# Improving Registered Nurse (RN) Medical Doctors(MD) Communication

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**BACKGROUND**: Ineffective physician-nurse collaboration has been shown to cause job dissatisfaction, high turnover, and patient safety and above all affect the quality of care received by patients. Our unit admits high acuity and complex patients, from five different services (Internal medicine, Infectious disease, Allergy/Immunology and Dermatology). In 2010, as part of the National Database of Nursing Quality Indicator (NDNQI) survey, we found that our RN-MD interaction when benchmarked with the national average was at the 10th percentile. In 2011, the survey results were even worst, this time it was below the 10th percentile. As part of our continuous improvement program, we decide to improve this problem

**AIM:** To improve the communication between multinational nurses and Arabic speaking physician, in order to continue to provide the highest level of care to our patients.

**METHODOLGY**: The Model we used was the PDCA approach. We organized focused groups among the multi-national nurses and discussed at length what were the barriers they felt in communicating with the Arabic speaking physicians. We itemized the problems and together we came up with possible solutions. Another focused group was held with the Arabic speaking physicians to discuss at length what they felt was the major barriers to communication. We also came up with problems and possible solutions. We then went back and compared all the problems from each group, analyzing and looking for common themes. We identified the major issues which include:

- Ineffective communication between the physicians and the nurse
- Language and cultural barriers between the multi-national nurses (females) and Arabic speaking physicians
- Nurses been unable to attend patient rounds with physicians because of heavy workload and high acuity patients
- Staff shortage both on the physician and nurses side
- Frequent rotation of junior residents and lack of proper orientation to the unit/system
- Launching of a new Information system by the organization
- Physicians entering STAT orders, changing orders and discharge orders without informing the primary/charge nurse.
- Non-compliance with discharge orders as per the Internal Policies and Procedures
- Inadequate number of on call physicians after working hours and on weekends
- Lack of appropriate sign out of sick patients to the on call team

**INTERVENTION:** Having identified the major issues, a Unit Based Collaborative strategy was developed:

- Which included a welcome breakfast and orientation, every month to introduce the new physicians to the unit's scope of service, expectations and routine activities in the unit? During this breakfast meeting physicians and nurse interacted and discussed what they were expecting from each other, especially how to improve quality of care given to our patients and patient safety.
- A charge nurse was assigned to each team on the floors every day and concerns about patient overnight was communicated immediately physicians come in the morning.
- A problem list sheet was formulated where nurses working during the night shifts could communicate with the physicians in the morning about issues relating to their patients.
- The charge nurse of a daily basis updated the physician on call list on the notice board for nurses to know who the covering physician was his/her pager / mobiles was displayed visibly at all times.
- The Head Nurse of the unit requested administration to add more staff to the unit as the acuity and complexity of the patients admitted to the unit was higher compared with past years.
- On the physician side additional physicians were requested as the complexity and acuity of the patients admitted to the unit increased.
- The physician number increased from three physicians to ten physicians. The section head at the time divided the physicians into two teams which consisted of five physicians to cover 17 very sick patients each.
- Monthly unit based collaborative meeting was established with both the physicians and nurses to discuss potential issues before they became problems.
- A physician on call schedule, pager numbers and phone numbers were displayed in strategic areas in the unit and if there were any changes this was communicated immediately to the charge nurses.

**RESULTS:** The Registered Nurse (RN) - Physicians interaction result in RN satisfaction survey, went up from a below the 10th percentile in 2011 to 90th percentile, in 2013 (see tables below).

- The Physicians expressed satisfaction in their work with the nurses in the unit. There were fewer problems at night as the physicians at the day time renewed medications and dealt with all the problems that needed to be addressed during the day.
- The staffing improved, nurse patient ratio during the day time became 1:3, and 1:4 at night time.
- The nurse turnover reduced.
- The collaborative meeting was scheduled on a monthly basis between the head nurse, assistant heard nurse, chief resident, sections heads of all the departments that admitted patients to the unit and the chairman. Issues that could become potential problems were dealt with before they became a problem.
- Improved team work on both sides' best residents were identified each month and recognized by the Head nurse and an appreciation letter sent to the Chairman's office. On the physician side, each year an outstanding nurse was selected and honored at the Physician recognition day.
- Patient satisfaction on the unit went up from 50% to 90%.
- Several patient indicators where in their all-time highs, incidents of falls decreased, documentation improved, and most importantly the incidence of unit acquired Pressure Ulcers (UAPU went from 11% to zero percent Pressure ulcers on the unit have consistently been 0% for the last 3 years.

