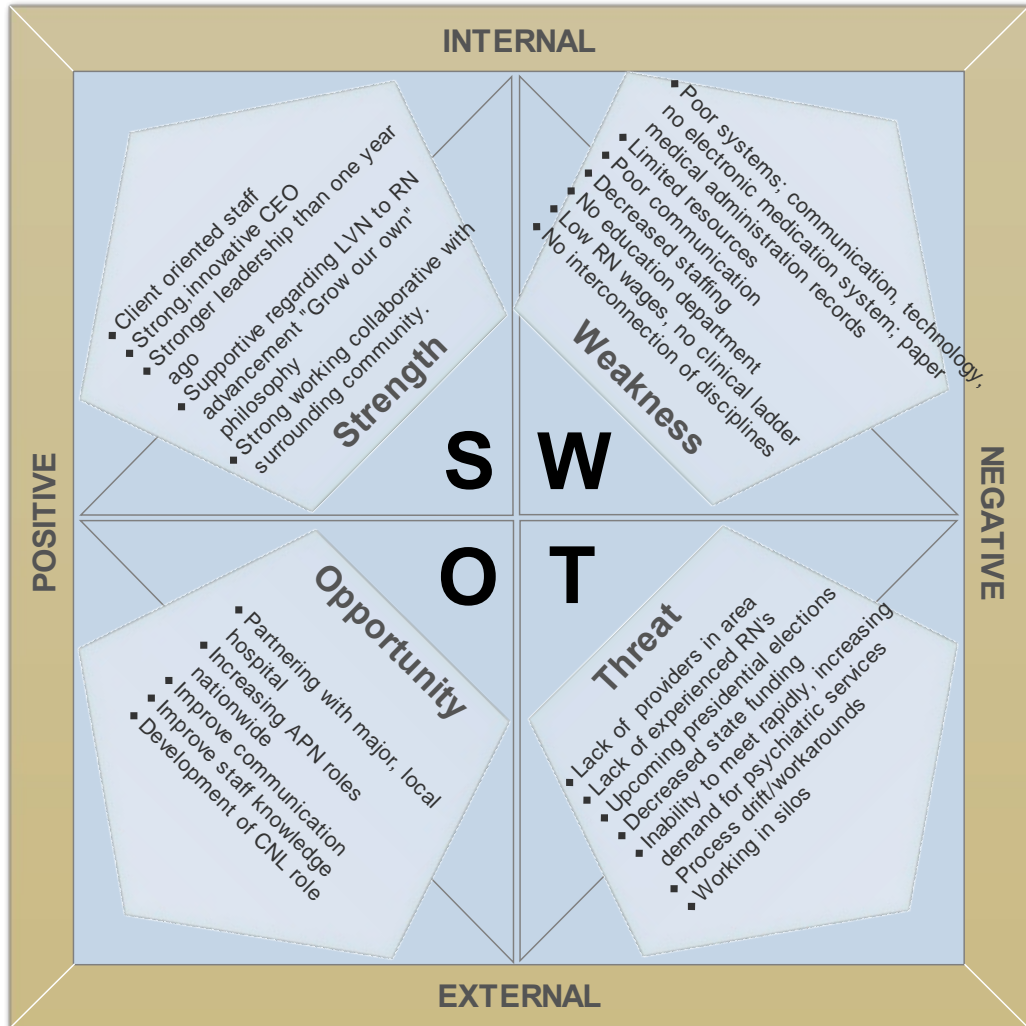
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Appendix A

SWOT ANALYSIS

INTERNAL

POSITIVE

NEGATIVE

EXTERNAL

S W
O T

Strength
- Client oriented staff
- Strong,innovative CEO
- Stronger leadership than one year ago
- Supportive regarding LVN to RN advancement "Grow our own" philosophy
- Strong working collaborative with surrounding community.

Weakness
- Poor systems; communication, technology, no electronic medication system; paper medical administration records
- Limited resources
- Poor communication
- Decreased staffing
- No education department
- Low RN wages, no clinical ladder
- No interconnection of disciplines

Opportunity
- Partnering with major, local hospital
- Increasing APN roles nationwide
- Improve communication
- Improve staff knowledge
- Development of CNL role

Threat
- Lack of providers in area
- Lack of experienced RN's
- Upcoming presidential elections
- Decreased state funding, increasing
- Inability to meet rapidly, increasing demand for psychiatric services
- Process drift/workarounds
- Working in silos

Appendix B

PROVIDER/NURSING COMMUNICATION ROOT CAUSE ANALYSIS

FISHBONE

Surroundings

Two separate buildings for Units C and D

Patient charts located physically in another area, separate from nursing work space.

