

Summer 8-12-2018

# Enhance Nurse-Physician Communication

Samira Samimi  
samimisamira@gmail.com

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## Recommended Citation

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An Improvement Project to Enhance Nurse-Physician Communication

Samira Samimi

University of San Francisco

### **Abstract**

Communication is the soul of healthcare, without it the microsystem cannot survive. There are many disciplines in healthcare, in order for safe and effective care to be delivered strong communication is key. With initiatives taken there is always room for improvement where gaps can be identified. In particular, a gap in communication between night shift nurses and primary care physicians. According to the CRICO Strategies (2015) there has been a \$1.7 billion-dollar loss and 2,000 deaths in healthcare nationally as a result of miscommunication. Poor communication has serious devastating effects if it is not corrected promptly. The duty of a clinical nurse leader (CNL) quickly becomes apparent that change is in order, to bridge this gap and ensure patient safety. A CNL has a distinct role in designing, implementing and evaluating patient care. This is done through collaborating, delegating, and overseeing the success of care. With the use of evidence based practice and innovation a CNL ensures the best care is provided for patients within the microsystem (GraduateNursingEDU.org, 2018). A long-term acute care medical surgical unit was assessed, which revealed under efficient scores from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) that only 20 percent of staff felt efficiency in communication between nurses and primary care physicians. The goal for this project is to create a standardized communication tool to improve efficiency in communication in three months' time. After implementation of this project, efficiency in communication improved and nurse satisfaction was achieved in the process.

### **Problem**

Communication is a foundational and integral aspect of healthcare. All disciplines of healthcare need to collaborate and communicate with one another effectively in order to provide progressive, efficient, and safe care. Without effective communication, consider a microsystem a failure. Night shift nurses have been facing a challenge of communicating patient needs with on call physicians, as they are not the primary care physician on duty. A common complaint of nurses from a survey conducted (See Appendix A), was that information or patient concerns are not being followed up on even though it is expressed during the shift change report. During a staff meeting, this problem was discussed and input from the staff was sought out on how to enhance communication in the unit. The current Situation, Background, Assessment and Recommendation (SBAR) reporting method to on call physicians is simply not effective on its own to communicate the necessary changes in care (Joffe et al., 2013). Thus, requiring a need for further improvement in the communication process by utilizing evidence based practices to guide and influence change for positive outcomes.

According to the American Nurses Association (2018) miscommunication between providers or lack of information during handoffs has been a cause of an estimated eighty percent of medical errors. Additionally, miscommunication has led to delay in care, incorrect treatment, and increased length of hospital stay. CRICO Strategies National Comparative Benchmarking system (CBS) in 2009-2013 displayed more than 350,000 malpractice claims. Thirty percent of these cases were a direct result of miscommunication. Furthermore, 7,149 cases were direct causes of miscommunication that led to patient harm. This was represented by \$1.7billion dollars in total losses and a devastating 2,000 deaths. Data showed miscommunication of patient conditions and poor documentation as contributing factors (CRICO Strategies, 2018).

### **Available Knowledge**

The Population, Intervention, Outcome (PIO) statement was utilized as a guide for the literature review. In the medical-surgical unit the nurses and physicians (P) will utilize a communication tool (communication binder) (I) to bridge the gap in communication, which will prevent delay in care, improve HCAHPS scores, and increase patient satisfaction. Keeping the PIO statement as guidance through finding evidence, key terms such as “improve,” “nurse-physician communication,” “communication tools”, “patient satisfaction” were utilized to find data using CINAHL, Fusion, and Science Direct. In addition, the American Nurses Association and Joint Commission sites were used for supporting material.

McFarland, Shen, and Holcombe (2017) conducted a study to evaluate the effects of nurse-physician communication on patient satisfaction. HCAHPS scores are highly weighed in the healthcare organization. To see what are the contributing factors when it comes to communication can help improve the current system. This particular study focuses on what ecological factors, such as population density, rates of minorities and non-English speaking patients, and the number of hospital beds, can influence a patient’s rating when it comes to communication and patient-rated satisfaction with medical providers. Furthermore, socioeconomics and level of education were also taken into consideration. The study evaluates patient satisfaction with doctor and nurse communication in all HCAHPS-participating hospitals across the United States. Findings of this research were those who are non-English speaking who come from lower socioeconomic backgrounds and lower education levels were more likely to rate lower than those on the opposite side of the spectrum. After understanding the knowledge of what is influencing patient’s ratings, education can be provided to healthcare providers as

guidance on how to improve communication in these populations. It is important to educate healthcare providers on the importance of clear and concise communication across all disciplines. For example, proper use of translators when involved in the care of a non-English speaking patient. Efficiency is achieved with clear communication among nurses and physicians to collaborate and address care with specific needs accordingly.

