CHAPTER 5

Working and Communicating with an Interdisciplinary Team

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LEARNING OBJECTIVES

1. Analyze the complexities of children's care in relation to the need for effective and safe interdisciplinary communication.
2. Apply successful communication techniques that are supported by nursing, medicine, and ancillary health science literature.
3. Implement the components of SBAR in various interactions and settings.
4. Critically evaluate communication models used by pediatric healthcare teams.
5. Analyze the concept of safety during handoffs.

KEY TERMS

Child Protective Services (CPS)
Communication
CUS protocol
Empowerment
Handoffs
Interdisciplinary team
Power distance
SBAR protocol
Specialists
Therapeutic relationship

Introduction

Communication—defined as the sharing of information and meaning—is an essential part of safe pediatric health care. Communication needs to be accurate, concise, and purposeful if care is to be coordinated and safe. During every encounter, the pediatric nurse is instrumental in providing information to team members, to outside agencies and referrals, and, most importantly, to the family. Unfortunately, miscommunication remains the primary source of medical and medication errors. Nurses can be leaders in decreasing errors by providing clear communication using a structured approach.

Complexities in working with children require that team members communicate clearly, thoroughly, professionally, and often with urgency. Identifying healthcare problems in children often requires that members of an **interdisciplinary team** work closely together to provide for the needs of the child and family; such a team comprises a group of healthcare professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient. In an environment characterized by high unemployment rates, insurance coverage concerns, frequent geographical moves for employment, high divorce rates, and increasing diversity in languages, cultures, and lifestyles, families can present with complicated needs requiring a team effort to meet them. Sometimes it takes immediate action to care for a child and family while they are in the healthcare arena, before they leave and the team misses the opportunity to provide continued care.

This chapter presents ideas about how strong communication skills between interdisciplinary team members can be fostered and implemented. If a child presents with an exacerbation of a chronic illness such as type 1 diabetes mellitus, severe asthma, or cystic fibrosis, the team must first identify the child's immediate healthcare needs, then identify the professional team members who have been involved with the child's care. These team members may be found across clinical settings—from providers of outpatient services to home care providers to providers during previous hospitalizations.

Prioritizing the child's needs is essential. If a child presents to the emergency department with respiratory syncytial virus (RSV)–related bronchiolitis and pneumonia, but is found to have evidence of physical child abuse or neglect, the team must provide for the child's immediate health care needs first. They must also piece together the puzzle of associated concerns and communicate with previous care providers, including social services and government agencies such as **Child Protective Services (CPS)**, which investigates cases and protects children from further abuse or maltreatment. Much more so than with adult patients, the vulnerability of a child requires all healthcare team members to work closely together, communicate assessments findings and concerns, and work collaboratively to create a comprehensive and agreed-upon plan of care.

Team Members

The provision of pediatric health care requires team members identify and communicate the needs of the child, and subsequently plan for treatment and care. When children are hospitalized with continuing medical needs, the team must work with case managers, home-care providers, community services, and the child's regular healthcare provider and office. The child might require services such as therapy, follow-up laboratory tests or diagnostic exams, and consultations with **specialists** (i.e., healthcare professionals with extensive knowledge in a particular area). The **Quality and Safety: Communicating with Team Members** box identifies team members who may potentially be involved with providing holistic and comprehensive care to children and their families (**Figure 5-1**).

QUALITY AND SAFETY

Communicating with Team Members

Communication among members of interdisciplinary teams is imperative for safe outcomes. Members of the team may include personnel who fill the following roles:

- *Advanced practice team members:* Clinical nurse specialists, midwives, pediatric nurse practitioners, nurse anesthetists, and other advanced practice clinicians who create care and treatment plans that include team approaches.
- *Child Life:* Specialists who create a plan for recreational play, therapeutic play, education, distraction, medical play, and schoolwork. Their roles may include contacting the child's school to plan for missed work or arranging for a teacher to come to the hospital to help the child stay current and engaged.
- *Child Protective Services:* Authorities who provide immediate assistance to the team if child maltreatment is suspected or confirmed; they are tasked with creating and coordinating a safe plan of care for a child with confirmed maltreatment.
- *Child psychologists:* Mental health professionals who support children through difficult emotional times, evaluate the child's mental health concerns or needs as well as developmental functioning level, and create a plan of care

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QUALITY AND SAFETY *(continued)*

for psychological evaluation, intervention, teaching, and support.

