WR P EM
Wellness Resilience and Performance

Communication Learner guide

Learning objectives:

- Discuss why effective communication is paramount in the ED
- Identify the types of communicators in the room
- Describe the barriers to effective communication in the ED, based on the analysis of a few case studies provided
- Discuss solutions for improving communication, in a variety of situations. – "below ten thousand feet", closed loop communication, graded assertiveness, sign posting, effects of recency and primacy, use of silence
- Demonstrate using the above mentioned solutions in simulated situations

Case Studies for discussion

Case 1:

Anna is the registrar in charge of a night shift in a busy department. It is 0100am, Resus is full, there is one intubated patient waiting to go to ICU and there are 2 intoxicated patients from a motor vehicle accident who have just arrived. There are 2 patients with chest pain waiting to be seen in acute along with a few more patients who have been triaged as category 3's . The 2 eager interns are waiting patiently to discuss the patients they have seen. The Social worker gently reminds Anna for the 3rd time that the intubated patients family are waiting for her and the nursing team leader says the last bed in Acute is full and she really has to do a round and get some disposition plans sorted. As Anna walk to the computer a nurse from resus hands her an ECG to look at. As Anna is walking whilst looking her phone rings. Once off the phone she recommences the trip to the computer to do a round. The Intern asks her "can I send that patient with CP in bed 4 home, their troponin is normal and they look fine." Anna say in a short, slightly annoyed tone which is un-usual for her "just give me five minutes." The phone rings again and it's a family member of the patient intubated in resus. Anna snaps and says "I am just about to go and talk to all of your family and they can tell you what you need to know!" There is silence at the other end of the phone and then crying… Anna feels awful about snapping and begins to apologise. She is even more uncomfortable as she can see the looks of surprise on the faces of the nurse team leader and waiting intern.

a. What is making it difficult for Anna having a more appropriate response to the intern and the family member on the phone.
b. What can Anna do to rectify the situation.
c. If you are the other (more senior) registrar on and you hear from the nurse TL that this has happened how might you deal with it?

Case 2:

John is the one of the new SHOs' working in acute. He has just seen a 23-year-old male patient with acute onset of testicular pain. He is concerned about torsion and following a brief discussion with the consultant, he calls the Urology registrar to organize urgent exploration. The Urology registrar barks down the phone, "Why on earth are you calling before you get an ultrasound? That is basic ED care. What is wrong with you doctors in the ED? Why can't you deal with something so simple? Get the ultrasound and call me back." He hangs up. John is speechless! Ronan is one of the registrars in the ED that morning, and he notices John looking upset and asks why. Upon hearing, he is surprised as the Urology registrar is his best mate and this sounds very unusual for him. Ronan is concerned about his mate the Urology registrar as he is normally a very relaxed, friendly and easy going guy. He is more worried as he had noticed that his mate has been looking more tired than normal over the last few weeks and seemed to be on the phone lots.

a. What maybe happening that caused the urology registrar to behave that way?
b. What advice would you give John about dealing with this kind of interaction?

Learning points:

- Recognising the importance of trying to understand another person's perspective.
- Developing empathy and kindness towards colleagues.
- Building skills of persuasion and compromise.

Case 3:

George is the registrar in resus and he is looking forward to his shift. He is on with one of the consultants (James), whom he gets on well with, which is a bonus. He has never done a resus shift with him but is looking forward to seeing how it goes. Soon enough there is a call to say there is a male patient in status epilepticus who will be in the department in 5 minutes. Everyone starts to prepare and James allocates roles – he is going to team lead and he asks George "to take the airway". George is nervously excited as he has not done an anaesthetics term and is not overly confident with airway management, but he feels he can rise to the challenge and starts setting up. On arrival of the patient, who has stopped seizing, things go smoothly. However, he is post ictal and has some evidence of airway obstruction. The decision is made to intubate the patient. James seems concerned about the ongoing patient snoring and wants to crack on and intubate the patient. He says, "Come on guys. We need to intubate. Someone get some propofol and rocuronium stat." George quickly picks up the airway equipment. He can feel his heart rate start to rise and his palms start to sweat. James asks, "Come on. Are the drugs ready?", and no one replies. Finally, a nurse asks George, "So what doses of drug do you want?" George refers them to James. The patient starts to seize again and James appears stressed. He shouts "Midazolam stat now!!" There is a 5-minute delay and by the time the midazolam arrives, the patient has stopped seizing. Now the patients sats are persistently 89% despite the non-rebreather mask at 15L. James barks, "Come on George! Let's crack on and intubate. His sats are low." George asks, "Should I pre-oxygenate?" and James says, "No need for that. Just crack on!" George feels very uncomfortable.

a. What can James do better here?

