Fostering Effective Communication between Health Care Providers and Patients

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Communicating with Obstetrics Patients
When the Unexpected Occurs:
A Multi-Disciplinary, Multi-Level Program

Raymond Sandler, MD
Loraine O’Neill, RN
Mount Sinai Hospital
• Describe the various working styles
• Define concept of active listening
• Introduce “Crucial Conversations” key concepts
Working Styles
Active Listening
What Second Victims Want

“In their own words” from research from University of Missouri Health System
Crucial Conversation

Three factors present:

• Varying opinions
• High stakes
• High emotions
What Do Patients/Families Want Following an Adverse Event?

- Transparent communication in real time
- An acknowledgment or an apology
- Organizational response to prevent recurrence
- Support
Building Rapport Through Disclosure

- Style Awareness
- Share Information
- Crucial Conversation
- Active Listening
Communicating “Safe Facts – Known” during consent process
Possibility of adverse event discussed:

- Inadvertentotomy
- Shoulder dystocia
- Hemorrhage

Who: Conducted by primary provider
How: After HUDDLE
When: As soon as is feasible
Documentation: Just the facts and timeline
Communicating “Facts Unknown”:
- Did not discuss possible risks
- Unpredictable event
- Temperature

Who: Conducted by primary physician and designated trained member (EI officer)

How: After HUDDLE and consultation with risk/attorney

When: As soon as is feasible

Documentation: Just the facts and timeline
Communicating to family severe adverse event:

- Stroke
- Demise, infant/maternal
- Temperature

Who: Conducted by primary physician, senior leadership/trained member (EI Officer)

How: After HUDDLE and consultation with Risk/Attorney

When: As soon as is feasible

Documentation: Just the facts and timeline
Patient Communication Process

Event: Huddle

Patient Harm?

Yes → Investigation

Level I → Patient advanced Communication

Level II → No ENHANCED communication

Level III → Process improvement

No → Event reported to risk management

Advanced communication
Bibliography


Shared Decision Making in Obstetrics: Informed Consent for the Pregnant Patient

Michael R. Berman, MD
Mount Sinai Beth Israel
A Definition—Shared Decision Making (SDM)

SDM in general…

…Belief that patients have a fundamental right to understand all the medical options and the right to participate fully with their providers.

…involves *directive counseling* using available data.

…is a process to improve knowledge of the benefits and risks of maternity care options and to increase consumer and provider engagement.

…serves as a *tool* and *catalyst* that promotes more appropriate high-quality care by providing thorough, evidence-based information.

…provides options that women can access and use throughout pregnancy, labor, and delivery.

—*Adopted from Berkeley Center for Health Technology*
A Definition – Doctrine of Informed Consent

Protects patients’ right to *voluntary consent or refusal* of any medical treatment, procedure, or intervention based on information regarding the *risks, benefits, and alternatives of care.*

This includes the *provision of sufficient, evidence-based information* to make a decision that reflects *self-determination, autonomy, control*¹

“…it presupposes knowledge about and understanding of all the available options.”²

¹Cahill, 1998; Cook & Dickens, 2001; Coy, 1989; Guadagnoli & Ward, 1998
²ACOG Committee on Ethics
Patient consent or refusal is more than a legal doctrine to obtain a patient’s signature…

…it is a process of information exchange and involvement of patients in decision making.

**INFORMED CONSENT REQUIRES**

**DIALOG and COMMUNICATION**

**IN A MILIEU OF TRUST**
Birth Plan
“I do not want any intervention…”

Post-Dates (Late-Term)
“I want to go into labor myself…I do not want to be induced…”

Elective C-Section
“I want the ultimate intervention”

Elective Induction
“I am tired of being pregnant…I want to be induced…”

Education
IC
SDM
Trust
Provide Education

Provide practitioners with evidenced-based decision support systems and paradigms to *present to* and *educate* patients as part of prenatal care in collaboration with hospitals, health systems, state Medicaid programs, ACOG (directive counseling)

Foster Dialog/Communication

Follow Doctrine of Informed Consent

- Provide sufficient, evidence-based information to make a decision that reflects *self-determination, autonomy, control.*
- Understand that consent or refusal is more than a legal doctrine to obtain a patient’s signature…it is a process of *information exchange.*
1. **Implementation of a tool for practitioners to use and discuss with patients regarding all scheduled deliveries**
   - Developed a software program to provide **hard stops** and **decision support** for all scheduled inductions of labors and cesarean sections
   - Compels and enables an opportunity for discussions between providers and patients about timing of deliveries, trials of labor, versions, etc.

2. **Creation of a separate informed consent/informational form for a Non-indicated/ Patient Choice C-section**
Conclusion: Shared Decision Making/Informed Consent

- Every pregnant woman has the right to base her maternity care decisions on accurate, up-to-date, comprehensible information
- To participate fully with providers in the process of discussing options
- Informed consent must be must use language that is understandable to the patient and provide evidence-based research
- SDM will be maximized in an environment of trust (time)

–Adopted from Journal of Perinatal Education Winter 2009, Volume 18, Number

Shared Decision Making in obstetrics must ensure:

“…a decision that respects both the patient's autonomy and the physician's obligation to optimize the health of both the mother and the newborn”

–Kalish, Chervenak, et al.
Engaging and Educating Obese Surgical Patients to Achieve Informed Consent

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Engaging and Educating Obese Surgical Patients to Achieve Informed Consent

Goal:
To evaluate and communicate the risk of surgery for obese patients

Target Audience:
- Surgeons, anesthesiologists, internists, medical subspecialists, nursing, hospital support service
- Patients and families
## Management of the Obese Patient: Surgical Risk

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Engaging and Educating Obese Surgical Patients to Achieve Informed Consent