- *Community pediatricians:* Clinicians who provide historical perspectives on a child's health and communicate current health concerns and treatment plans. They may confirm immunization records and well- and ill-child encounters.
- *Developmental therapists:* Therapists who offer assessments, information, and guidance to team members and families of children with developmental issues, and locate developmental services in the community.
- *Lactation consultants/educators:* Specialists who assist a nursing mother to learn, practice, and be successful at breastfeeding, especially when a health concern arises in regard to the infant (e.g., cleft lip, cleft palate, neurologic impairment, illness, motor impairments), and who provide instructions for pumping and storing breast milk.
- *Licensed vocational nurses (LVNs)/licensed practical nurses (LPNs):* Nursing staff who assist the interdisciplinary team to provide direct nursing care to children and families while staying within their scope of practice; they communicate directly and frequently with the registered nurse assigned to supervise their care of patients.
- *Medical specialists:* Physicians with specialist credentials who work with the team to address a specific subset of medical issues (e.g., endocrinologist, cardiologist, pulmonologist).
- *Nursing assistants:* Clinicians who support the child's physical and emotional needs while assisting the nursing team in many aspects of care; they also support the family in adjusting to their child's hospitalization.
- *Occupational therapists:* Specialists who enable a child to learn and adapt to new circumstances or disruptions in lifestyle, preventing loss of function and improving psychological well-being.
- *Pediatric nutritionists:* Specialists who coordinate appropriate diets for children with a variety of healthcare needs (e.g., failure to thrive, malnutrition, weight management, special diet needs, food alternatives in the presence of allergies) and provide education and a plan of care for the child at home.
- *Pediatric pharmacists:* Pharmacy specialists who provide accurate pharmacologic medical treatments in weight-based safe doses while children are hospitalized; prepare plans for medications needed at home; and teach or provide information to families concerning home medications.
- *Physical therapists:* Specialists who enable a child to reduce pain, improve or restore mobility, and treat physical dysfunction or injury through therapeutic exercise and restorative activity.
- *Physician assistants:* Practitioners who provide primary care in a team-based approach or in the absence of physicians.
- *Respiratory therapists:* Clinicians who support a child with airway management concerns by providing direct respiratory support skills; managing respiratory equipment such as oxygen, chest physiotherapy, pulmonary toileting, and ventilator services; and offer education on new or ongoing respiratory-related diagnoses such as asthma, bronchiolitis, or cystic fibrosis.
- *Social workers/case managers:* Social services professionals who assist the team to coordinate efforts to meet the needs of the family, including shelter, financial resources, resources, community referrals, counseling, insurance issues such as enrolling in Medicare or Medicaid, and planning for care beyond the immediate need (i.e., hospitalization).
- *Speech therapists:* Providers who evaluate a child with speech impairment or delay and develop a plan to address any physical, emotional, or neurologic issues associated with the structures of speech.
- *Spiritual care providers:* Individuals who provide religious, cultural, and spiritual support to families, especially during difficult times of crisis, loss, or emotional distress.

Figure 5-1

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Communication Techniques

Establishing a **therapeutic relationship** is a central task for nurses working with children and families (Roberts, Fenton, & Barnard, 2015). In a therapeutic relationship, the nurse uses a style of communication that puts a person at ease, makes the individual feel reassured knowing that he or she is being taken seriously, and allows patients and families to express their concerns, questions, and emotions. Therapeutic relationships improve motivation and promote **empowerment**, the process through which a family comes to feel competent to provide care for their child (Collins, 2015). Numerous studies have found that parents' satisfaction with their child's care is correlated

with their perception of the quality of communication—whether it is communication between the team and the family (Corlett & Twycross, 2006; October et al., 2016) or communication among team members (Giambra, Stiffler, & Broome, 2014; Khan et al., 2015).

