Raising SBAR to a Higher Level

P.U.R.E. Conversations in Obstetrics

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Despite a widespread effort to improve patient safety in obstetrics, injuries still occur. These injuries can be devastating both to families who sustain them and to the caregivers involved in the actual event. Additionally, the injuries are reflected by a continued number of high-profile, high-award lawsuits. One needs only to Google "malpractice verdicts obstetrics" to see a list of willing plaintiff attorneys, multimillion-dollar verdict amounts, and snapshot discussions of cases that have resulted in these awards. Why do these adverse outcomes and subsequent injuries occur? The Joint Commission, in a Sentinel Event Alert (2004) concerning perinatal deaths and permanent neurologic neonatal injuries during delivery, found that communication errors were involved in 72% of the cases. In the perinatal unit there are multiple opportunities for communication breakdown: the triage assessment, discussions about fetal monitor tracings, requests for the physician to come to the hospital (how soon and how fast), and sign outs between nurses and from practitioner to practitioner (Burrell, 2006). When these important conversations about patient care are misinterpreted, incomplete, disrespectful, blocked, abbreviated, unclear, or absent altogether, patient safety can suffer and an injury may follow (VitaSmarts).

In a widespread attempt to correct communication errors, healthcare has looked to other high reliability organizations for clues to making communications more effective. These organizations include the military, NASA, and the commercial airline industry. These types of organizations employ structured communication styles that are specifically designed to give the right information to the right person at the right time as a routine part of their every day conversations.

In 2001, Michael Leonard of the Kaiser Permanente of Colorado Group introduced SBAR to the healthcare industry to improve communications between all disciplines. SBAR stands for situation, background, assessment, and recommendation (Leonard, 2004). The data regarding reduction in errors surrounding the use of this structured communication tool has been positive. OSF St. Joseph Medical Center in Bloomington, Illinois. significantly reduced medication errors with the introduction of structured communication using the SBAR format (Haig, Sutton & Whittington, 2006).

Other organizations, both in and out of healthcare, have developed structured communication formulas and acronyms that bring the opportunity for a more formal approach to conversations within the organization. All have the same purpose, to organize relevant information, make passage of information a formal process, and make the approach to transfer of information part of the organization's culture. Some of these include: S-A-F-E (Baylor University; Situation, Assessment, Findings and Figures, Express and Expect); S-H-A-R-E-D

(Northwest Community Hospital, Arlington Heights, Illinois; Situation, History, Assessment, Request, Evaluate, Document); S-T-I-C-C (US Forest Service; Situation, Task, Intent, Concern, Calibrate); N-B-A (Crew Resource Management; Needs, Background, Assessment); I- P-A-S-S the B-A-T-O-N (U.S. DOD; Introduction, patient ID, assessment, situation, safety concerns, background, actors, timing, ownership, next steps); I-M-S-T-A-B-L-E (Vanderbilt University; ID, Mechanism of injury, Status, Treatment, Allergies, Background. Last, Extras) and S-B-A-R or S-B-A-R-R, (for example, Kaiser Permanente Colorado, Providence St. Vincent Portland, Oregon; situation, background, assessment, recommendation, repeat back).

Extensive orientation and teaching programs for nurses and physicians throughout the country have generally resulted in the adoption of SBAR as the most popular method of structuring conversations that relate to patient care. However, despite widespread implementation efforts to standardize communication with a structured format, the authors and others (Daton & Henriksen, 2007) have found challenges to the adoption of structured communication as regular and standard universal practice. Depending on the time of day or night, the urgency of the situation, and the individuals involved, there have been instances of communication breakdown even when one of the parties was attempting to use the SBAR approach. When an assessment of SBAR effectiveness was undertaken in the authors' perinatal unit, gaps were seen in its effectiveness as illustrated by the following quotations: "The lines are drawn between us and them." "It's not my job (to communicate)." "They get paid the big bucks to make the decisions." "An emergency to one provider is routine to another; how are we supposed to know which it is today?" "I am not going to say anything." "We don't ever get the information we need." "It all depends on who you are working with if it is going to be a good team or not." "We are afraid to make a recommendation to some providers; if we're wrong we'll pay for it." These attitudes and breakdowns in the communication process led to the search for additional tools to enhance the process and foster teamwork as a critical safety element in obstetrics.

