When doctors and nurses become partners

Care is safer, better and more efficient

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Doctors and nurses traditionally have had very different approaches to their professions. Doctors have worked as independent practitioners while nurses have worked as part of nursing teams. In many hospitals, their contact is brief and hurried. The result in these settings has been parallel rather than collaborative care.

The July Snapshot profiles the fantastic journey taken by a recognised world leader in patient care and healthcare leadership – The Baptist Healthcare Group in the United States. Baptist Health was the first organisation to have all of its hospitals achieve Magnet recognition simultaneously. The Group also includes Baldrige Quality Award winners, the highest award for quality excellence.

One of the key factors in Baptist’s success is their approach to doctor-nurse collaboration.

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As doctors and nurses juggle constant demands, finding the time to collaborate may seem too much to overcome. Doctors say they can’t spend precious minutes seeking out a staff nurse. Nurses say they’re too busy with patient needs to round with doctors. Some fear being seen as the sidekick to a doctor rather than a professional in their own right. As nurses, particularly those with advanced credentials, seek to expand their scope of practice, some doctors are uncomfortable with a change from their simply carrying out doctors’ orders. In the most strained environments, doctors and nurses can move into separate camps that are mistrustful, casting the other in the least favourable light and focusing on why their own needs are being neglected. When nurses are afraid to call a doctor in the middle of the night or doctors fail to communicate critical information, the patient can be at risk.

Meanwhile, the evidence continues to mount that collaborative teamwork in the delivery of care plays a significant role in patient safety and providing high-quality care. That has been the experience at Baptist Health Group in the US, which scores at the 99th percentile for doctors’ perception of doctor-nursing collaboration as well as at the 99th percentile of the Press Ganey systems database for overall doctor partnership with its five hospitals. Baptist clearly has a track record worth examining. It is no coincidence that Baptist is a National Baldrige Quality Winner and has achieved Magnet status.

Supporting a culture of collaboration

Diane Raines, MSN, chief nursing officer of Baptist Health, has worked with the Baptist Organisation for her entire career. She says the group has a tradition of collegiality among caregivers. Today that emphasis on collaborative culture is actively promoted by the organisation’s Group CEO, Hugh Green, who is described by Raines as a believer in doctor partnership and a vocal advocate for nursing. This belief in the value of relationships extends from the organisation’s board of directors to each individual hospital’s leadership. The culture is so ingrained, Raines says, that, “If you’re not collaborative by nature, it’s hard to fit in here.”

The theme is echoed by Jerry Bridgham, MD, chief medical officer of Baptist’s Wolfson Children’s Hospital. “We try to emphasise developing a relationship with those you work with. We are not heavy on hierarchy in interactions between doctors and nurses,” he says.

“We put a lot of value in having people in leadership positions where they foster those relationships. We try to make it so that there’s no distinction between doctor and nursing leadership, but a collaborative relationship.

We try to avoid where the doctors work in one silo and nurses in another.” One of the reasons Baptist’s leaders are so committed to collaboration is because they see it as a patient safety issue. There is a strong belief that if competent, collaborative doctors and nurses are working together, the patient is safer. There are also payoffs in efficiency and the work atmosphere. “It’s not a perfect environment, but we’re all committed to making it better,” Raines says. “We want it to be a safer and more pleasant environment to work in.” Another driver is that Baptist views this partnership as integral to delivering patient-centred care.

As with most successful health care initiatives, this commitment starts at the top at Baptist. Senior leadership intentionally models collaboration with the organisation’s CEO, CMO and CNO making regular rounds together. “To get out of the silo, you need to find common ground; that common ground is quality care. If you agree on that, you look for what are the barriers,” Raines says. Raines also describes the structures and processes that need to be in place to facilitate collaboration, starting with codes of conduct for all so that it’s clear what kind of behaviour is expected or not acceptable.

Supporting these behavioural expectations is unambiguous communication of how to report that a doctor or nurse isn’t respectful. Bridgham says, “We address aberrant behaviours quickly. I try to maintain a strong relationship with the medical staff leadership so that everybody has the same understanding of what we’re looking for.” Key protocols have been developed for such potential hot-button issues as contacting a doctor in the middle of the night. Before calling, a nurse gets confirmation from a supervisor or mentor that he or she has all the information needed for the call, which ensures full preparation. The nurse is trained to use SBAR (Situation-Background-Assessment-Recommendation), a structured and efficient communication tool. The doctor isn’t awakened without valid reasons and the nurse has all the information the doctor needs to make treatment decisions, including acting on the nurse’s recommendations. Other collaborative structures Baptist Health has put in place include admitting orders that meet the needs of both doctors and nurses and encouraging joint rounding whenever possible. Bridgham also sees Baptist's low turnover, particularly in nursing, as another facilitator of collaboration. “Having lower turnover equates to opportunities for better relationships between nursing staff and doctors. There is also an improved knowledge base and higher quality.”
Where to start

In recent years, Baptist turned its focus first to continuing to improve bedside nursing. Nursing leaders emphasised enhanced competency and education for nurses through multiple approaches. One successful program involved bringing doctors into “lunch and learn” educational sessions. The personal contacts, as well as the learning experience of these sessions, paid off. Beginning to pursue the standards of excellence inherent in the Magnet Recognition Program further supported the enhancement of nursing skills. Raines believes that nurses must be perceived as skilled and knowledgeable by doctors to increase their interest in collaboration. Bridgham notes that at Wolfson Children’s, developing collaborative relationships has been dependent on two factors:

- Doctors who recognise that nurses are an essential part of the whole team in delivering care, and
- Acknowledging that we have superb nursing staff.