A therapeutic relationship is goal oriented, has a definitive purpose, and ends with closure. The development of an effective therapeutic relationship requires 12 elements to be in place (Collins, 2015; Nursing Association of New Brunswick, 2000; Pullen & Mathias, 2010):

1. Establishing rapport with child and family
2. Showing respect to all members
3. Building trust by being honest, genuine, and authentic in all relationships; never making promises one cannot keep and never breaching privacy or Health Insurance Portability and Accountability Act (HIPAA) guidelines
4. Actively listening to the child and family while maintaining eye contact, direct attention, and solicitation of concerns, feelings, and emotions
5. Being aware of one's verbal and nonverbal communication
6. Showing empathy, understanding, and concern
7. Providing conflict management using creativity, clarification of feelings, negotiation techniques, and safety
8. Clarifying, verbally and nonverbally, the true concerns of the child and family
9. Maintaining professional boundaries; not sharing personal information (e.g., via social media)
10. Using humor when appropriate to encourage disclosure of feelings and promote relaxation
11. Being aware of feelings of inequality, shyness, resistance to disclosure, or any other boundaries that might prevent the establishment of a therapeutic relationship
12. Acknowledging when a therapeutic relationship is experiencing closure and being forthcoming in respectful goodbyes

The pediatric nurse's role in developing a therapeutic relationship is to develop trust, solicit information, support the child and family, and offer solutions and education. Because the pediatric nurse has more contact with a child and family during a hospitalization than any other team member, it is important to understand the meaning of this relationship, do the "connecting work" needed to support the family, and act as the "glue" by identifying what the family needs and how to get it. The therapeutic relationship is a positive alliance in which the nurse–patient relationship is based on trust, respect, sensitivity, helpfulness, and emotional/spiritual support (Pullen & Mathias, 2010). Regardless of the clinical setting where the nurse-family-patient relationship is established, the principles underlying this relationship are the same (**Figure 5-2**). The nurse, in any setting, must give his or her full attention, establish trust, provide care, and communicate all pertinent information to all team members.

Figure 5-2

BEST PRACTICES

A therapeutic relationship includes four critical components:

- *Trust:* Securing this critical component when a patient/family is in a vulnerable state.
- *Power:* Knowing there is an unequal relationship and using specialized knowledge and education to assist the child and family who may feel vulnerable.
- *Respect:* Protecting dignity, worth, culture, and all aspects of individuality.
- *Intimacy:* Providing closeness, privacy, and emotional support.

Data from Nursing Association of New Brunswick. (2000). Standards for the therapeutic nurse-client relationship. Retrieved from http://www.nanb.nb.ca/PDF/practice/Standards_for_the_therapeutic_Nurse-Client_Relationship_English.pdf

Techniques and Tools for Interdisciplinary Communication

Effective communication within a healthcare team lays the foundation for successful communication with patients and families. In high-stress environments, including the sometimes chaotic healthcare environment, it is helpful to use tools to organize one's thinking before and during communication between team members. Learning to be confident and organized during professional communication exchanges takes practice. Three tools—SBAR, CUS, and handoffs—have been shown to improve the effectiveness of interdisciplinary communication.

Structuring Communications with SBAR

The **SBAR protocol**, which was developed by the military and adopted by a network of physicians and nurses from Kaiser Permanente, is a mnemonic that represents a series of steps to organize one's thinking prior to communicating (Institute for Health Care Improvement, 2015). It provides structure when communicating with others in high-pressure or stressful situations. Using SBAR allows a nurse, or any other team member, to prepare for a conversation. Communication that follows this protocol is purposive, direct, and structured to promote an exchange of information between communicating parties such as a bedside nurse or clinic nurse and a primary care provider, while maximizing clarity and securing a plan.

SBAR includes four elements:

- **S**ituation: A concise description of the problem at hand.
- **B**ackground: A brief summary of information related to the problem at hand (i.e., what led up to the problem).
- **A**ssessment: A summary of what was found and is pertinent to the problem, such as the nurse's most recent assessment of the child.
- **R**ecommendation: A request for action in the form of a recommendation to help alleviate the problem.

Nurses can benefit from the structure of SBAR when they face a clinical problem that must be communicated. This protocol, which is considered the healthcare industry's best practice for standardized communication, promotes safety and quality by providing an efficient and well-structured format. SBAR is particularly helpful for new nurses who might feel uncertain about calling physicians to report changes in clinical status that need rapid interventions.

