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Addressing Communication Dilemmas Through Clinical Nurse Specialist Leadership

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Poor communication and collaboration are common problems in critical care units because of the complex, dynamic, unpredictable, and time-pressured environment. The condition of patients in critical care units is typically rapidly changing, requiring clinicians to manage large amounts of data (eg, symptoms, hemodynamic and laboratory values), which must be interpreted and effectively communicated. Critical care nurses must skillfully analyze clinical situations, make decisions based on this analysis, and rapidly intervene to ensure optimal patient outcomes.[1] Complicating this response is a need for physicians to make "just in time" critical clinical decisions that are often independent of timely and effective communication.[2,3] As clinical practice leaders on their units, clinical nurse specialists (CNSs) can identify and strategically address communication and collaboration issues that may be compromising the delivery of quality patient care. Through CNS leadership, interprofessional health care team members can engage in partnership activities that facilitate communication and collaboration, thus fostering a mutual respect of roles, improved patient care, and enhanced satisfaction of team members in the work environment.[4-8]

Using CNS core competencies of systems leadership, collaboration, and coaching,[9] the CNS can direct changes in methods of collaboration and communication between nursing staff and interdisciplinary health care team members. This column describes the leadership role of a coronary critical care unit (CCU) CNS in directing the implementation of effective communication and collaboration strategies between disciplines, resulting in a positive transformation of unit culture.

Background

Collaborative health care is a dynamic process in which health care disciplines work together to develop the patient's plan of care with open communication.[10] This process is composed of interdependent knowledge sharing, effective communication, and collective decision-making.[10,11] Many structural factors can influence the effectiveness of communication, including professional, organizational,

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and educational processes.[4] Challenges to communication may surface as a result of team beliefs about the traditional role of the physician as the clinical leader and decision-maker and about the paternalistic model, which reinforces that nurses are handmaidens to physicians.[4,6,11]

Perceptions by interprofessional teams of shared decision-making, teamwork, and communication are recurring themes in effective physician-nurse collaboration.[12] Key factors for nurses that facilitate effective professional communication and collaboration include (1) having professional autonomy; (2) assuming responsibility and maintaining accountability for one's actions; (3) preparedness and competence of the nurse; and (4) the presence of mutual dignity and respect.[12] Studies demonstrate that nurses desire to work collaboratively with physicians, with an exchange of knowledge, concerns, and suggestions for the patient's plan of care.[4,12] Physicians and nurses may perceive collaboration differently, so a standard operational definition must be developed in order for effective communication to occur.[12,13]

A culture of collaboration can be promoted through relationship building (informal and formal), education of strategies for best practices in communication, and techniques for managing conflict.[14] Initiatives involving coaching strategies to improve communication have been found to be effective; these initiatives can include establishing an interprofessional journal club, incorporating morning/evening interdisciplinary team rounds, developing interdisciplinary appreciation awards, and initiating deliberate physician-to-nurse bedside verbal communication to ensure nurses understand medical orders beyond what is documented in the electronic medical record.[8,15]

Communication and Collaboration Dilemma

The nursing and medical leadership team of a 10-bed CCU, located in a large academic Midwestern hospital setting, identified that they had an interprofessional communication and collaboration dilemma, which was fostering a poor unit culture. Feedback from an informal survey of nurses, fellows, and residents in the CCU revealed that nurses did not feel valued, listened to, or taken seriously. Many of these cardiac nurses had 10 or more years of experience. Additionally, the physicians did not feel that they could easily talk to the nurses. One physician commented, "Some of the nurses are unapproachable." Nurses and physicians alike became aware that changes needed to occur. Staff members who took the time to identify concerns also identified solutions. When staff members were asked about the greatest opportunities to build collegiality among nurses and physicians, their responses were to have team conferences and interdisciplinary rounds. Both of these processes were in place, but this survey result afforded a chance to revisit them.

Clinical Nurse Specialist Leadership Role

The CCU CNS led the structural and process changes to be implemented. First, the CNS combined 2 existing committees into 1: the cardiology fellow–led multidisciplinary committee with the CNS-led clinical quality committee. Both committees had overlapping physician and nursing membership, but each lacked key multidisciplinary team players. The new committee, known as the CCU Clinical Quality Initiative (CQI),[16] was composed of first-year and senior cardiology fellows, the medical and nursing directors, the CNS, the nursing supervisor, an infection control liaison, a dietician, a physical therapist, an occupational therapist, a respiratory therapist, a pharmacist, and 2 staff nurses.