Frequent interruptions

Paper Kardex separated from patient chart

Phones located off patient unit

Ratio: 2 RN's:16 patients irregardless of pt. acuity

People

Majority of Nursing staff younger and inexperienced

Each Nurse/Provider using their own style of communication

Frequent Provider turnover

Poor Leadership

No education regarding effective communication provided to Nursing/Providers

Lengthy/poor quality Communication

Nursing responsible for checking orders. Ward Clerk transcribes > 90% of orders from chart to hand written MAR.

Staff unaware of Provider expectations when calling for orders.

No standardized communication process

Orders obtained during crisis

Process

Patient escalating behaviors increasing staff/milieu anxiety levels

Disruptive/exhibiting self harm or aggressive behaviors

Medically Compromised

Patients

Appendix C

PROVIDER/NURSE PROCESS MAP

FLOWCHART

Appendix D

BASELINE DATA COMMUNICATION SURVEY

ERRORS

Q5 In the past year, have there been any errors in patient care due to miscommunication or lack of communication to a team or a member of a team involved in a patient's care?

Answered: 15   Skipped: 0

Appendix E

BASELINE DATA COMMUNICATION SURVEY (PRE TOOL)

Percentage of Respondents

Q9 On a scale of 1 to 10, 10 being the best and 1 being the worst, how would you rate the quality of the communication between teams/members in your organization?

Answered: 15   Skipped: 0

13.33%   6.67%   13.33%   13.33%   13.33%   13.33%   6.67%

20.00%
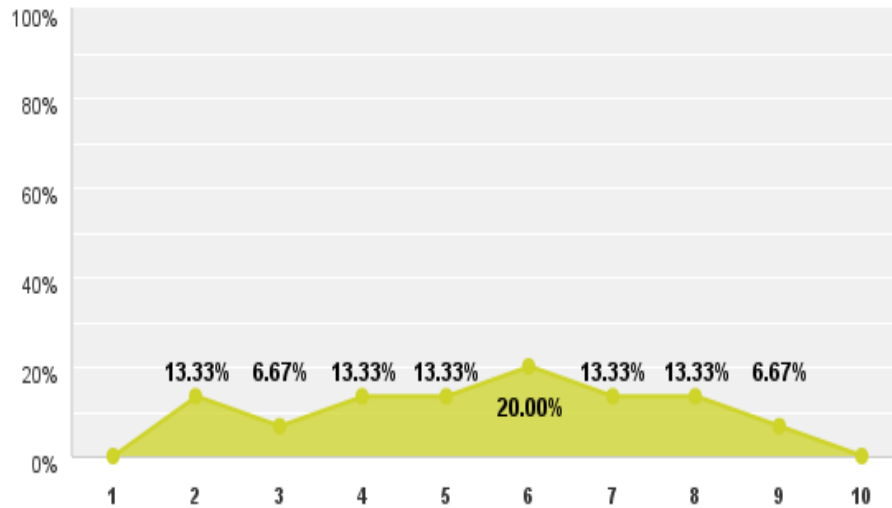
Quality of Communication
(1 = Poor   10 = Excellent)

Appendix F

COST & IMPACT ANALYSIS

EXPENSES	ESTIMATED COSTS	IMPACT/OUTCOMES
Education hours: 6-member team Printing: - Update on project (posters) - Psychiatric SBAR tool	$ 0.00 - CNL Team Leader (student-non salaried) - Using elevator speech delivery of education $100.00 Total: $100.00	Impact: - Decreased time away from patients - Decreased medical errors - Effective communication education Outcome: - Increased Interdisciplinary collaboration - Increased perception of safety - Increased quality of patient care - Improved staff satisfaction - Improved productivity/workflow process