Moving Toward Dialogue

The Society for Health Systems (SHS) recognized the importance of working toward dialogue as a communication style in their July 2004 newsletter. The key elements in establishing dialogue are the incorporation of thinking and relationship. SHS advocated that communication and conversation must move from a debate style where there are always winners and losers to true dialogue where

> *"…there is listening, respecting, suspending assumptions, (and) speaking your own voice…. (It is) a way of thinking and reflecting together. In other words, true dialogue incorporates certain mental processes in real time and takes into account not only the information needed to be transferred, but the context, relationships and behaviors of the individuals having any conversation (Society for Health Systems, 2004)."*

Clinical Scenarios for P.U.R.E. Conversations

- Triage Time
- Temperature Talk
- Trapped Shoulder
- Time to Call The Chief
- Trip to The OR
- Time to Call For Help
- Transfusion Pending
- Trouble with The Strip
- Trouble with The Baby
- "Turn Up the Pit"
- Time for a Ventilator

P.U.R.E. Conversations

Using the idea that dialogue and improved communications were based on the principles of preconversation thinking, context, and relationship, we sought to develop a new approach to teaching communication skills through a new acronym incorporating these principles. The acronym chosen for this approach is P.U.R.E. Conversations. This stands for conversations that are *purposeful* (or *prepared,) unambiguous, respectful,* and *effective.* The key to the approach was to use the existing structure of S-B-A-R and incorporate these P.U.R.E. principles into the conversation in which the message is delivered. We also wanted to develop a forum in which we could bring physicians and nurses together (often for the first time for this purpose) to focus on improving communication skills through practice on simulated clinical scenarios seen regularly on the perinatal unit. The P.U.R.E. Conversations in Obstetrics approach was organized into a daylong workshop for physicians, midwives, nurses, and anesthesia personnel who work together on a perinatal unit. Didactics, video vignettes, group discussions, and exercises were used throughout the workshop to illustrate the principles of P.U.R.E. Conversations.

More specifically, the elements of P.U.R.E. Conversations in Obstetrics are practiced and integrated into every conversations involving patient care:

P – Purpose/Prepared. The purpose of all communication is to get results; to get something done. This component describes the mental processes necessary before the conversation is initiated to establish a purpose for the conversation, to adequately prepare, and to produce the desired result. It reviews the rationale for using structured communications during important conversations and asks that the conversant take some time thinking, not only about the conversation, but what are the goals of the conversation, i.e., "What is it that is most important to accomplish at this time?"

U – Unambiguous. An ambiguous SBAR can be just as dangerous as no SBAR at all. This component emphasizes choosing language (words, phrases, terminology) that is always clear and doesn't leave room for misinterpretation or mixed messages. For example, it stresses the importance of a common language for electronic fetal heart pattern using NICHD language. It stresses using the chart and specific data rather than using descriptive language. Finally, it emphasizes the importance of obtaining unambiguous time frames for

required actions such as when the physician is asked to come to the hospital.

R – Respectful. Disruptive and intimidating behavior has been shown to inhibit communication, shut down the flow of important information, and contribute directly to adverse outcomes (Rosenstein & O'Daniel, 2005). It is important for all disciplines to understand the spectrum of disruptive, intimidating, and uncivil behaviors and their effect on patient safety. It is also important, in order to maintain focus on the issues at hand, to know how to respond when one of the parties responds in an intimidating or disruptive manner. Scripts and tools to effectively deal with conflict and disrespectful behavior are offered and practiced during the workshop.

E – Effective. This component involves training for real time monitoring of the effectiveness of conversations. This is a mental process that allows for adjustments, repetition, cross checking, and managing conflict, which could be associated with any type of structured communication. Various tools, such as those offered in the TeamSTEPPS approach to managing conflict (AHRQ) and those from the University of Maine Cooperative Extension on Active listening (2004) are introduced and practiced.

Example of a Scenario Used for Constructing a P.U.R.E. Conversation

Obstetric Triage/Evaluation

Location: Triage Unit of Labor & Delivery
Time: 0210
Attending MD: Dr. Harris (covering for the patient's physician, out of house, doesn't particularly like to do VBACs)
Assigned RN: Deborah Miller
Patient Name: Vanessa Marshall
Room: Triage bay 381
Chief Complaint: Painful contractions starting at 2300
Pain rating: 6/10
Prenatal History: G2P1 @ 40 2/7 weeks gestation, previous cesarean section 2 years ago for breech 7 pound 15 oz. Female. No other medical problems. GBS+.
Allergies: NKDA
EFW: 8 pounds
Cervical Exam: 5/90%/0
Membrane Status: Intact, pink tinged bloody show
Contraction pattern: Contractions are regular every 2-3 minutes, 60-90 seconds, firm by palpation.
Fetal heart rate status: Baseline 135, moderate variability, accelerations, 2 variable decelerations in a 20 minute period, to 90 bpm, lasting 40 seconds.
Pain management plans: Desires epidural analgesia
Delivery plan: Desires vaginal trial of labor. There is no written consent other than saying, "VBAC discussed."
Social history: Married, stay at home mother, no history of drug use, no social concerns.