The CUS Protocol for Expressing Concerns

Expressing concerns can be difficult in certain circumstances—for instance, if a nurse is new to a team or setting, if there is a power differential in the relationship, or if the changes in process or status are happening rapidly. Using the **CUS protocol** allows for the expression of concerns in a respectful and professional manner. CUS stands for Concerned, Uncomfortable, and Safety (Agency for Healthcare Research and Quality, 2013, 2014):

C = "I am **concerned** about. . ."
U = "I am **uncomfortable** with. . ."
S = "I think we have a **safety** issue that needs to be addressed. . ."

QUALITY AND SAFETY

Effective Communication Decreases Errors

Multidisciplinary rounding and huddles are two interdisciplinary modes of communication that can be used in most healthcare settings.

Multidisciplinary rounding (mostly bedside but can be anywhere) allows for open and collaborative communication geared toward sharing pertinent child and family information, clarifying treatment decision making, planning for interdisciplinary care, and discussing patient safety issues. Multidisciplinary rounding is known to improve healthcare quality, reduce hospital length of stay and reduce costs (Curley, McEachern, & Speroff, 1998; O'Mahony et al., 2007). For pediatric nurses, the information that is shared during shift changes, as well as the latest information found on current assessments and care, is communicated during rounding.

A *huddle* is a brief communication process that takes place in nursing healthcare settings such as nursing units in the hospital or nursing desks at clinics; it allows nursing administration and nursing care teams to exchange information. This quick meeting is focused on functional work, with the personnel present discussing the plan for the day, reviewing safety tips, delegating work to huddle members, and updating administration on any specific needs of families. Huddles are typically held at the beginning of the day or the shift, but when a complication arises, a huddle can be called to bring key team players together to solicit advice or solve problems. It is not uncommon that representatives from many pediatric disciplines are present and actively contribute to huddles. Medicine, Child Life, Social Workers, Pharmacy and members of Nursing Administration may be present with the goal to reduce errors, strengthen follow-through, and improve care.

Handoff Processes

An integral part of interdisciplinary and intradisciplinary communication is the passing or transfer of critical information and responsibility between healthcare providers through **handoffs**. Structured handoffs can be of enormous assistance when time is of the essence or the situation has a critical component. Although the literature includes many recommendations for specific handoff procedures and processes (see **Best Practices: Strategies for Effective Handoffs**), it is important that teams identify which set of processes is most likely to work in the context of their specific patient-care setting and given the needs of the individual patient and family. Team members should contribute to the discussion at patient intake and evaluate how the processes worked (or did not work) at discharge or, in the case of long-term patient care, at intervals throughout the care process. It may be useful to identify a nurse case manager or patient advocate to coordinate complex

interactions involving multiple handoffs: Such coordination not only helps the team to avoid errors, but also increases the parents' and family members' understanding of who is on the team and what their role is in caring for the child.

Essential Formats for Handoffs

Safe and thorough handoffs also reduce errors. Nurses should share specific data about a child prior to handing the care of the child off to another healthcare professional (**Figure 5-3**). According to The Institute of Medicine (2001), "it is in inadequate handoffs that safety often fails first." Components of a safe handoff should include the following:

- Demographics, including age, developmental stage, weight, allergies, and medical diagnosis
- The child's current condition, associated previous hospitalizations and any recent or anticipated changes in the child's condition
- Up-to-date information on treatments, care needs, orders, lab values, and results of diagnostics

Patient Name: Age: Weight: Height: Known Allergies: Code Status: Developmental Stage:	IV in Place: Date of Insertion: Gauge: Location: Last Flush: Next Tubing Change:	Pertinent Medical History:
Presence of Family/ Support Systems:	Developmental Pain Scale Used: Last Pain Score: Last Pain Med Administered:	Pertinent Lab Values: Date Drawn: Reported?
Play Needs:	Other Symptoms:	Pending Labs to Draw:
Medical Diagnosis:	Pulse Oximetry:	Pertinent Diagnostic Exams:
Isolation Precautions:	Oxygen Therapy in Use:	Findings Reported?:
Diet:	Type of Oxygen Delivery Device:	Pending Diagnostics?
Activity Orders:	Wounds or Drains:	Output:
Previous Nurse:		Toileting Needs:
Body System Assessment: Respiratory: Cardiac: Neuro: Endocrine: Skin: GI: GU: MS: Sensory: Nutrition: Cognition: Emotional State:	Medications Due: 0800: 0900: 1000: 1100: 1200: 1300: 1400: 1500: PRNS Ordered:	Vital Signs: _____ _____