Appendix G

STAKEHOLDER ANALYSIS
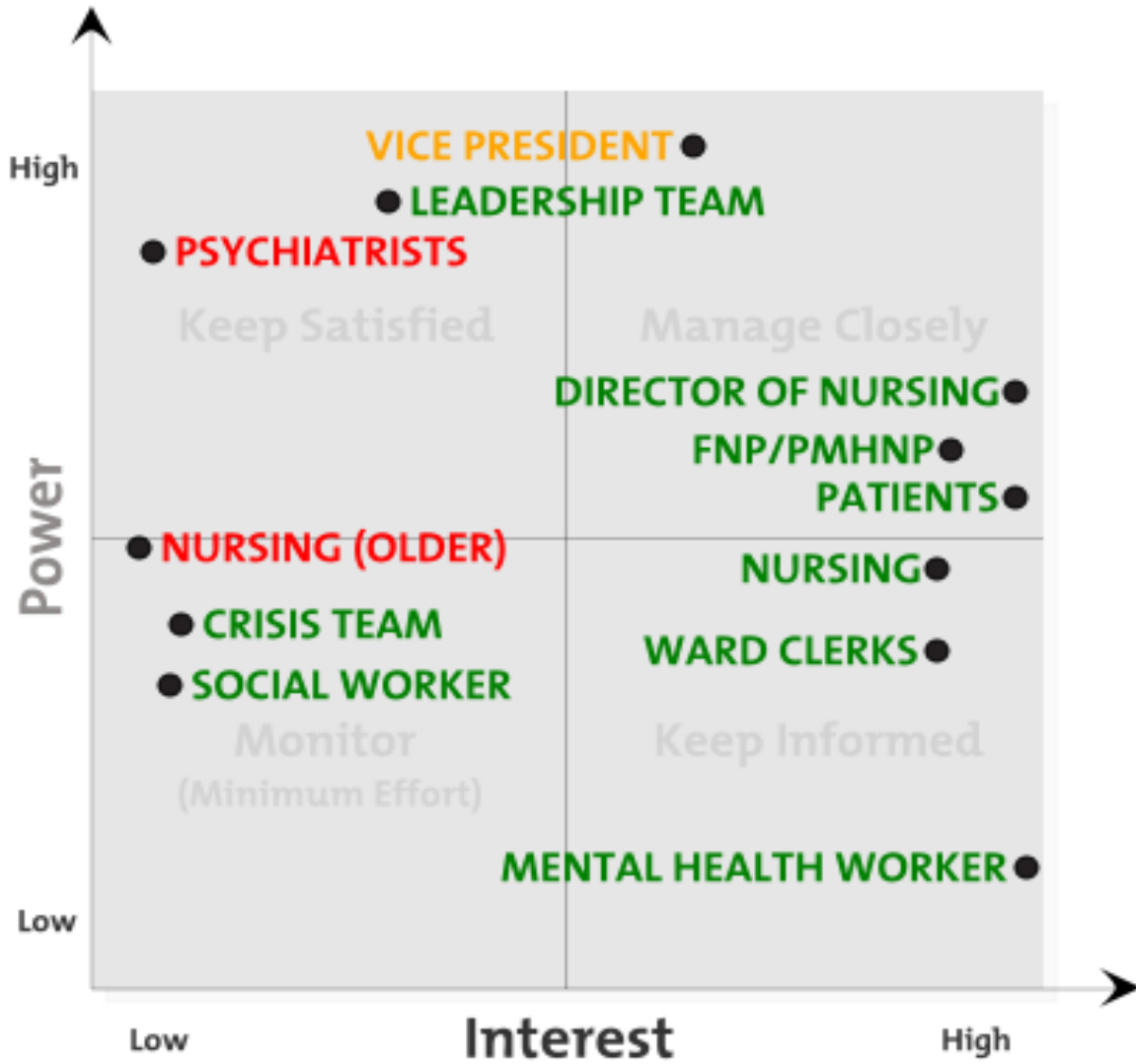
Appendix H

COMMUNICATION SURVEY

Communication

Communication

This survey is designed to evaluate your healthcare organization's communication and teamwork. The information contained from this survey will be used both in an academic research paper and a quality improvement project regarding interdisciplinary communication. Nothing specifically identifying is asked for in this survey. I would like to know the geographical location of your organization for my research. You may respond with city/state or just geographical location (ex: Texas).

Thank you for your cooperation and assistance in my research paper and project.