Carolyn Johnson, DNP, Wolfson’s vice president of Patient Care Services, says, “Children’s is a Magnet hospital, and part of that is our emphasis on education. We are strong in encouraging nursing staff to go back to school, and to continue to learn. We are trying to improve the competency of the nurse and, obviously, the value of what the nurse has to say.” When Raines began in her role as the Baptist group CNO, she not only spent time with nursing leadership, she also began meeting with doctors. She says, “I asked what they wanted from us; not what we wanted from them. Then when we went back, there was more openness on their part to hear what we needed from them. Someone has to move from the stand-off. Someone has to say, ‘I’m going to put the needs of the patient ahead of my own issues.’ ” Keith Stein, MD, chief medical officer of Baptist Health, invited Raines to medical staff meetings and to speak at their annual doctor retreat. Reciprocally, Stein sits on various Magnet committees.

Baptist Health began surveying its doctors in 2008. Stein explains: “The doctor satisfaction survey is a tool we’ve used to evaluate the effectiveness of our relationship management and our collaborative efforts.” In its most recent Press Ganey Doctor Survey, Baptist took the initiative of having the senior nursing leader, as well as the CEO and doctor leader, at each hospital sign the cover letter inviting participation. Moreover, nursing leaders are fully involved in action planning to improve doctor satisfaction and engagement. "Probably half the questions on a doctor survey come back to nursing in some way," Johnson says. "When we got the previous data, we worked on the issues together to make things better. When I get the nursing surveys back with potential doctor issues, we also address those together."

Collaborative rounding

A multi-disciplinary approach is used throughout Baptist Health hospitals, whether it’s looking at improving quality, patient outcomes, core measures or operational performance. Its hallmark is multidisciplinary rounding on patients that may include the doctor, nurse, pharmacist, respiratory therapist and other professionals. At Wolfson, the rounding may also include parents and paediatric residents. Major benefits include each member of the team hearing the perspective of others providing care, ensuring that there is consistency and being able to fully answer patient questions. Pharmacists are assigned to units so they are part of the clinical environment and directly evaluate patients. Although not all doctors round with nurses across Baptist, the strong emphasis has led to more than half of patients receiving joint rounding.

"Communication is the key,” Stein says. “Rounding together is an effective methodology, but certainly not the only one. There are many different ways of supporting effective communication between clinical providers. For example, the electronic medical record allows more people to instantaneously access the documentation that others have provided. So rather than interrupting a nurse who’s busy with a patient, the doctor might read the nurses’ note from earlier that day.”
Bridgham describes the breadth of the multi-disciplinary emphasis. “Every significant clinical arena in our hospital has a steering committee. The emergency department, oncology, PICU, the OR – all have steering committees. You put in place a structure where doctors, nurses and ancillary staff are in the same room at the same time to discuss topics of importance to them.” Steering committee meetings are carefully scheduled to be convenient for doctors and are tightly managed to efficiently address issues. Patient satisfaction scores, quality measures, operational performance improvement, patient safety and infection control are all addressed in the forums. Johnson describes the steering committees at Wolfson as determining how its units work. “It’s not done in a silo. The medical staff leaders in those areas are very much involved in developing practice on the units.” The multi-disciplinary groups have been in existence for an unusually long time – more than 15 years. Started originally in the ICU, the success achieved there resulted in expansion to all areas of the hospital. Johnson points to the following examples:

- The steering committee functions in oncology to address such issues as keeping patients in school while they receive care. It addresses the continuum of care, including both inpatient and outpatient services.

- They moved patients with tracheotomies to medical/surgical floors where previously they’d been cared for exclusively in the ICU.

- The PICU and medical floor steering committees worked jointly to develop the policies for placing care-improved patients on the floor.

All these examples involved doctors, nurses and respiratory therapists working collaboratively allowing Baptist to expand the kind of care they provide on the floors and do it in a safe fashion. It helps the patients because before they couldn’t enjoy the amenities and privacy of the floor. “Unlike many hospitals, there is no segregation of patient notes in Baptist Health medical records. Johnson explains, "We’ve always worked very strongly in an inter-disciplinary approach – rounding, discharge planning and so on. We don’t have nurses’ notes, PT notes, doctor notes. We have the notes integrated together.” Nurses are encouraged to “practice to the upper capability of their registration” which results in greater service to patients and significant value to doctors.