Figure 5-3 *Example of a handoff sheet.*

- Code status and level of severity (i.e., condition is currently stable, guarded or critical in nature)
- Recent medications administered or medications soon to be due (emphasis on medications administered in another department requiring re-timing, serum therapeutic levels, required patient or family education, or any consideration to medication safety)
- Any other pertinent data related to the child's condition or status

QUALITY AND SAFETY

Problems with ineffective handoffs affect the team function. Having to go back, find who gave the report, and clarify missing information takes time and creates havoc, breaches, failures, and gaps in vital information. Nurses may transfer between 40% and 70% of their patients every day (National Center for Biotechnology Information, n.d.)—rates that show how frequent and important the process is. According to Frank et al. (2005), error rates are as high as 68% in handoff sheets, including failure to include vitally important data such as accurate anthropometrics (especially accurate weights required for safe medication calculations), current allergies, and accurate information about medications.

Human Errors

- Omissions (left-out critical pieces of care information)
- Commissions (errors in information shared)
- Illegible documentation
- Lack of standardized form and lack of organization in thinking
- Lack of clarity or solicitation for clarity
- Being in a hurry

Environmental Issues

- Distractions and noise
- Interruptions
- Lack of clear space in which to work
- Poorly functioning or unavailable equipment, including computers
- Poor lighting

BEST PRACTICES

Strategies for Effective Handoffs

- Use only clear language that is universally known.
- Use only acceptable abbreviations, mnemonics, or shortened phrases that all team members would know.
- Limit any interruptions, but keep care safe.
- Ask clarifying questions. If you have a question, other team members will as well.

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BEST PRACTICES *(continued)*

- Utilize the safety of "read backs" or "check backs" if checking, clarifying, or receiving orders.
- Use a standardized handoff report form *accepted by your institution.*
- Be smooth, accurate, and clear between units (such as the emergency department and the pediatric unit) and ensure there is no change in quality or comprehensiveness between the care units.
- Use technology to enhance handoffs.

Data from Joint Commission, International Center for Patient Safety. (2005). Strategies to improve handoff communication: Implementing a process to resolve questions. Retrieved from http://www.jcipatientsafety.org/15274

Barriers to Effective Communication

Challenges in establishing effective communication are real. The diversity and uniqueness of people, previous experiences with healthcare teams, and the environment in which communication takes place all influence whether a therapeutic relationship can be developed and fostered. In general, two types of barriers may hinder effective communication: physical barriers that need attention, and psychosocial barriers that need to be acknowledged and overcome.

Physical barriers:

- Physical space—crowding, lack of privacy, distractions (e.g., a television or computer taking attention from the speakers and listeners)
- Acoustics and ambient noise
- Qualities of the environment such as temperature, lighting, and seating

Psychosocial barriers:

- The emotional state of communicating parties (stressful healthcare environments and the child's acute state can add to distress)
- Trust within and between communicating persons
- Previous experiences with pediatric healthcare teams
- Cultural beliefs, expectations, and personal values that may influence effective communication
- Resistance to new processes and procedures or new technology

Power Distance

Power distance is a term used to capture the feelings and perceptions of inequality that exist between people and teams. It also refers to the extent to which individuals and groups accept the fact that inequality exists in society (Hofstede, 2001; Hofstede & Hofstede, 2005). As a result of power distance, communication barriers can develop between individuals who are perceived as having differing amounts of power. This imbalance, in turn, impacts the nonverbal aspects of communication (Richardson & Smith, 2007). When a perception of high power distance exists, persons deemed to have less power tend to be more polite, show more respect, and express agreement (whether they actually agree or not) in the presence of the person with the perceived higher power.