Preoperative
1. Preop evaluation must include a checklist (the checklist ideally is completed in a preop clinic, but in any case must be on the patient's chart prior to surgery) with the following:
   - Supplemental informed consent document for obese patients
   - Preop medical assessment form (PMAP)
   - Anesthesia assessment completed by an anesthesia provider (attending, resident, CRNA) that includes sleep apnea assessment and a plan for intraop and postop anesthesia management
   - For patients on CPAP:
     - The patient has brought the machine to the hospital
     - There is a hospital CPAP machine available
     - There is a note in the preop medical evaluation stating that it is not needed

2. Consider discharge planning needs to facilitate discharge (see discharge requirements)

3. Nursing admission assessment:
   - Document BMI
   - Triggers nutritional assessment to initiate education on healthy eating habits either during the postop hospital stay or after discharge
   - Includes patient-specific mobility abilities
   - Skin care assessment

4. Before incision:
   - Antibiotic administration consistent with SCP protocols with appropriate dose based on patient's weight
   - DVT prophylaxis
     - Sequential compression stockings (large or extra-large) or foot pad
     - Chem prophylaxis with appropriate dose and frequency
     - Document rationale for not providing prophylaxis

Intraoperative
1. One attending and one other experienced anesthesia provider (attending, an anesthesia resident with floor intubation credentialing, or CRNA) required for intubation

2. Anesthesia staffing for extubation to be determined by intubating attending depending on ease of intubation and consideration of intraop events

3. Readily available difficult airway cart and/or advanced airway technology

4. Appropriate size:
   - OR statues (including foot plates, padding)
   - Gowns
   - Large B/P cuffs
   - Long instruments, trocar available if needed

5. Yearly nursing in-service on pre-op care of the obese patient to include precautions for development of paraneurogenic and pressure sores

Best Practices for the Obese Surgical Patient (Triggers at BMI ≥40)

Postoperative
1. Anesthesia attending will determine and then document a treatment plan consistent with events in the OR and ICU; and other assessment findings when discharging/transferring patients from the ICU. These recommendations should be communicated directly to the surgical team.

2. Patients who have been on CPAP prior to surgery should have CPAP machine available until discharge, unless there is documentation that they no longer require it or it is contraindicated

3. Availability of pain management protocol for the obese surgical patient

4. Nutritional assessment in the postop period either during the hospital stay or after discharge to provide education on maintaining a healthy diet and handouts to take home

5. Nursing postop admission assessment to include baseline mobility abilities

6. Availability of:
   - Bariatric beds
   - Bariatric gowns
   - Bariatric wheelchairs
   - Bariatric room chairs
   - Bariatric stretchers

Best Practices for the Obese Surgical Patient – page 1/2
Effective January 2014

Best Practices for the Obese Surgical Patient – page 2/2
Effective January 2014
Each point guides the surgical team to identify and explain the unique risks for obese patients.

The patient’s initials and signature memorialize the conversation and their understanding of the risks.
Engaging and Educating Obese Surgical Patients to Achieve Informed Consent

Early Outcomes/Comments:

• Surgeons
• Anesthesia
• Nursing
• Patients
Communication Strategies to Achieve Improved Outcomes with Obese Surgical Patients

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Challenges in the Management of Patients with BMI >40

The high-BMI surgical patient has unique medical, physical, and social service needs when compared with the low-BMI patient

• **Medical problems:**
  – Diabetes
  – Obstructive sleep apnea
  – Coronary artery disease
  – Risk for thromboembolic disease
  – Skin and soft tissue infection

• **Physical:**
  – Mobility challenges
  – Pressure ulcers

• **Social service and post-discharge needs:**
  – Homebound
  – Nutritional requirements and counseling

• **Caregiver support**
To achieve optimal care, all of these constituencies must communicate with each other and the patient in a CONSISTENT fashion.
Complexity of Care for High-BMI Patients: Consistent Education/Information from All Providers

Preoperative Medical Evaluation

OR Nursing
(Instruments, OR bed)

Anesthesia
(Antibiotic/DVT dosing, pain plan, intubation cart)

Surgeon

Nursing
(Coordinate care, assess mobility, ambulation, patient/family education, determine safe discharge)

Respiratory Therapy
(CPAP/BIPAP, ET-CO2 monitoring, Pulmonary Toilet)

Environmental Services
(Size appropriate beds, gowns, chairs, lifts)

Consults:
Nutrition
Pulmonary
Rehab
Continuum of Consistent Care and Expectations

• Develop reasonable “best practices”
  – Educate each of the care providers with supporting evidence

• Discuss the plan of care with patient and family
  – Emphasize the rationale for intensified evaluation and therapy
    (risks, pain management alternatives, multiple providers,
    need for increased monitoring)

• Create reasonable expectations based on best practices
  – Reduce potential discrimination from caregivers due to high BMI
  – Program is for “BMI > 40” rather than “Obesity Program”

• Implement sensitivity training for staff specific to high-BMI patients
Best Practices and Communication

• Consistent care planning across all disciplines engenders trust leading to better outcomes, patient satisfaction, and active participation in their own care.

• Reinforce the consistent plan of care and patient education along the continuum (office, pre-admission, OR, PACU, in-patient, discharge).

• Electronic health record (EHR) and computerized provider order entry (CPOE) prompting best practice leads to consistent discussions with high BMI patients across the continuum.

• Encourage face-to-face handoffs and include patient in these processes (OR to PACU, PACU to unit).
Establish Best Practices

Provide consistent communication with patients and family members

- Education of providers
- Establish patient expectations
- Discuss rationale for all aspects of care with patient preoperatively
  - Avoid inconsistencies in care plans across various disciplines
  - Provide EHR and CPOE support for best practices
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