Nurse-physician communication around identifying palliative care needs in nursing home residents

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JAMDA xxx (2021) 1–2

JAMDA

journal homepage: www.jamda.com

Research Letters

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To the Editor:

Timely identifying changing physical, psychological, social, and spiritual care needs is crucial. Physicians are responsible for treatment decision making, but in nursing homes, nurses see residents more frequently and may be best positioned to identify changes.[1] Ineffective nurse-physician communication is associated with patient safety and outcomes.[2–4]

Our qualitative interview study aimed to assess experiences of specialized medical practitioners who are on the staff of nursing homes regarding communication with nursing staff about identifying emerging and changing (palliative) care needs of nursing home residents.

With maximum variation sampling, we selected 15 physicians and 2 nurse practitioners employed by 8 care organizations in the western urbanized region of the Netherlands who participated in individual semistructured interviews in 2018. The topic list was informed by literature and a qualitative data set about facilitators to palliative care in dementia reported by elderly care physicians.[5] The interviews were recorded, transcribed verbatim, and analyzed with Atlas.ti version 7.5.18 (2012). We used both deductive and inductive coding adding refined codes related to communication. Using the "framework method,"[6] we identified important themes regarding nurse-physician communication. The Medical Ethical Committee of the Leiden University Medical Center declared the study exempt from the Medical Research Involving Human Subjects Act (P17.256, May 25, 2018). A more detailed report of the study is available elsewhere.[7]

Eleven female and 6 male practitioners participated (mean age 49 years, range 27-67) and most also practiced on dementia units. The interviews lasted 36-62 minutes. Initially asked in an open manner, the interviewees were quite appreciative about the communication with nursing staff concerning identifying residents' care needs. However, with specific probes, they raised a number of communication difficulties. Two main themes covering positive and negative experiences emerged from the data: (1) teamwork and (2) continuity of information.

Teamwork involved dealing with team structure and dynamics (subtheme 1a). The physicians often did not know the exact size and structure of the care team they were working with. Staff shortage and temporary workers with no access to the electronic record resulted in inadequate daily reporting, gradual deterioration going unnoticed, and not following up physician's orders with physicians sometimes taking over, measuring vital signs themselves. Quality of relationships within the team (1b) was facilitated by knowing each other both professionally and personally and may lower a threshold for nursing staff to consult the physician because of perceived hierarchical difference. However, if too low, nursing staff consulted the physician for minor issues. Disagreements complicated communication around identifying care needs, imposing emotional burden on nursing staff when it concerned residents they had grown particularly fond of. Ideally, nursing staff was on the same page regarding residents' condition prior to consulting the physician, but physicians felt they could help settle disagreements. Regarding clarity in hierarchical relationships (1c), most physicians saw themselves as a supervisor or coach rather than the leader, encouraging nursing staff in their role of identifying changes for them to perform their tasks with "more energy."

Continuity of information was facilitated by effective routes of information (2a), and face-to-face contact was seen as the most effective and primary route to communicate gradual deterioration. It was often sought in response to communication via phone, electronic health record, and e-mail. Some disclosed not to read nurses' reports as incomplete or mostly for the nursing staff themselves. Reporting on care goals was believed to be *un*helpful, missing overall deterioration as not part of any care goal. Whereas awareness of deterioration was not perceived as problematic, the quality of communicating observations (2b) was a concern, in particular communicating a "gut feeling" about residents with dementia, causing hesitancy to consult the physician. Nurses with more education communicated with the physicians directly but they may hear about changing needs secondhand.

Despite physicians' presence in nursing homes, we found room to improve communication with nursing staff on subtle changes in residents' condition. Relational and informational continuity facilitate continuity of care,[8] and these were concerns even with on-staff physicians supervising the team. Table 1 provides recommendations based on the perspectives of the practitioners we interviewed. They felt that nursing staff need a proactive attitude, developed through education and experience, and good communication skills to make sense of, and report their observations. Nurses may start explaining patient's background rather than with a clear question.[9] Physicians and nurses are trained differently with a more fact-based, structured, cognitive approach and succinct communication styles vs a systems-oriented approach steeped in emotional intelligence and highly descriptive communication.[3,10] Interprofessional education may improve physician-nurse

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This study was funded by the ZonMw, the Netherlands Organisation for Health Research and Development, project number 844001306 and the Department of Public Health and Primary Care of Leiden University Medical Center (LUMC), Leiden, the Netherlands. The sponsor of the study, LUMC, had no role in the design, methods, subject recruitment, data collections, analysis, and preparation of this letter.

The authors declare no conflicts of interest.

https://doi.org/10.1016/j.jamda.2021.09.034

Table 1
Recommendations for Nurse-Physician Communication on Identifying (Palliative) Care Needs From the Perspective of Interviewed On-Staff Physicians

Physicians	Nursing Staff	Both Physicians and Nursing Staff
Explain background when decisions need to be made and involve nursing staff. Encourage the nursing staff in their role. Explore (divergent) opinions and ensure you are accessible for communication on disagreement matters. Create a climate of mutual respect and trust. Create opportunities for regular and open contact with the members of the nursing staff (also outside of scheduled meetings; *"Just invest a lot when you are new somewhere, just drink many cups of coffee with staff when you are new and just show your face all the time. Even if you don't do anything, but just because of the fact, if they see your involvement, then communication is often OK as well"*).	Focus on clear communication clarifying the request about what help is needed while avoiding overly demanding appeals. Use objective arguments, substantiate with, eg, recorded symptoms and measurements of vital functions, without your interpretations (eg, as pain or anxiety). Make sure you are well informed about a resident prior to consulting the physician. Use daily meetings within the nursing team to discuss a resident's condition and what should be discussed with the physician. Remain calm and confident when consulting the physician, also in more chaotic or acute situations.	Make sure all understand the background in case a decision should be made, and preferably decide in consensus. Discuss mutual expectations (telling the physician something *"just so he or she knows,"* may be viewed as shifting responsibilities). Plan regular multidisciplinary team meetings and audits. Get to know each other both professionally and personally.

communication,[10] and tools structuring conversations.[11] Educating all staff and investing in relationships pay off when staff can be retained and can also help reduce staff turnover.

Acknowledgments

We appreciate the willingness of the physicians to participate in the study and we thank them for their openness.

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