In the United States, power distance can be perceived to be very low. As such, it is common practice to address individuals by their first names irrespective of their positions in a perceived hierarchy. At the same time, differential status may be accorded to some providers due to greater specialization of practice or training than to others who are equally engaged in patient care (Zwarenstein, Rice, Gotlib-Conn, Kenaszchuk, & Reeves, 2013). In U.S. healthcare settings, which are often characterized by rich cultural diversity, healthcare providers are often seen to have higher power distance, since they have expertise that a patient does not possess. Unfortunately, the concept of power distance may also result in inequities and disparities in health care (Joint Commission, 2007, 2008).

Perceptions of power distance can be detrimental to the relationships among healthcare providers on a team as well as to the relationships between healthcare providers and family members. Errors may be introduced when higher-ranking team members (physicians or specialists) fail to communicate effectively with other team members due to power distance. In one study focused on intraprofessional communication, interactions among nursing and allied health professionals were frequent and in-depth, but few of these discussions involved physicians (Zwarenstein et al., 2013). For the most part, physician communication was limited to discussions with other physicians; when it included non-physicians, the discussion was often "one-way" in nature (Reeves et al., 2009). Such issues must be addressed if the team is to function effectively.

Greater power distance can add to errors if family members perceive that they are on an unequal footing, hold back information, do not disclose pertinent cultural practices, or simply do not wish to share their family health practices. Pediatric nurses must act as the conduit between a family and the healthcare team by whom the family feels intimidated.

Culture and Power Distance

Consider a scenario in which a Chinese immigrant father of a two-year-old girl who was recently diagnosed with leukemia expresses to the nurse—and only to the nurse—that he does not intend to sign consent forms for diagnostic exams, chemotherapy protocols, or surgical procedures such as the insertion of a central line. The father tells the nurse that he will be taking the child away from the large healthcare setting and plans to use traditional Chinese medicine to treat his child. When asked if he discussed this intention with the interdisciplinary team, the father says no, as he felt "bombarded with information," "not respected" for his culture, "not listened to," and "not allowed to speak." The father describes feeling intimidated and believes that if he shared his intent for treatment for his child, the team members would not respect him. Further care conferences held between the family and the oncology team that focus on reducing feelings of power distance ultimately may lead to the father's consenting to combine Western medicine with Chinese cultural practices to treat his daughter's leukemia.

As illustrated in this scenario, if the nurse finds that family members are demonstrating evidence of power distance or feelings of inequality, further support is needed. The pediatric nurse is in a key position to provide support; to encourage patients and families to speak up, express concerns, and give cultural guidance; and to work with team members who might be seen as intimidating by the parents, child, and extended family.

BEST PRACTICES

Early in the care process, the registered nurse should identify the primary decision maker for the family, who may not always be the person one expects. Establishing an effective line of communication with the primary decision maker for the child and family will allow for rapid education on the plan of care, consent when needed, clarification of critical information, expedited agreement to care and treatments, adherence to the plan of care, and compliance with home care and follow-up.

Written Communication

Current professional practice requires pediatric nurses to use a variety of written communication techniques. These techniques include electronic medical charting, sharing of electronic charting between departments and institutions, and confirmation of the accuracy of electronic checklists, notes, and entries. Computerized communication may be brief and concise—but unless the nurse takes a cautious approach, excessive brevity can lead to legal consequences. It is imperative that attention is given to learning electronic charting techniques and adhering to institutional policy and protocols concerning charting, as failure to do so has been associated with an increased rate of errors (Jylhä, Bates, & Saranto, 2016). The value of electronic communications in decreasing power distance among healthcare professionals has also been noted (Zwarenstein et al., 2013).

Case Study

The parents of twin girls, age 4 months, presented to the hospital's pediatric emergency department (ED) with both infants demonstrating weight loss, inconsolable crying, and bruises to the upper thighs. The parents both work full-time, have no respite infant care, and depend on each other to flex their demanding work schedules to attend to the twins. The father expressed concern about the girls' persistent crying and their changing eating patterns.

Upon assessment, the pediatric nurse noticed extreme crying during a diaper change. The ED staff ordered an X-ray of one of the girl's lower extremities and found a hair-line fracture on the inner aspect of the femur. Both girls underwent a complete skeletal survey, and the second twin demonstrated a healing fracture on the left fourth rib.