In the research article by Smith (2015) it discusses the importance of patient centered care and how effective patient-provider communication facilitates many opportunities as well as supports patients to be interactive in their care. This creates a healthy communication to construct continuous healing relationships that are very integral for patient-centered care. Conversely, poor healthcare communication results to unfavorable outcomes, such as, delay in care, lack of continuity of care, and health disparities. This study focuses on veterans with and without disabilities, as well as those who are non-veterans. 2,994 participants who identified as veterans were considered in the study. The goal was to determine if those with disabilities were receiving proper patient centered communication by medical providers versus those without disabilities. Findings of the survey conducted on the patients showed that veterans without disabilities were likely to say their concerns were heard by physicians, care was explained thoroughly, and they were included in decisions of their care. This study displays the importance of spending time with patients, regardless of their circumstances and thorough explanations of every aspect of patient care need to take place. Poor patient- centered communication is directly related to poor patient outcomes. Nurses play an integral role in special circumstances as such. When needs are identified, it is important that nurses are able to communicate clearly and to collaborate with physicians to ensure positive patient outcomes.

Joint Commission Center (2012) has introduced a Targeted Solutions Tool (TST), specifically a handoff communication tool to enhance information that is being handed off, whether it is from provider to provider, from department to department, or among multiple disciplines. This concept can be applied to many different areas of healthcare. The use of the TST displayed an increase in patient and family satisfaction, staff satisfaction, and successful transfers of patients. Data from the Joint Commission displayed that hospitals were able to implement the TST improvement project within four months, utilizing minimal resources. This project does not require additional staff, but only minimal changes in responsibilities. The acronym SHARE depicts the concept to initiate a solid change. S stands for standardizing critical content, which includes providing details of patient history, key/pertinent information. H is for hardwiring the system: meaning developing standardized tools such as checklists or in this particular case a communication binder to ensure effective communication takes place. A is for allowing opportunities to ask questions. R is to reinforce quality and measurement, this is demonstrating leadership commitment for successful handoffs, holding staff accountable, and monitoring compliance with the utilization of the standardized forms. E stands for educate and coach which includes teaching and coaching staff members on the communication tools, providing real time feedback, standardized forms, and making sure that successful handoffs are achieved. This concept tool and ideology is utilized in this project as a guide to incorporate the communication binder within the medical-surgical department to enhance hand offs as well as have a documentation of the material that is clearly communicated with the physicians.

Stewart and Hand (2017) is an integrative literature review on SBAR, communication and patient safety. Multiple literatures were reviewed to determine effectiveness of the SBAR during handoffs between healthcare providers. It depicts the importance of the SBAR methods

that serves as guidance of structured communication. In one of the articles discussed in this review, the results showed that the experiences with SBAR were found to be helpful in improving communication and collaboration skills, which allowed users to focus on patient safety. Another study's finding displayed there was a perceived reduction in communication errors with the use of the SBAR structure. Lastly, a study showed that the use of SBAR structure is not just beneficial to the nursing staff but in other disciplines as well. SBAR improves efficiency, efficacy, and accuracy of handoff reports. In addition, it is well received among healthcare staff regardless of level of command. This structure of communication creates common language to communicate integral aspects of patient care and if it is documented and utilized as a common platform information can never get lost. Problems of miscommunication can be resolved with very simple and minor changes, yet will play a huge part in positive outcomes and patient safety.

Joffe et al. (2013) is a randomized trial of after hour nurse physician phone communication. In its evaluation, it displays the fact that SBAR methods of communication with the on-call physician is simply not sufficient.

Wickersham, Johnson, Kamath, and Kaboli (2018) focuses on a study of electronic devices that indicated bedside rounds are initiated. The core of the research is to improve nurse-physician communication, teamwork and care coordination during bedside rounds. The study showed that technology alone did not enhance communication, but with teamwork and presence of the nurses and physician's communication was enhanced. These enhancements can lead to a culture of safety and improve patient care.

Tan, Zhau, and Kelly (2017) conducted an integrated review of nurse-physician communication. The aim was to review current evidence on what factors have an impact on



nurse-physician communication and the interventions that were developed to improve communication. Although communication between nurses and physicians remains a challenge, localization of physicians dedicated to clinical areas and structured nurse-physician rounds improved communication in smaller controlled settings. This randomized trial focuses on twenty nurses who are utilizing the SBAR as a structure to guide communication via telephone with the on-call physicians during after hour. Ninety-two calls were analyzed for the study and from these calls it was concluded that SBAR alone was not sufficient enough to communicate necessary information to address specific problems.

### **Rationale**

Based on the evidence and the trending problems of communication between nurses and physicians, in particular the night shift nurses and primary care providers a significant change needs to take place. This change will prevent potentially devastating errors that can ultimately be costing the life of a patient if not addressed as identified by the CBS national reports. Nurses and even patients express concern that certain aspects of care are not being followed through. This downfall directly influences patient satisfaction. In a pre-implementation survey conducted, only 20% of nurses felt efficiency in the current communication process. The creation of a communication binder will utilize a SBAR structure which includes pertinent background information regarding certain concerns that arise during night shift. This documentation will be managed by charge nurses to deliver to primary care physicians at bedside rounding. This will include patients in the direction of their treatment and healthcare, as well as, allow open communication between the physicians and patients. Concerns from the shift before will get addressed promptly and in turn prevent delay of care. The process of communicating important information is what needs great attention so information does not get lost and patient concerns

are documented thoroughly. With the use of the communication binder, nursing staff and physicians will have a common communication platform that will allow for collaboration and effective continuum of care.