The instructions are for the triage nurse to call the physician to give a P.U.R.E. SBAR report to the physician on call who will be caring for this patient.

Eleven clinical scenarios representing common clinical situations that occur regularly on a perinatal unit were developed to practice building conversations that incorporated the elements of P.U.R.E. (page 29).

A key principle in any exercise exploring communication failures is for the group to recognize differences in communication styles between nurses and physicians (Coeling & Wilcon, 1994). The opportunity for physicians and nurses to take time to understand these differences through analysis of these clinical scenarios and to practice conversations is, by itself, an important opportunity to improve communications and strengthen the perinatal team.

One challenge for the perinatal unit as they face any change is how to hardwire new skills into the culture of the unit. In addition to posters, pins, or mouse pads that constantly put the structured communication acronyms in front of the perinatal team, templates can be constructed in the electronic record that remind and require the structured format to be used. Finally, leadership rounding, stories of effective communication practices at staff meetings, and reminders from nurse and physician leaders in day-to-day operations will help to assimilate structured communications so all of the members of the team become fluent in its use.

Does all of this work? How does one measure the effectiveness of structured communication and its ability to reduce errors in obstetrics? We know that structured communication reduces errors in some organizations, but because adverse outcomes rarely occur (in relationship to successful outcomes) in obstetrics (Chaauhan et al., 2003), it is difficult to show a direct relationship between changes in communication styles and a direct reduction in adverse perinatal outcomes. However, we do know that focus on structured communication enhanced team building; it was a first time for many when physicians, midwives, and nurses worked together in an effort to improve their communication practices. Feedback from those who have participated stressed the importance of this team building activity as a positive force to enhance communications on their perinatal unit. Feedback also included positive responses in that it was the first time that there was an opportunity to practice the mental process of constructing conversations about common important occurrences in the perinatal setting. Finally, as there is evidence that disruptive and intimidating behavior increases the chance for errors in obstetrics (Veltman, 2006), there was a positive response to addressing this issue from the participating individuals.

A final question regarding the importance of such an activity is: can this format and the approach to improving communication work to change the culture of a perinatal

unit? Given that it takes many years to change culture in an organization, preliminary results show that it may be possible. In a recent 6-month follow up questionnaire given after a P.U.R.E. Conversations program in a community hospital, the following results were obtained:

- 81% felt that they used the principles of P.U.R.E. Conversations in their daily practice.
- 83% felt that communications were improved on their perinatal unit.
- 69% felt that the unit had hardwired P.U.R.E. Conversations and the culture of the unit had changed.
- 61% felt that the changes in communication practices were permanent rather than temporary.

Some verbatims from the 6-month follow-up included:

- "Positive influence. First time all of our OB providers and almost all of the L and D nurses were in the same room, learning the same concerns and standards and expectations."
- "In an emergency situation, I felt we had good P.U.R.E. communication between the MD and nurses and nursing supervisor. This really helped keep everybody calm and on the same page, and we were able to manage the problem effectively."
- "It aided in the ability to have MD come quickly to unit to further assess FHR decels leading to decision for emergent c-section to be done for fetal intolerance of labor with Apgars outcome 7 and 9."

Finally, this was not all perfect. There is still work to be done. This is evidenced by the following verbatims from participants when asked what still needs to be done to improve communications on the unit:

- "The most important factor I've noticed on the unit in regards to communication is the intimidation of some staff, causing them to not communicate clearly. I don't have any idea how to fix that."
- "I don't really feel that …(all)… were on board with P.U.R.E. – it needs both parts of the relationship engaged to work."

What is clear from multiple sources is that communication failures are a major component of many obstetric adverse outcomes. Structured communications help to eliminate communication mishaps, and tools to enhance structured communication should be a part of the training of obstetrical teams. Developing additional tools to insure that conversations are appropriate and take into account context and relationships should be an important contributor to patient safety in obstetrics. PSQH

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