The mother, when interviewed in private, broke down in tears and described verbal threats, yelling, and physical abuse meted out by her husband and asked for help. Subsequently, the infants were placed on a police hold. After their acute healthcare needs were met, they were transferred under the direction of Child Protective Services to a medical foster home for care while an investigation of the potential abuse and neglect was conducted. The smooth interdisciplinary team communication efforts ensured a rapid sequence of safety and extended care.

Case Study Questions

1. Who were the members of the healthcare team who provided for the safety of the family?

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Case Study *(continued)*

2. How can interdisciplinary team members best communicate to ensure all aspects of this complicated case are addressed?
3. Which tools can be used for interdisciplinary team communication?

As the Case Evolves. . .

Suppose that during the process of examining the twin girls, one of the attending clinicians noted a bluish tint in the sclera of one child's eyes. She verified that this condition was present in the second child as well, and noted that both infants have loose joints and somewhat curved spines. The X-ray studies revealed the same fractures described in the original scenario, but the mother denied any conflict with the father and stated that all is well in the home. She anxiously indicated that she could not understand how her children came to have fractures as they have not yet begun crawling. One team member suggests that the infants might potentially suffer from a rare condition called osteogenesis imperfecta, in which bones are brittle and prone to low-impact fractures (Osteogenesis Imperfecta Foundation, n.d.).

4. Which of the following actions should be taken, and who should be added to the team, to appropriately care for the infants and their parents?
   A. After completing acute treatment, obtain a complete family medical and social history and request a consult with a clinical geneticist.
   B. After completing acute treatment, obtain a bone scan on both parents to determine whether they also have brittle bones and call for a consult with an osteologist.
   C. After completing acute treatment, obtain blood samples from the parents for DNA analysis and call for a consult with a hematologist.
   D. After completing acute treatment, obtain evaluations of the parents from social welfare and psychiatric professionals to determine whether a call to Child Protective Services may be warranted.

Chapter Summary

- Communication is an essential part of safe pediatric health care. Communication needs to be accurate, concise, and purposeful if care is to be coordinated and safe. During every encounter, the pediatric nurse is instrumental in providing information to team members, to outside agencies and referrals, and, most importantly, to the family.
- Complexities in working with children require that team members communicate clearly, thoroughly, professionally, and often with urgency. Identifying healthcare problems in children often requires that an interdisciplinary team work closely together to provide for the needs of the child and family.
- Use of successful communication techniques is supported by the health science literature, including SBAR, CUS, and safe handoff procedures and practice.
- Two types of barriers may hinder effective communication: physical barriers that need attention, and psychosocial barriers that need to be acknowledged and overcome.
- Power distance (the perception of inequality between people or parties) is a very real concern and poses challenges to effective communication, both within interdisciplinary teams and between team members and patients' families.
- Written communication is an important part of teamwork. Techniques include electronic medical charting, sharing of electronic charting between departments and institutions, and confirmation of the accuracy of electronic checklists, notes, and entries.

Bibliography

Agency for Healthcare Research and Quality. (2013). Team strategies and tools to enhance performance and patient safety. In Agency for Healthcare Research and Quality (AHRQ). *TeamSTEPPS pocket guide (2.0).* Retrieved from http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html

Agency for Healthcare Research and Quality. (2014, October). *Examples of the SBAR and CUS tools: Improving patient safety in long-term care facilities: Module 2.* Rockville, MD: Author. Retrieved from http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmod2ap.html

Collins, S. (2015, May 14). Good communication helps to build a therapeutic relationship. *Nursing Times.* Retrieved from https://www.nursingtimes.net/roles/nurse-educators/good-communication-helps-to-build-a-therapeutic-relationship/5003004.article

Corlett, J., & Twycross, A. (2006). Negotiation of parental roles within family-centered care: A review of the research. *Journal of Clinical Nursing, 15*(10), 1308–1316.

Curley, C., McEachern, J. E., & Speroff, T. (1998). A firm trial of interdisciplinary rounds on the inpatient medical wards: An intervention designed using continuous quality improvement. *Medical Care, 36*(8 suppl), AS4–A12.

Frank, G., Lawler, L. A., Jackson, A. A., Steinberg, T. H., & Lawless, S. T. (2005). Resident miscommunication: Accuracy of the resident sign-out sheet. *Journal of Healthcare Quality.* Retrieved from http://lists.amctec.net/email/link_redir/176/www.nahq.org/journal/online/pdf/webex0305.pdf

Giambra, B. K., Stiffler, D., & Broome, M. E. (2014). An integrative review of communication between parents and nurses of hospitalized technology-dependent children. *Worldviews on Evidence Based Nursing, 11*(6), 369–375.

Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviors, institutions, and organizations across nations.* Thousand Oaks, CA: Sage.

Hofstede, G., & Hofstede, G. J. (2005). *Cultures and organizations: Software of the mind.* New York, NY: McGraw-Hill.

Institute for Health Care Improvement. (2015). SBAR Toolkit by Kaiser Permanente, Oakland California. Retrieved from http://www.ihi.org/resources/Pages/Tools/sbartoolkit.aspx

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system of the 21st century.* Washington, DC: National Academy Press.

Joint Commission. (2007). What did the doctor say? Improving health literacy to protect patient safety. Retrieved from http://www.jointcommission.org/assets/1/18/improving_health_literacy.pdf

Joint Commission. (2008). Promoting effective communication: Language access services in health care. *Joint Commission Perspectives*, *28*(2), 8–11.

Joint Commission, International Center for Patient Safety. (2005). Strategies to improve handoff communication: Implementing a process to resolve questions. Retrieved from http://www.jcipatientsafety.org/15274

Jylhä, V., Bates, D. W., & Saranto, K. (2016, April 14). Adverse events and near misses relating to information management in a hospital. *Health Information Management Journal*. [Epub ahead of print]. pii: 1833358316641551

Khan, A., Rogers, J. E., Melvin, P., Furtak, S. L., Faboyede, G. M., Schuster, M. A., & Landrigan, C. P. (2015). Physician and nurse nighttime communication and parents' hospital experience. *Pediatrics, 136*(5), e1249–e1258.

National Center for Biotechnology Information. (n.d.). Retrieved from https://www.ncbi.nlm.nih.gov

Nursing Association of New Brunswick. (2000). Standards for the therapeutic nurse-client relationship. Retrieved from http://www.nanb.nb.ca/PDF/practice/Standards_for_the_therapeutic_Nurse-Client_Relationship_English.pdf

October, T. W., Hinds, P. S., Wang, J., Dizon, Z. B., Cheng, Y. I., & Roter, D. L. (2016, April 7). Parent satisfaction with communication is associated with physicians patient-centered communication patterns during family conferences. *Pediatric Critical Care Medicine*. [Epub ahead of print]. doi: 10.1097/PCC.0000000000000719

O'Mahony, S., Mazur, E., Charney, P., Wang, Y. & Fine, J. (2007). Use of multidisciplinary rounds to simultaneously improve quality outcomes, enhance resident education, and shorten length of stay. *Journal of General Internal Medicine, 22*(8), 1073–1079. doi:10.1007/s11606-007-0225-1

Osteogenesis Imperfecta Foundation. (n.d.). Child abuse or osteogenesis imperfecta? Retrieved from http://www.oif.org/site/DocServer/_Child_Abuse__Child_Abuse_or_Ostegenesis_Imperfecta.pdf?docID=7189

Pullen, R., & Mathias, T. (2010). Fostering therapeutic nurse–patient relationships. *Nursing Made Incredibly Easy!, 8*(3), 4.

Reeves, S., Rice, K., Conn, L. G., Miller, K. L., Kenaszchuk, C., & Zwarenstein, M. (2009). Interprofessional interaction, negotiation and non-negotiation on general internal medicine wards. *Journal of Interprofessional Care, 23*(6), 633–645.

Richardson, R. M., & Smith, S. W. (2007). The influence of high/low-context culture and distance on choice of communication media: Students' media choice to communicate with professors in Japan and America. *International Journal of Intercultural Relations, 31,* 479–501.

Roberts, J., Fenton, G., & Barnard, M. (2015). Developing effective therapeutic relationships with children, young people and their families. *Nursing Children and Young People*, *27*(4), 30–35; quiz 36.

Zwarenstein, M., Rice, K., Gotlib-Conn, L., Kenaszchuk, C., & Reeves, S. (2013). Disengaged: A qualitative study of communication and collaboration between physicians and other professions on general internal medicine wards. *BMC Health Services Research, 13,* 494.