### **Specific Project Aim**

The aim of this project is to bridge the gap of communication and enhance satisfaction in nurses and patients in three months' time from the initiation of this project. Nurses will experience the improvement in communication, knowing that care is being followed through and they are being heard. Furthermore, patients will win the benefits of prompt and safe care. If patient satisfaction is achieved HCAHP scores can also be increased, in particular physician communication because of the promotion of open communication at bedside rounds. By utilization of this communication tool many benefits will result from this system with the ultimate goal of positive patient outcomes.

### **Methods**

The IHI science of improvement is utilized to create a guideline to follow in order to move forward in an organized manner with this communication project. Assessment of the microsystem is necessary where the IHI provides great assessment tools such as the Assessment tool-A culture of Respect, Communications, and Disclosure (See Appendix B) and also the Clinical microsystem assessment tool (See Appendix C). The Fishbone diagram will illustrate the cause and effect of the root problem with an aim to resolve the gap in communication (IHI, 2018). In this particular project, there is a lack in communication between nurses and physicians Appendix D. SWOT analysis of the microsystem is utilized to determine the strengths, weaknesses, opportunities, and threats of the microsystem (MindTools, 2018). SWOT analysis

of the microsystem demonstrates that the attitude and willingness to provide quality care is present among the nursing team as well as the desire for a positive change (See Appendix E). The communication binder will house unit specific SBAR worksheets. The binder is divided into sections by patient's room number. Should an issue arise during the night shift a worksheet can be completed, labeled with a patient sticker, fill out pertinent information, and filed in the binder accordingly. In the morning when the next nursing staff and physicians arrive and are ready for bedside rounds the charge nurse is to utilize this communication binder to address the patient concerns that came up during the night. This will ensure promptness of care and excellent way to enhance communication. Mindtools (2012) describes the Kotter's eight step change model to guide one through an effective change process (See Appendix F). The first step is to create urgency for a change, which was done through the pre-implementation assessments and nurses survey. In step two, a team was initiated with night shift supervisors, charge nurses from the unit as well as the director of nurses. Among the team a goal was established to improve communication between night shift nurses and primary care physician. The goal was a constant reminder in every step of the change process. One of the obstacles discussed in the SWOT analysis was to promote physician bed side rounding. Short term wins were to see every step as a success, the use of the binder was by nursing staff was given positive feedback for utilization. After a few entries in the binder, feedback was sought out from the nurses on how and where the binder can be enhanced. Over the course of the improvement project the binder was utilized often by the nursing team. During this process education was provided for all staff on the importance of this communication binder and the ultimate goal. This project, overall, utilized the PDSA cycle (See Appendix G) to establish a plan, implement the plan, evaluate how

the intervention is functioning within the microsystem, and once the plan is deemed effective the goal is to spread its use to other disciplines in the organization (IHI, 2018).

### **Measures**

Continuous measures will be taken to ensure the process is working efficiently by evaluating the use of the communication binder. Interviewing nursing staff on binder utilization and focusing on their inputs to ensure the binder is suitable and user friendly. Nurses will be the primary users of the communication binder therefore receiving their feedback is essential to this change process. In addition, monitoring HCAHPS trends on communication and satisfaction is vital. The goal of this communication binder is to improve nurse-physician communication which in turn will improve physician-patient communication. HCAHP scores will be reflective of this change process. The current HCAHP scores for MD communication is at 57.85% the goal is by end of August it will increase to 75%.

### **Ethical Considerations**

The binder will be upheld by HIPPA policies and ensure privacy and confidentiality. It will be localized for use at the nurse's station along with patient charts. This communication binder promotes autonomy where it will allow nurses to recommend and advocate for patient needs.

### **Results**

The aim of this project was to enhance communication between night shift nursing staff and the primary care physicians. After the implementation of the communication binder, there was nothing short of positive feedback. Some template modifications were needed in design, but

otherwise the binder was embraced and put into use in full force. In a post-implementation nurse survey it was expressed how effective the binder has been and results went up to 80% in efficiency compared to the 20% prior to the use of the communication binder (See Appendix H). Early on in the implementation of the binder, one nurse took the time to explain how an order needed adjusting which he passed on to the day shift nurse. After coming back from being off for two days the order was still not adjusted. He said he quickly remembered to utilize the communication binder. By doing so, the order was immediately fixed the next morning. This qualitative result clearly depicts the efficiency and effectiveness the communication binder has to offer. The timeline (See Appendix I) for the goal to be achieved in three months was partially reached as the HCAHPS data are not available at this time, as results get updated every ninety days. However, the goal is to increase numbers from fifty-two percent up to 75% (See Appendix J). Over the course of the project, one down fall was that physician bed side rounding were not happening as consistently among physicians. This can be another focus for a CNL improvement project in the future.