1. What is the highest level of education you have completed?

○ Graduated from high school

○ 1 year of college

○ 2 years of college

○ 3 years of college

○ Graduated from college

○ Some graduate school

○ Completed graduate school

2. Please provide the following information.

Job Title:

City/Town:

Appendix H

COMMUNICATION SURVEY

3. **On a scale of 1 to 10, 10 being the best and 1 being the worst, how would you rate your team member's communication among one another?**

4. **On a scale of 1 to 10, 10 being the best and 1 being the worst, how would you rate the communication to your team from other teams that are involved in the same patient's care? Ex: The nursing team to provider.**

5. **In the past year, have there been any errors in patient care due to miscommunication or lack of communication a team or a member of a team involved in a patient's care?**

6. **On a scale of 1 to 10, 10 being the best and 1 being the worst, how would you rate your team keeping you up to date on all relevant information needed to care for a patient?**

7. **On a scale of 1 to 10, 10 being the best and 1 being the worst, how would you rate other professionals delivering knowledge to you that is necessary to the patient's care. Ex: Did nursing let you know what information they have on the patient that could help you deliver care to that patient?**

8. **In an emergency situation, have you ever been stressed out because other members of the healthcare team were not communicating with you so that you could deliver safe and quality care to the patient?**

Appendix H

COMMUNICATION SURVEY

9. On a scale of 1 to 10, 10 being the best and 1 being the worst, how would you rate the quality of the communication between teams/members in your organization?

10. On a scale of 1 to 10, 10 being the best and 1 being the worst, how would you rate feeling safe and/or supported when relaying information regarding the care of a patient on the unit to other members of the team.

Appendix I

PROVIDER PHONE SURVEY

On Call Phone Data Sheet   Communication
Date: _____   **Psychiatric SBAR**
Implemented
Provider:_____

For each call received:
1. First client (client #1) record minutes spend per each call re client #1   2. Check the appropriate description for that call   3. Repeat process for client #2

<u>Client #1</u>

<u>Minutes</u>	<u>Admit Orders</u>	<u>Meds</u>	<u>Other</u>
	•	•	•
	•	•	•
	•	•	•

Comments:

_____

_____

Appendix J

PSYCHIATRIC SBAR TOOL POSTER (PRE TOOL)

Communication:
Psychiatric SBAR Tool

STEP 1
STAFF SURVEY (Results)
1. Current quality of communication 6/10 (10=best quality)
2. 67% of staff reported medical errors as a result of poor communication
3. 30% of staff felt supported when relaying patient information to peers/providers

STEP 2
1. Three providers gathering current data on length and quality of phone calls received from staff regarding patient's care/status.
2. Average length of phone call to provider = 3 - 5 minutes

STEP 3
1. Three providers and volunteer nursing staff will be oriented to psychiatric SBAR tool.
2. Tool will be utilized over 10 day period (10/11-10/21), reassessed and redesigned if indicated, monitoring of length/quality of phone calls to providers continues
3. Average length of provider phone call (post tool intervention)
4. STAFF SURVEY (Results)

STEP 4
1. Presentation of psychiatric SBAR to K. Boe, D. Sharpe and K. Kejellerson for approval
2. Role out of new tool if indicated

Appendix K

PSYCHIATRIC SBAR TOOL TIMELINE

Activity	Responsible Party	Start Date	End Date	Duration
Microsystem Analysis	CNL Team Leader	08/19/2016	08/29/2016	11 days
Develop/Initiate Staff Communication survey	Communication Team	08/30/2016	09/04/2016	6 days
Educate staff: Poster, elevator speeches	CNL Team Leader	08/30/2016	09/05/2016	1 week
Meeting with Leadership	Communication Team	09/02/2016	09/02/2016	1 day
Develop provider/nurse phone survey	CNL Team Leader/ Providers	09/06/2016	09/09/2016	3 days
Pre Psychiatric SBAR Tool Data Collection	Communication Team	09/10/2016	10/1/2016	3 weeks
Develop Tool	Communication Team	10/1/2016	10/11/2016	11 days
Post Psychiatric SBAR Tool Data Collection	Communication Team	10/11/2016	11/1/2016	3 weeks
Post tool: Staff Communication Survey	CNL Team Leader	11/1/2106	11/8/2016	7 days
Educate staff on results: poster, elevator speeches	CNL Team Leader	11/8/2016	11/12/2016	4 days
Meeting with Leadership	Communication Team	TBD	TBD	
In-service: Units A, C, D	Communication Team	TBD	TBD	
Evaluation of Tool	CNL Team Leader	Ongoing	Monthly	
Dissemination of	CNL			

result evaluations to staff/ leadership	Team Leader	Ongoing	Quarterly	

Appendix L

PSYCHIATRIC SBAR TOOL (PAGE 1)