Case 4:

Jane is a second year advanced trainee. She is excited because she has been given the opportunity to be the airway doctor in a resus situation. She is keen to practice the skills she had gained during a recent anaesthetic term. She sets up all the necessary equipment and discusses the plan with the team leader and the airway nurse. Everything seems to be set up for success. The only distraction is the amount of noise in the room. Jane wishes she could just call a time out and ask everyone to be quiet. The drugs had been given, but the team leader is now chatting to the anaesthetic consultant who has just arrived. A keen junior nurse runs in to the room with the VBG and asks if you want to see it because it "looks bad!"

Jane wants to focus on the actual intubation now and as she performs laryngoscopy, the consultant has moved to stand next to her, and asks, "Can you see the cords? What grade is it?"

What methods of communication can Jane use to optimize control of the situation?

Learning points:
Shared mental model and below ten thousand feet concepts

Communication Skills Practice – Role Play Cases

The Confederate role is to be role-played by the facilitator or can be delegated to another participant in the group with instruction to stick to the character and script

The Attendee role is given to one of the group's participants to respond to the situation and practice Communication skills further in a safe context

Case1

Case: Resus team is preparing for arrival of a critically unwell patient. The patient has had new onset seizures, 3 in total. They are febrile, tachycardic and hypotensive according to paramedics.

Confederate Role Player : Drugs nurse in resus. The facilitator can modify this to have a number of role players as different members of the resus team.

Attendee role : Resus team leader preparing the team for the arrival of a patient . They will be allocated the following tasks:

1. Allocate roles to the resus team explain to each team member what you would like them to prepare.
2. Provide a summary of what you are expecting and what you would anticipate may happen.

Case 2

Case: A 17-year-old man has been critically injured in a trail bike accident. The team has cared for him well and he has been transferred to the operating theatre.

Confederate Role Player: Parent of a 17yr old male patient who was brought to the ED after a trail bike accident. You know nothing else. Your child is normally fit and healthy.

Attendee Role: You have been caring for a 17yr old male who was brought to the ED with a GCS of 6 and a flail chest. He has been intubated, had a chest drain inserted. CT brain shows a large extradural haematoma with significant midline shift. He is in the operating theatre now having that decompressed. You are just about to speak to the patient's parent who has just arrived. Please explain the situation to the parent.

Case 3

Case: A 4-year-old child has fallen and broken her forearm. This needs reduction. The ED registrar has assessed and treated the child and referred them to the Orthopaedic registrar for Manipulation Under Anaesthetic (MUA) in theatre. The Orthopaedic registrar is attending the child in ED.

Confederate Role player: Orthopaedic registrar who is reviewing 4yr old female with an angulated fracture of both the distal ulnar and radius. The patient has a trauma slab in situ. The patient was referred to you with the view to going to theatre. However, you know the consultant on call for Ortho does not like operating on children and you don't want to upset him. So you feel you can very quickly manipulate the fracture in the ED and organize follow up in clinic with a view to delayed surgery as you have heard kids heal well and therefore there is unlikely to be much harm. When the ED registrar challenges you, you are defensive and decide to ignore her and carry on.

Attendee Role: ED registrar who has seen a 4yr old female with a significantly angulated fracture of both the distal ulna and radius, with mild associated paraesthesia in the median nerve distribution. You and your consultant felt she needed manipulation and fixation in theatre. You walk into the cubicle to find the orthopaedic registrar preparing to manipulate the arm with no sedation. How do you approach this?

Case 4

Case: A 2-year-old child has presented with their parents with Diabetic Ketoacidosis. This is the initial diagnosis of diabetes for this child. Initial appropriate treatment has been commenced.

Confederate Role player: Anxious parent of a 2yr old who has presented to the ED in DKA. She has not been diagnosed with diabetes before. You are very worried because your father died from the complications of diabetes. You wonder if the same will happen to your daughter. you are concerned she might die. You are keen to know everything about complications and how to avoid them. You disclose your concerns to the doctor, if given the opportunity and made to feel safe and listened to.

Attendee Role: You have been caring for a 2yr old who has presented to the ED in DKA. She has not been diagnosed with diabetes before. She is now stable and will be moving to the ward soon. Her BSL is now 12 down from 35, pH is now 7.31 improved from 7.01. Bicarbonate is 19 up from 10. K+ is normal. The patient has a GCS of 15. Mum is very anxious and has asked to speak to you. Speak to her and address her concerns.