Costs associated for this project in materials were minimal. The binder that was utilized was \$7.09, dividers were \$10.00, paper and printing cost at about 5 cents per sheet. Overall, cost of materials were under \$20. If a hired CNL were to run this project with 220 hours spent for the duration of the project, estimated projected cost of a CNL would be \$9,625.00. According to Nursing Journal (2018) the average salary for a CNL is \$84,000 which is roughly \$43.75. This number may be high for 220 hours that were spent, however over the life of this implementation delay of care is prevented, miscommunications are rectified, and ultimately patient satisfaction will be improved. This particular unit will not add more cases to the national CBS malpractice

cases nor will it contribute to the already high national costs of damage because of the harmful effects of miscommunication.

### Conclusion

This project identified a huge barrier within a microsystem, but had a very simple yet efficient solution. Staff were more than willing to participate in a positive change and were eager to see the barrier lifted. Nurses made great use of the binder and every entry was resolved by the next morning. Nurses agreed that the communication binder has really aided in addressing patient concerns promptly. Standardizing communication among other disciplines in the department can also benefit from this tool. It is cost efficient, doesn't require added staff members, yet its benefits prevent delay of care, provides efficiency in communication, and creates better patient outcomes.

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## Appendix A

### Pre/Post Nurse Survey

#### Pre-Implementation Survey

1. How satisfied are you with current nurse-physician communication?
2. What patient related concerns get missed during shift change report?
3. What do you think should be done to improve communication methods?
4. Do you think the current system is contributing to communication failure?
5. How efficient is nurse-physician communication?

#### Post-Implementation Survey

1. How satisfied are you with current nurse-physician communication?
2. Are concerns missed after use of communication binder?
3. Is the communication binder easily accessible and user friendly?
4. How efficient is nurse-physician communication?

Appendix B

Assessment Tool-A Culture of Respect, Communications, and Disclosure

Assessment Tool—A Culture of Respect, Communications, and Disclosure

	Element**	Y	+ -	N
<b>Internal Culture of Safety</b>	The organization is grounded in the core values of compassion and respect and the ethical responsibility to always tell the truth to the patient and family.	✓		
	There is an expectation for ongoing communication, honesty, and transparency that is set from the board and leadership and closely monitored.	✓		
	Error is seen as the failure of systems and not people.	✓		
	All can expect support at the sharp end of unanticipated outcome and near-miss.	✓		
<b>Malpractice Carrier</b>	There is a commitment to rapid disclosure and support.	✓		
	There is a written understanding of how cases will be managed in partnership between patient/family/carrier.		✓	
	Mechanisms are in place for rapid respectful resolution.	✓		
<b>Policies, Guidelines, Procedures</b>	There is a policy on patient and family communications.			
	There is a policy on patient and family partnerships.		✓	
	Organizational infrastructure for clinician support exists.		✓	
	There are policies on disclosure and documentation.	✓		
	Procedures are known and in place for internal and external communication of sentinel events.		✓	
	Guidelines/policies support a fair and just culture (non-punitive) and the reporting of adverse events.	✓		
	There is a written crisis communication plan. This plan is centrally located and easily accessible by all staff.	✓		
<b>Training</b>	Ongoing training programs are in place for all staff on communication, expectations, policies, procedures, guidelines.	✓		
	There is just-in-time coaching (training) for disclosures.	✓		
<b>Disclosure Processes in Place</b>	There is rapid notification of patient/family and activation of support—typically immediately around what is known.	✓		
	There is a team to support staff preparing to disclose (coaches).		✓	
	Root cause analyses commence immediately, are closely managed, and the results are shared, including with the patient and family.	✓		
<b>The Disclosure</b>	The organization is transparent and honest.	✓		
	Responsibility is taken.	✓		
	We apologize/acknowledge.	✓		
	There is a commitment to providing follow-up information.	✓		
	The caregiver is supported throughout the process.	✓		
	The organization provides continuing support for the patient/family.	✓		
	All hospital staff disclosing are trained in their role	✓		
<b>Ongoing Support</b>	Resources are available to assist families experiencing unanticipated outcomes (not limited to error) – support is defined by needs of the patient and family (e.g., emotional support).	✓		
	Resources are available to assist staff at the sharp end of unanticipated outcomes (not limited to error) – based on the needs of the clinician (e.g., emotional support).	✓		
	Procedures are in place and are known to ensure ongoing communications with patients, families, and staff.		✓	
<b>Resolution</b>	Procedures are in place and are known to bring the case to closure respectfully, as viewed by the patient and family.	✓		
<b>Learning</b>	Mechanisms are in place to ensure learning by the board, executive leadership, MSEC, and across the organization.		✓	
	Measurement systems are in place to assess the impact of communication, disclosure, and support (as well as quality and safety) practices on premiums, claims, cases, and payments.	✓		

\*\*Adapted from Medically Induced Trauma Support Services (MITSS)

Appendix C

Clinical Microsystem Assessment Tool

CLINICAL MICROSYSTEM ASSESSMENT TOOL

Instructions: Each of the "success" characteristics (e.g., leadership) is followed by a series of three descriptions. For each characteristic, **please check** the description that **best describes** your current microsystem and the care it delivers **OR** use a microsystem you are **MOST** familiar with.