☐   **Do you have the Mar with you?**

PATIENT:

☐ I am_____ (RN, LVN)
☐ Calling about (Pt. Name)_____   ☐ Age_____
☐ In Building (location): _____

Situation:

☐ What brought pt. in to hospital (brief/concise; DTO/DTS/GD, behavior):

☐ Drug Screen Results (UDS): _____

Your assessment: (changes from last assessment: agitated, suicidal, aggressive, delusional, medication changes)
☐

Critical information:

☐ Last medications given within last 12 hrs. : _____
☐ Dose _____
☐ At (time): _____

☐ Allergies: _____

☐ Recent CIWA score (if pertinent): _____

Help: (what do you need for pt. now/orders?)
☐ I think he/she would benefit from: _____

☐**Read Back:** Nurse: read back orders to ensure accuracy (e.g. let me make sure I understand that correctly…)

Appendix M

PSYCHIATRIC SBAR TOOL (PAGE 2)

Some Thoughts:

-According to the Institute of Medicine's, (1999) report "*To err is human",* 44,000 patients die yearly from preventable medical errors. E.G. Josie, K. an 18-month old girl died from preventable medical errors at John Hopkins Medical Center.

-The reports states:
   Majority of medical errors results NOT from individual recklessness, but from faulty systems, processes and conditions→that set up people to make mistakes or fail to prevent them.
<div align="right">(Institute of Medicine, 1999)</div>

```
It is the system that sets up people to cause
        errors: not people themselves
```

   ♦ 440,000 patients die yearly from preventable medical errors
<div align="right">(Journal of Patient Safety, 2013)</div>

   ♦ 1 in 3 patients admitted to a hospital will experience a medical error
<div align="right">(Health Affairs, 2011)</div>

```
So why use a PSYCH SBAR?
    1. Standardized tool which ensures everyone is on the same
       page
    2. Requires individuals to speak concisely and openly, no
       matter what their position in the organization
    3. Easy to use
    4. Results in an increased culture of safety and positive
       outcomes
```
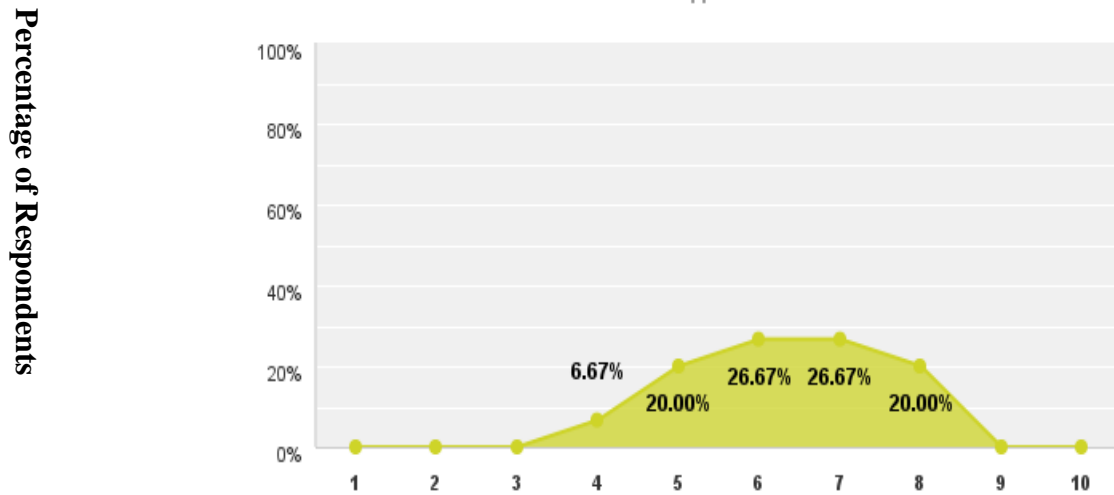
(Safer Healthcare, nd)

Appendix N

DATA COMMUNICATION SURVEY (POST TOOL)

Q9 **On a scale of 1 to 10, 10 being the best and 1 being the worst, how would you rate the quality of the communication between teams/members in your organization?**

