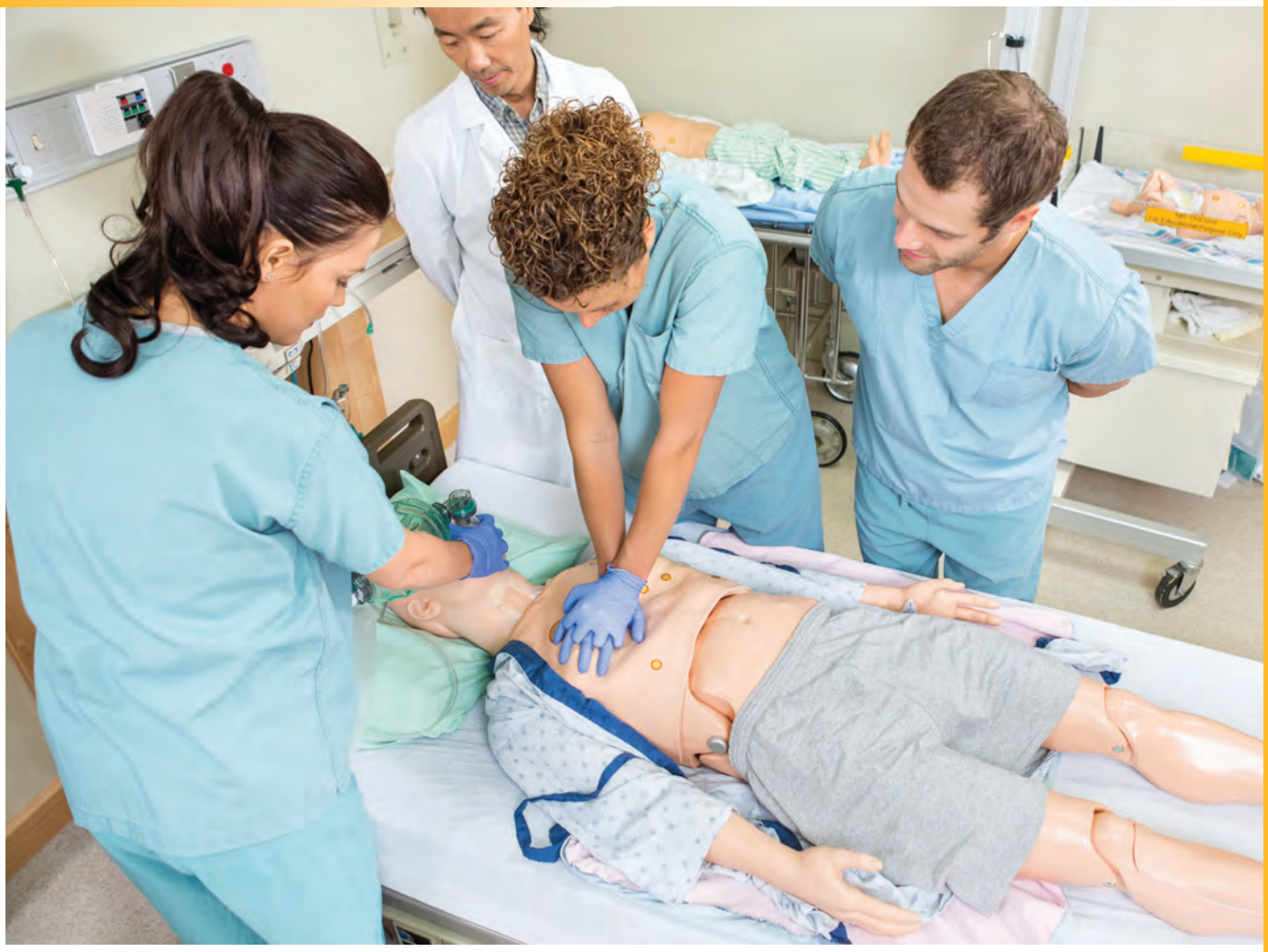

Patient-centered simulations can strengthen collegial relationships

"Breakthrough" projects help providers and nurses confront difficult issues together.

By Sarah Clark, MSN, RN, CCRN, CHSE

A few years ago, when Cone Health (based in Greensboro, North Carolina) decided to strive for top-decile health-system status by 2015, work began on changing the culture to match leadership's values. One of our seven breakthrough projects (those with the potential to fundamentally shift how we deliver patient care) targeted our four emergency departments (EDs). The mission was described as "transforming emergency care, easing suffering, performing acts of kindness, and healing one patient, one family at a time."

Five of Cone Health's six hospitals have achieved Magnet® recognition. The sixth hospital merged with the health system in 2015 and will begin the Journey to Magnet Excellence® in 2016. Cone Health employs more than 3,000 inpatient nurses; 73.9% are baccalaureate prepared or higher. Also, 37.3% of our nurses hold one or more professional certifications, exceeding the system's goal of 32.3%.

Initial staff resistance

When our ED breakthrough project began in 2012, staff resisted the change. At the time, the ED culture was defined by mistrust between providers and nurses and distrust of leadership. Staff reactions to the breakthrough project ranged from,

"We're not ready for change" to "Only drug seekers get patient satisfaction surveys, so why bother?"