	Characteristic and Definition	Descriptions			
Leadership	<b>1. Leadership:</b> The role of leaders is to balance setting and reaching collective goals, and to empower individual autonomy and accountability, through building knowledge, respectful action, reviewing and reflecting.	<input type="checkbox"/> Leaders often tell me how to do my job and leave little room for innovation and autonomy. Overall, they don't foster a positive culture.	<input type="checkbox"/> Leaders struggle to find the right balance between reaching performance goals and supporting and empowering the staff.	<input checked="" type="checkbox"/> Leaders maintain constancy of purpose, establish clear goals and expectations, and foster a respectful positive culture. Leaders take time to build knowledge, review and reflect, and take action about microsystems and the larger organization.	<input type="checkbox"/> Can't Rate
	<b>2. Organizational Support:</b> The larger organization looks for ways to support the work of the microsystem and coordinate the hand-offs between microsystems.	<input type="checkbox"/> The larger organization isn't supportive in a way that provides recognition, information, and resources to enhance my work.	<input type="checkbox"/> The larger organization is inconsistent and unpredictable in providing the recognition, information and resources needed to enhance my work.	<input checked="" type="checkbox"/> The larger organization provides recognition, information, and resources that enhance my work and makes it easier for me to meet the needs of patients.	<input type="checkbox"/> Can't Rate
Staff	<b>3. Staff Focus:</b> There is selective hiring of the right kind of people. The orientation process is designed to fully integrate new staff into culture and work roles. Expectations of staff are high regarding performance, continuing education, professional growth, and networking.	<input type="checkbox"/> I am not made to feel like a valued member of the microsystem. My orientation was incomplete. My continuing education and professional growth needs are not being met.	<input type="checkbox"/> I feel like I am a valued member of the microsystem, but I don't think the microsystem is doing all that it could to support education and training of staff, workload, and professional growth.	<input checked="" type="checkbox"/> I am a valued member of the microsystem and what I say matters. This is evident through staffing, education and training, workload, and professional growth.	<input type="checkbox"/> Can't Rate
	<b>4. Education and Training:</b> All clinical microsystems have responsibility for the ongoing education and training of staff and for aligning daily work roles with training competencies. Academic clinical microsystems have the additional responsibility of training students.	<input type="checkbox"/> Training is accomplished in disciplinary silos, e.g., nurses train nurses, physicians train residents, etc. The educational efforts are not aligned with the flow of patient care, so that education becomes an "add-on" to what we do.	<input type="checkbox"/> We recognize that our training could be different to reflect the needs of our microsystem, but we haven't made many changes yet. Some continuing education is available to everyone.	<input checked="" type="checkbox"/> There is a team approach to training, whether we are training staff, nurses or students. Education and patient care are integrated into the flow of work in a way that benefits both from the available resources. Continuing education for all staff is recognized as vital to our continued success.	<input type="checkbox"/> Can't Rate
Patients	<b>5. Interdependence:</b> The interaction of staff is characterized by trust, collaboration, willingness to help each other, appreciation of complementary roles, respect and recognition that all contribute individually to a shared purpose.	<input type="checkbox"/> I work independently and I am responsible for my own part of the work. There is a lack of collaboration and a lack of appreciation for the importance of complementary roles.	<input type="checkbox"/> The care approach is interdisciplinary, but we are not always able to work together as an effective team.	<input checked="" type="checkbox"/> Care is provided by a interdisciplinary team characterized by trust, collaboration, appreciation of complementary roles, and a recognition that all contribute individually to a shared purpose.	<input type="checkbox"/> Can't Rate
	<b>6. Patient Focus:</b> The primary concern is to meet all patient needs — caring, listening, educating, and responding to special requests, innovating to meet patient needs, and smooth service flow.	<input type="checkbox"/> Most of us, including our patients, would agree that we do not always provide patient centered care. We are not always clear about what patients want and need.	<input checked="" type="checkbox"/> We are actively working to provide patient centered care and we are making progress toward more effectively and consistently learning about and meeting patient needs.	<input type="checkbox"/> We are effective in learning about and meeting patient needs — caring, listening, educating, and responding to special requests, and smooth service flow.	<input type="checkbox"/> Can't Rate