Answered: 15   Skipped: 0

Percentage of Respondents

6.67%   26.67% 26.67%
      20.00%   20.00%

Quality of Communication
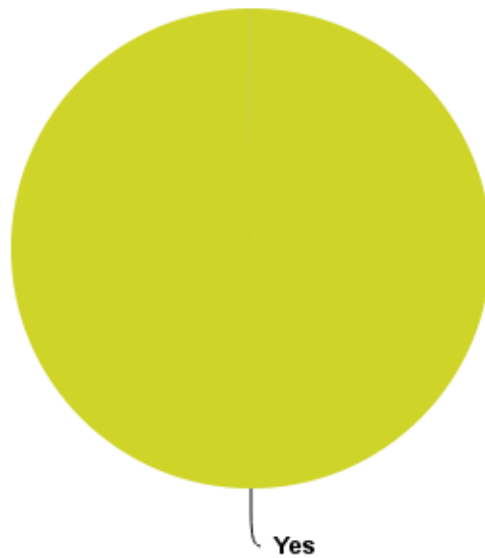**(1 = Poor   10 = Excellent)**

Appendix O

BASELINE DATA COMMUNICATION SURVEY (POST TOOL)

ERRORS

Q5 In the past year, have there been any errors in patient care due to miscommunication or lack of communication to a team or a member of a team involved in a patient's care?
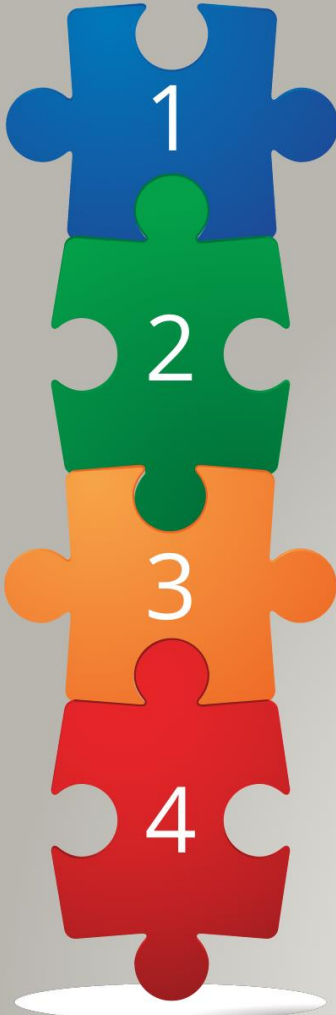
Answered: 15   Skipped: 0

Yes

Appendix P

PSYCHIATRIC SBAR TOOL POSTER (POST TOOL)

Appendix Q

A CNL bridges the gap between patient care and clinical leadership within the front lines of a healthcare system. CNLs regularly communicate with patients, staff nurses, physicians, pharmacists, social workers, clinical nurse specialists, nurse practitioners, and other members of the healthcare team. CNL's ensure that the patient's safety comes first while improving outcomes by creating effective point of care work environments characterized by continuous quality improvement.

In a study conducted by the VA, CNL's saved an estimated $461,775 in annual costs. The VA will implement CNLs at all points of care by 2016.

First new role in 40 years. American Association of Colleges of Nursing (AACN) developed role in 2003 in response to
-high rate of preventable deaths (98,000 yearly)
- $17-29 billion annual loss from medical errors yearly
- 20% projected nursing shortage by 2020

Suggests efficiency-boosting, cost saving ideas. Promoting safety and quality care through institution-wide committees.

$$$

Master's prepared generalist, providing and managing care at the point of care.

A CNL is not a manager or CNS.

WHAT IS A CLINICAL NURSE LEADER? (CNL)

Healthcare systems specialist that develops quality improvement strategies, facilitates team communication, implements evidence-based solutions at the frontline level of care.

Roles/competencies include: advocate, team manager, life- long learner, and member of a profession.
Goal: deliver measurable cost savings for both patients and healthcare providers, and improve team cohesion through transformational leadership.

Creates education materials for patients and staff. Improves patient and staff outcomes by using evidence-based knowledge, microsystem (at point of care) analysis, and aggregate data sets.

Roles/competencies include: outcomes manager, systems analyst/risk anticipator, information manager, clinician and educator.
Goal: constantly evaluate and drive higher quality, more affordable care.

EFFICIENCY

COST   QUALITY

Karen Richards, RN