Keying in on simulations

Greg Berney, then manager of patient experience at Cone Health, began laying the foundation for change. He shadowed ED providers (EDPs) and began building relationships with providers and nurses. Conversations generated by his activities helped providers decide it was time for a change. They created a steering committee to lead the way. Berney invited me into the conversation.

Seeking innovative ways to build teamwork and improve communication, the committee identified simulation as a way to continue "conversations of possibilities," which start with imagining the possibilities and opportunities we wish to see in our work life. These goals help guide our actions to create desired outcomes.

The Triad Hospitalists medical group at Cone Health had used simulation successfully in the past to improve communication with patients and nurses. Sendil Krishnan, MD, a hospitalist, met with the EDP group to share lessons learned from Triad's simulations. He strongly recommended that simulations be interprofessional and include nurses. The hospitalists had found that including nurses strengthened their teamwork and communication with each other, as well as with patients and families.

Our ED nurses are familiar with simulations. At Cone Health, all new graduate nurses are placed in an academy program to learn their specialty. Many ED nurses are academy graduates and had participated in multiple simulation activities during orientation.

Participant truths

All simulations are conducted according to "participant truths"—a set of rules I wrote to guide participants' behaviors and create a safe environment free of judgment and criticism. All simulation activities are kept confidential, allowing participants to speak freely without fear of repercussions. Academy graduates evaluate simulations as a positive part of the academy experience.

Skills blitz

From 2012 to 2015, Cone Health's annual ED "skills blitz" included simulations with positive outcomes. In fiscal year 2014, all nurses participated in a code stroke simulation as part of the blitz. Subsequently, stroke documentation compliance rose from 47% to 100%. Also, door-to-needle times for tissue plasminogen activator administration decreased system-wide by 11 minutes. As a result, Cone Health lowered the door-to-needle goal to 45 minutes, well below the American Heart Association standard.

Choosing a simulation theme

In a series of meetings in July 2014, the steering committee chose a theme for simulations—"The most difficult conversations EPDs have on a regular basis." I developed scenarios based on actual clinical experiences and created role cards for participants that described what was happening in that person's day. For example, one scenario involved a patient with chronic back pain requesting magnetic resonance imaging of his back. His role card stated he was afraid he had bone cancer. The

> Hospitalists who include nurses in **simulations** strengthen their teamwork and communication with each other, as well as with patients and families.

EDP and nurse had no knowledge of his fear; their role cards stated the shift was busy and this patient and family had been demanding and unreasonable. In August 2014, the committee and ED nursing leaders piloted the simulations to ensure the roles were written effectively to guide discussion toward these difficult conversations.

Simulation sessions and debriefings

To provide simulations for all EDPs and nurses who volunteered to participate, 10 sessions were conducted; groups of 12 to 14 attended each one. Sessions ran over a 6-week period, starting in September 2014. A provider from the steering committee facilitated each session, making opening comments that set the session's context and reviewed the driving forces for the culture change at Cone Health. Berney led an icebreaker activity in which all participants named either the first or last musical concert they'd attended. This activity helped the group connect on a personal level.

After I explained the participant truths, Berney reviewed the patient satisfaction score process, confronting myths and misunderstandings about them. He described the percentile rankings as an Olympics 25-meter dash, where a mere second might separate the gold medal winner's time from the last-place time. Nurses and EDPs said this analogy really resonated with them. Using "conversations of possibilities" as a framework, Berney then led the group in a brief discussion of how their new understanding of the scoring process

might influence their interactions with patients and colleagues.

Next came the simulations. Four participants took part in each scenario; the rest of the group viewed the simulation on live video feed. Berney recorded their observations on a whiteboard. Each simulation session included four scenarios.

In participant debriefings after the scenarios, rich discussions took place. Each person's story was discovered, and EDPs and nurses shared their individual best practices for dealing with difficult situations. Facilitators noted that the same issues and concerns came up each time.

Nurses, providers, and nursing leaders discovered they had more in common than they had differences. One nurse commented, "I'm really glad we did the simulation about the patient wanting pain meds. I feel as if we're on the same page now." A provider stated, "I don't think some of the docs realized how they were being perceived. It was a real eye opener." Another nurse said, "This helped me understand that we want the same things for our patients."

Patient satisfaction scores soar

Three years into our ED breakthrough project, we've seen patient satisfaction scores rise from the 5th percentile in September 2012 to the 88th percentile in September 2015. The average improvement for a hospital's ED patient satisfaction scores is less than 0.5 percentile points per year; from September 2012 to September 2014, Cone Health's scores improved by 4.6 percentile points.

Simulations helped some participants understand that nurses and doctors want the same things for their patients.

Also, providers' job satisfaction increased by 58 percentile points. Nurses' job satisfaction also increased and nurses reported better working relationships with providers and increased trust between nurses and nursing leaders.

As we discovered, using simulation is an innovative approach for learning and confronting difficult issues between disciplines. At Cone Health, this approach helped staff significantly improve their work environment, personal job satisfaction, and patient-care delivery. ■

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