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Side A

Please continue on Side B

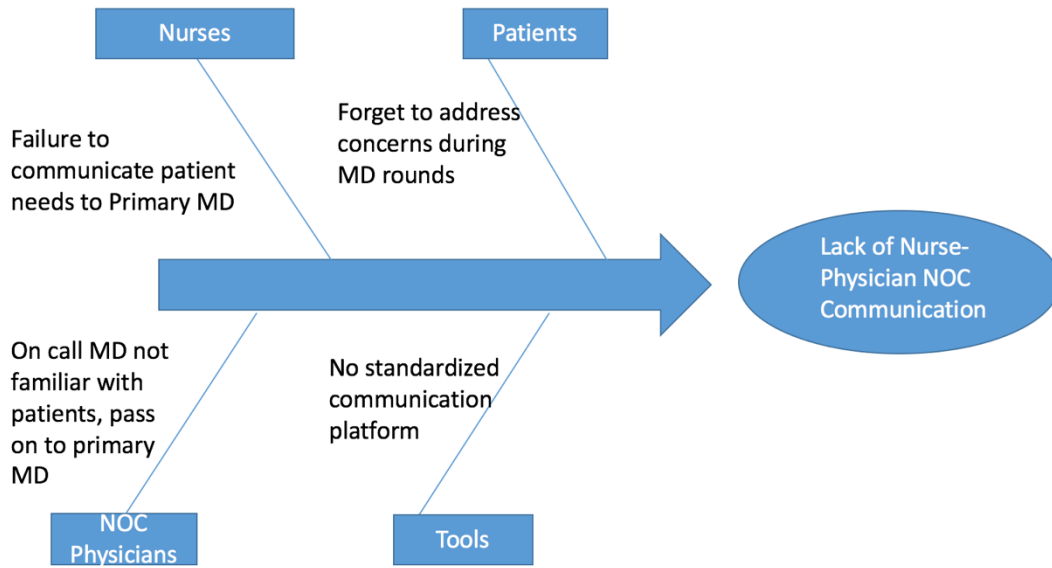
CLINICAL MICROSYSTEM ASSESSMENT TOOL

- CONTINUED -

	Characteristic and Definition	Descriptions				
Patients	<b>7. Community and Market Focus:</b> The microsystem is a resource for the community; the community is a resource to the microsystem; the microsystem establishes excellent and innovative relationships with the community.	<input type="checkbox"/> We focus on the patients who come to our unit. We haven't implemented any outreach programs in our community. Patients and their families often make their own connections to the community resources they need.	<input type="checkbox"/> We have tried a few outreach programs and have had some success, but it is not the norm for us to go out into the community or actively connect patients to the community resources that are available to them.	<input checked="" type="checkbox"/> We are doing everything we can to understand our community. We actively employ resources to help us work with the community. We add to the community and we draw on resources from the community to meet patient needs.	<input type="checkbox"/> Can't Rate	
Performance	<b>8. Performance Results:</b> Performance focuses on patient outcomes, avoidable costs, streamlining delivery, using data feedback, promoting positive competition, and frank discussions about performance.	<input type="checkbox"/> We don't routinely collect data on the process or outcomes of the care we provide.	<input type="checkbox"/> We often collect data on the outcomes of the care we provide and on some processes of care.	<input checked="" type="checkbox"/> Outcomes (clinical, satisfaction, financial, technical, safety) are routinely measured, we feed data back to staff, and we make changes based on data.	<input type="checkbox"/> Can't Rate	
	<b>9. Process Improvement:</b> An atmosphere for learning and redesign is supported by the continuous monitoring of care, use of benchmarking, frequent tests of change, and a staff that has been empowered to innovate.	<input type="checkbox"/> The resources required (in the form of training, financial support, and time) are rarely available to support improvement work. Any improvement activities we do are in addition to our daily work.	<input checked="" type="checkbox"/> Some resources are available to support improvement work, but we don't use them as often as we could. Change ideas are implemented without much discipline.	<input type="checkbox"/> There are ample resources to support continual improvement work. Studying, measuring and improving care in a scientific way are essential parts of our daily work.	<input type="checkbox"/> Can't Rate	
Information and Information Technology	<b>10. Information and Information Technology:</b> Information is THE connector - staff to patients, staff to staff, needs with actions to meet needs. Technology facilitates effective communication and multiple formal and informal channels are used to keep everyone informed all the time, listen to everyone's ideas, and ensure that everyone is connected on important topics.  <i>Given the complexity of information and the use of technology in the microsystem, assess your microsystem on the following three characteristics: (1) integration of information with patients, (2) integration of information with providers and staff, and (3) integration</i>	<b>A. Integration of Information with Patients</b>	<input type="checkbox"/> Patients have access to some standard information that is available to all patients.	<input checked="" type="checkbox"/> Patients have access to standard information that is available to all patients. We've started to think about how to improve the information they are given to better meet their needs.	<input type="checkbox"/> Can't Rate	
		<b>B. Integration of Information with Providers and Staff</b>	<input type="checkbox"/> I am always tracking down the information I need to do my work.	<input checked="" type="checkbox"/> Most of the time I have the information I need, but sometimes essential information is missing and I have to track it down.	<input type="checkbox"/> The information I need to do my work is available when I need it.	<input type="checkbox"/> Can't Rate
		<b>C. Integration of Information with Technology</b>	<input type="checkbox"/> The technology I need to facilitate and enhance my work is either not available to me or it is available but not effective. The technology we currently have does not make my job easier.	<input checked="" type="checkbox"/> I have access to technology that will enhance my work, but it is not easy to use and seems to be cumbersome and time consuming.	<input type="checkbox"/> Technology facilitates a smooth linkage between information and patient care by providing timely, effective access to a rich information environment. The information environment has been designed to support the work of	<input type="checkbox"/> Can't Rate