Magnet status enhances collaboration

Baptist Health was the first organisation in the United States to have all of its hospitals achieve Magnet recognition simultaneously. As Raines began to lead that initiative, a doctor asked to meet with her. He said that in his experience hospitals seeking Magnet recognition had the potential to either bring doctors in or to use it to drive doctors away while making it “all about nursing.” He urged the collaborative path, and Raines says she took his advice to heart.

“If you make Magnet all about nurses, advocating only for nurses, I think you can disenfranchise not only doctors, but other team members as well, like pharmacy,”

Raines says. “You can include everybody or exclude everybody. Because we have such a strong relational environment, we chose to include others,” says Raines.

The result was that doctors got on board to support Magnet recognition as they saw the improvements it brought to nursing. When nurses were first surveyed on their satisfaction as part of the Magnet recognition application process, some of the doctor groups did not achieve the same results as others. The findings were shared with doctors and had particular impact on the lowest scoring groups. Given the competitive nature of most doctors, it’s not surprising that they were willing to work in joint nurse-doctor task forces to address the issues that emerged. Considerable doctor effort went into improving the nursing satisfaction scores and the nursing relationship. Bridgham believes that as doctors have seen the improvements in nursing associated with the Magnet journey, they have become strong supporters. Doctors saw that Magnet recognition goals such as a higher percentage of bachelor’s and master’s degree nurses and national certifications improved the overall level of quality of nursing. That in turn translated into the care provided to their patients. Nursing unit councils became places that addressed doctor concerns about care.
Spirit of Magnet doctor award

Two years ago, nursing leaders at Baptist took an unusual step – they decided to recognise doctors who had done the most to be their partners in living the ideals of Magnet at their hospitals. Nurses are invited to nominate doctors they feel exemplify the “Spirit of Magnet” – compassion for patients and families, good collaborators, excellent educators and doctors who practice evidence-based medicine. The winners are selected by nursing leaders, shared governance chairs and other nurses at each hospital. The award is announced at the medical executive boards as well as throughout the hospital. Doctors who have received the award describe it as having tremendous importance to them.

Every doctor who is nominated receives a personal letter describing why he or she was nominated and expressing appreciation for modeling the Spirit of Magnet. The result has been a clear strengthening of the doctor-nurse bond in every hospital.

Using collaboration to enhance safety

As in most hospitals these days, sicker patients often involve multiple doctors in care. That adds complexity to patient management as not all doctors may be fully aware of the totality of the care being delivered. At Baptist, the nurse is often a coordinator and communicator of the patient’s treatment. Raines gives an example of an ICU nurse who intervened when a patient was about to be discharged by one of several doctors involved in care. When another doctor then reviewed the pathology with her, he indicated the patient should absolutely not be discharged. It’s that type of communication she cites as critical for patient safety and higher quality care. In this instance, the nurse not only advocated for the patient, she collaborated with the doctors for better care. Raines says that when the doctor-nurse relationship is built on respect and trust, even difficult conversations when something has gone wrong are possible.

Electronic health record (EHR) implementation is revolutionising patient care around the country and inherent in that are patient safety ramifications. A parallel concern is efficiency, or lack thereof, for doctors, nurses and other users of the EHR. This is another arena where Baptist Health has set up teams made up of doctors, service line leaders and nursing staff. It works jointly with the software vendor as design overseers.

Attracting and keeping the best

As hospitals compete to attract and retain both nurses and doctors, the Baptist Health model of affirming professional relationships offers considerable insight. Built on a culture that emphasises competency and connection as well as inclusion rather than exclusion, those who work at Baptist Health consistently describe shared goals and truly patient-centred care. Stein’s counsel to others seeking to foster more collaboration is this: “It’s often less about the structure. It’s about relationships, mutual respect and trust. If doctors and nurses have that, together they will work to break down the silos. Doctors and nurses all have the same deep commitment to great patient care. Once you achieve trust, everything is possible. I feel very fortunate to be at a place where that is the value system. I look forward to going to work every day.”
checklist for DR/RN collaboration

✓ CEO and doctor and nursing leaders must align expectations of collaboration, nursing excellence and doctor partnerships.

✓ Start with nursing excellence and nursing satisfaction issues.

✓ Emphasise that the patient’s care, safety and quality are bettered by collaboration.

✓ Promote a culture of collaboration based on mutual respect and listening.

✓ Write it into the doctor and staff codes of conduct, including how to handle violations.

✓ Train nurses on SBAR communication to doctors.

✓ Craft admitting orders that work for both doctors and nurses.

✓ Develop protocols for middle-of-the-night doctor calls.

✓ Establish joint DR/RN rounding with mutual discussions of patients.

✓ Create multidisciplinary teams to design EHRs.

✓ Ask what the other needs to perform well.

✓ Celebrate wins and reward/recognise without restraint.

Source: Press Ganey Associates