| | Adapted Index of Work Satisfaction T-Scores | | | | |
|---|---|---|---|---|---|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| **OMN: F1 - Medicine Unit** | | | | | |
| **Tasks** | n.d. | 45.63 | 34.82 | 61.10 | 57.30 |
| **RN-RN Interactions** | n.d. | 65.84 | 59.83 | 75.13 | 75.96 |
| **RN-MD Interactions** | n.d. | 53.86 | 46.50 | 62.45 | 68.98 |
| **Decision Making** | n.d. | 48.29 | 39.08 | 55.92 | 61.85 |
| **Automony** | n.d. | 42.62 | 33.92 | 55.80 | 57.49 |
| **Professional Status** | n.d. | 59.59 | 53.12 | 67.84 | 75.82 |
| **Pay** | n.d. | 38.06 | 30.40 | 35.67 | 37.98 |

<40 = low satisfaction 40-60 = moderate satisfaction >60 = high satisfaction

| | Adapted Nursing Work Index T-Scores | | | | |
|---|---|---|---|---|---|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| **OMN: F1 - Medicine Unit** | | | | | |
| **Professional Development** | n.d. | 66.20 | 59.82 | 69.95 | 77.97 |
| **Nursing Management** | n.d. | 63.32 | 57.71 | 68.40 | 68.39 |
| **Nursing Administration** | n.d. | 56.55 | 42.23 | 51.58 | 67.46 |

<40 = low satisfaction 40-60 = moderate satisfaction >60 = high satisfaction

| | Tasks | RN-RN Interactions* | RN-MD Interactions* | Decision-making | Autonomy* | Professional Status* |
|---|---|---|---|---|---|---|
| | < 40 = low satisfaction, 40-60 = moderate satisfaction, > 60 = high satisfaction | | | | | |
| **Adult Medical** | | | | | | |
| OMN: F1 - Medicine | 57.30 | 75.96 | 68.98 | 61.85 | 57.49 | 75.82 |
| *Hospital Adult Medical Median* | *54.77* | *75.59* | *68.76* | *59.41* | *55.04* | *74.12* |

| | NDNQI-Adapted Index of Work Satisfaction Scale T-Score *Excluded from Short Form | | | | | |
|---|---|---|---|---|---|---|
| | Tasks | RN-RN Interactions* | RN-MD Interactions* | Decision-making | Autonomy* | Professional Status* |
| | < 40 = low satisfaction, 40-60 = moderate satisfaction, > 60 = high satisfaction | | | | | |
| **National Comparative Information - Non-Magnet Facility** | | | | | | |
| Mean | 44.27 | 71.42 | 59.80 | 49.48 | 52.75 | 66.06 |
| S.D. | 7.02 | 6.55 | 5.81 | 8.36 | 6.82 | 7.84 |
| 10th Percentile | 35.10 | 61.47 | 50.73 | 39.21 | 42.52 | 54.41 |
| 25th Percentile | 39.21 | 67.40 | 56.63 | 43.47 | 47.92 | 60.79 |
| 50th Percentile (median) | 43.73 | 71.33 | 59.51 | 49.36 | 51.99 | 67.10 |
| 75th Percentile | 49.18 | 76.33 | 63.63 | 55.68 | 58.69 | 71.40 |
| 90th Percentile | 53.43 | 80.08 | 68.26 | 59.12 | 62.22 | 75.37 |
| # of Units² | 99 | 76 | 76 | 99 | 76 | 76 |

**CONCLUSION:** Improvement in Physician-Nurse communication can lead to less turnover, job satisfaction and improve patient care. Health care organizations should endeavor to develop educational programs that will improve collaboration and communication between physicians-nurses.

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