Appendix D

Fishbone Diagram



Appendix E

SWOT Analysis



Appendix F

Kotters Change Diagram

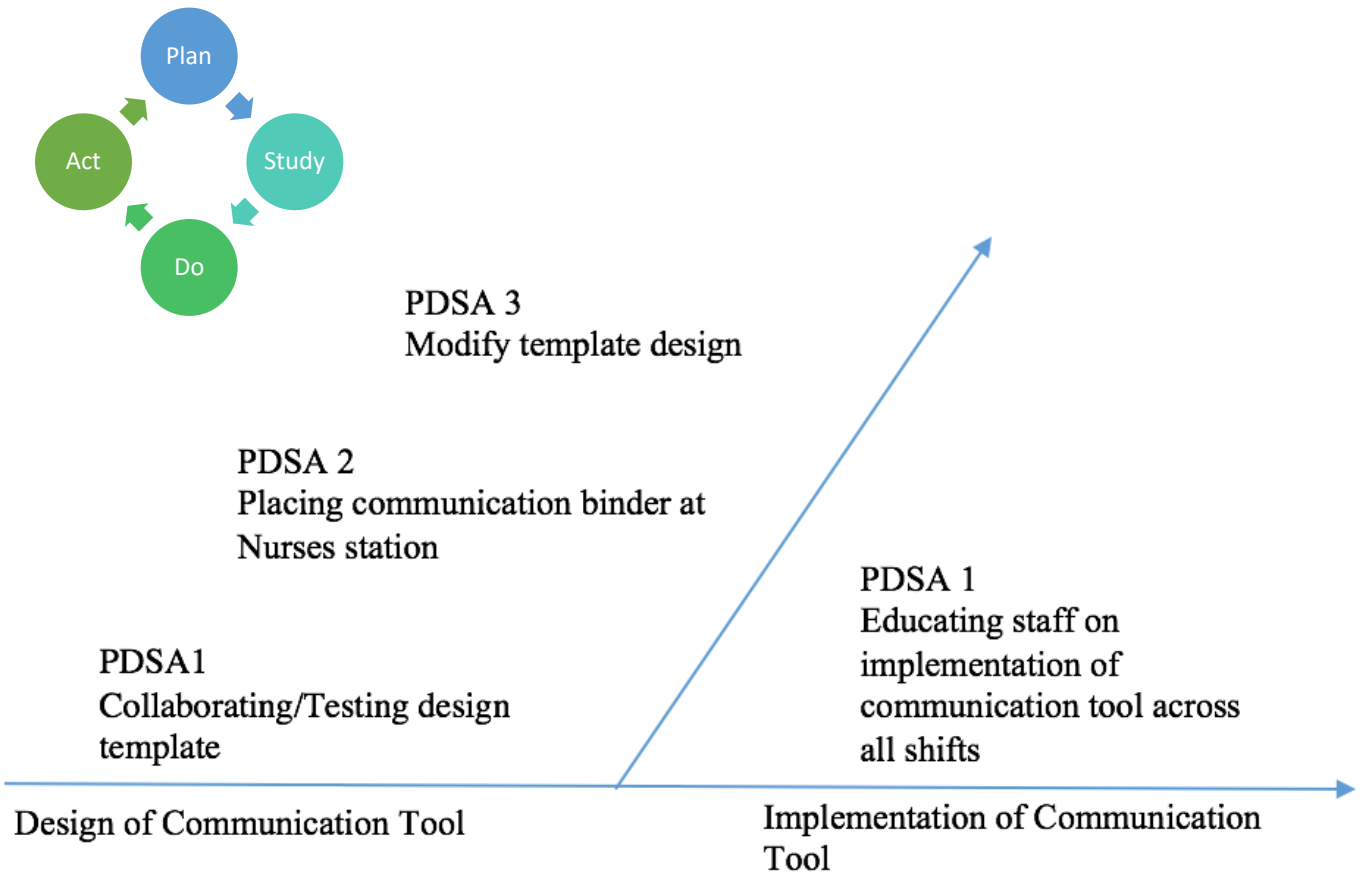
# Kotter's 8 step change model



[www.oneclearmessage.co.za](http://www.oneclearmessage.co.za)