Within the CQI, the multidisciplinary team addresses unit-based clinical issues and hospital-acquired conditions data. The cardiology fellow directs team discussions, and with the CNS, facilitates the group in problem-solving together. Often, the CNS will bring in experts to provide additional data with which the team can make informed decisions for practice changes. For example, when catheter-associated urinary tract infection (CAUTI) rates were rising, the medical director of infection prevention and epidemiology was also invited to discuss CAUTI prevention from an expert provider's perspective. Furthermore, when occurrences of *Clostridium difficile* increased, the CNS invited a clinical epidemiologist to meet with the team. The CNS and clinical experts guide the group in understanding each discipline's role and responsibilities related to addressing the identified problems. As the clinical practice leader for the unit, the CNS identifies applicable nursing protocols and guidelines that may need to be modified or clarified for the nurses. The CQI has successfully improved

collaboration and communication among all team members, providing each discipline with a common understanding of the unit-based problems and their respective roles and responsibilities in the collaborative plan for improvement.

Beyond facilitating and leading the CQI to address unit-related problems, the CCU CNS worked with the CQI to enhance interprofessional communication. The CNS found that nurses and physicians had been working on methods to enhance communication but were doing this in separate silos. The CQI developed and implemented several communication strategies targeting improvement of the unit's culture of teamwork and collaboration, including flash rounds, night rounds, nurse-led rounds, and daily goals sheets.

Communication and Collaboration Strategies

Flash Rounds

Flash rounds are a 10-minute collaboration that occurs after the daily morning team rounds. Led by the cardiology fellow, the meeting includes a multidisciplinary team consisting of a respiratory therapist, physical therapist, occupational therapist, discharge planner, social worker, dietitian, and charge nurse. Each discipline has the opportunity to hear decisions made during rounds, ask questions, finalize details, and request physician orders be placed to move therapy forward. This has been embraced by the team, resulting in improved communication and streamlined patient care.

Night Rounds

Occurring at 10 PM each evening, night rounds are an abbreviated form of flash rounds. This conversation revisits mutually established goals of care such as clinical parameters related to evening diuresis, hemodynamics, and plans for morning extubations. Night rounds have resulted in the promotion of increased patient rest and sleep during the night, leading to a decreased risk for delirium and/or falls.

Nurse-Led Rounds

Nurse-led rounds are an evidence-based strategy derived from the awakening and breathing coordination, delirium monitoring/management, and early mobility (ABCDEF) bundle of care, designed to promote best patient outcomes in critical care.[17,18] This bundle includes the assessment of pain, breathing/sedation, delirium, early mobility, and family engagement.[17] The bedside nurse leads daily interprofessional team rounds for his or her patient, sharing the ABCDEF bundle of care information first. Cues for the ABCDEF information were placed on a 3-inch by 5-inch card that could be attached to the nurse's badge to help prompt a comprehensive report to the team. Recently, the process of nurse-led rounds was enhanced to incorporate the daily goals sheet/poster discussed below.

Daily Goals Sheet/Poster

The daily goals sheet[17-20] is a document completed for each patient by the physician during morning rounds. Upon reviewing this process, the CQI identified that the form was often not completed as expected. The CQI found a more effective method of communication, a successful project in the medical intensive care unit, and adopted it for use in the CCU. The daily goals sheet was combined with nurse-led rounds and transformed into a poster that brings to life the ABCDEF bundle.[17-20] The bundle assessment components have been placed on a 2-foot by 3-foot poster that is mounted on the inside of the patient's room window, facing into the hall. The bedside nurse is able to complete the ABCDEF bundle of care information by writing with an erasable marker outside of the patient's room. The nurse then leads the team discussion of the bundle as patient rounds occur. At the end of rounds, the fellow/intern writes the specific plan for the patient on the same document, which is reviewed and used by the nurse, respiratory therapist, physical therapist, and occupational therapist. Staff have been very satisfied in using this nurse-led rounding strategy that incorporates the ABCDEF bundle of care.

Conclusion

The CCU CNS established a positive CCU culture, which engaged interprofessional health care team members in partnership activities, thus improving communication and collaboration. Each discipline developed a mutual respect and understanding of roles and responsibilities, which streamlined and improved the quality of the care delivered to patients. Three years into this initiative, the CQI continues to move care delivery forward by identifying and addressing unit-based problems and improving staff relations. Clinical outcomes

include significant decreases in catheter-associated blood stream infections, CAUTI, and fall rates. Employee engagement markers demonstrate significant improvement, as well; for example, staff willingness to recommend the CCU as a "good place to work" increased from 35% to 87%. The cardiology fellows' perception of the CCU as a "good place to work" increased from 40% to 82%. The CCU, once a fragmented unit of disciplines that worked in silos, is now a thriving environment of best practices in communication, collaboration, and quality patient care delivery.

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