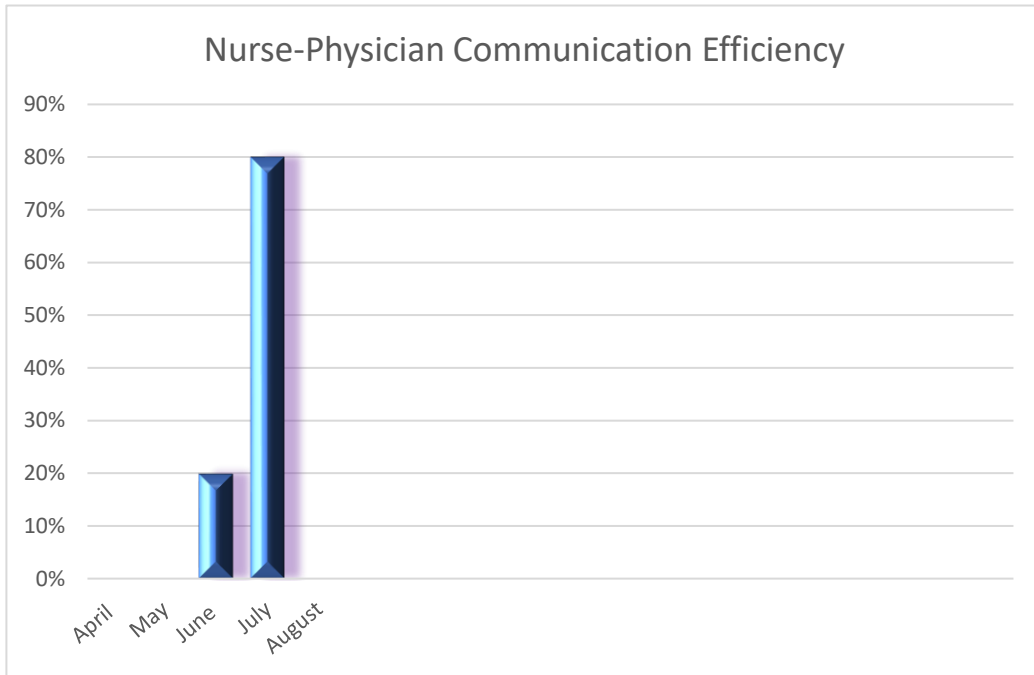
Appendix G

PDSA Cycles



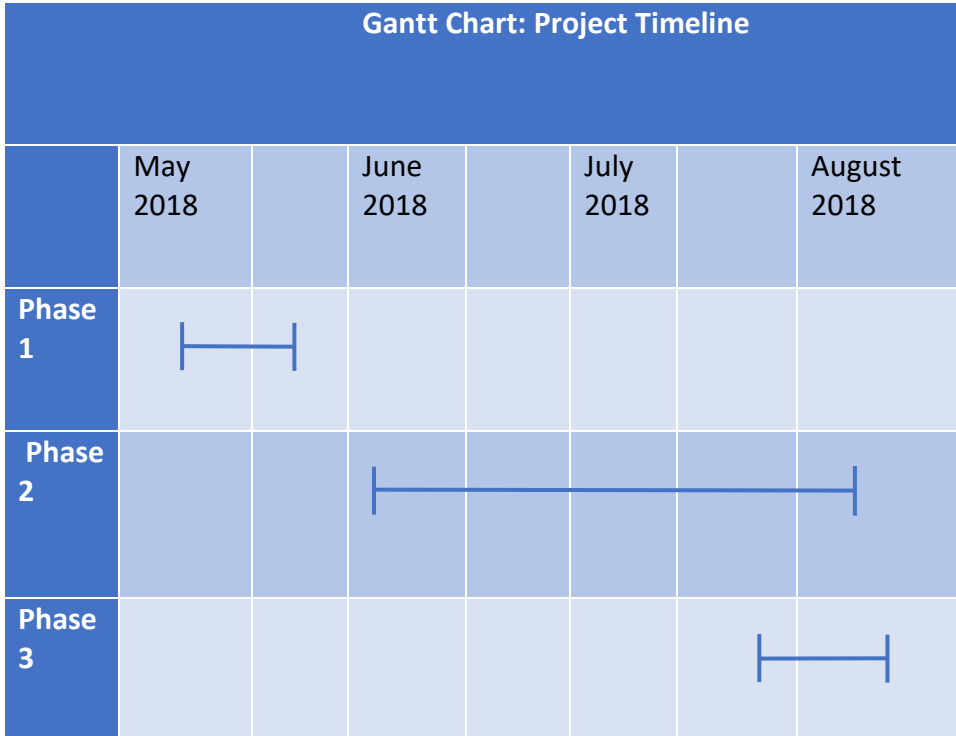
Appendix H

Nurse-Physician Communication Efficiency Graph





Appendix I  
Gantt Timeline



Phase 1= Assessment of unit/need for change/identifying problem/nurse survey/approval for implementing project

Phase 2= Creating communication binder/implementation of communication binder/ongoing feedback and staff education

Phase 3= Evaluate/post-implementation nurse survey/outcomes

Appendix J

Pre-Implementation MD HCHAPS

