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# Long-Term Care Survey Alert

## STAFF DEVELOPEMENT: Get Physicians, Nurses On The Same PageIn Responding To Acute Care Needs

**Here's how to bridge the communication gap between docs, nurses.**

Nurses represent the physicians' eyes and ears in detecting and reporting residents' acute changes in condition. But physicians who don't receive the information they need from nurses -- or don't pay attention -- can derail resident care. And surveyors will hold the facility's feet to the fire for what's really a two-way communication street.

Researchers have identified "issues that facilitate and hamper" nursing home clinicians' attempts to manage an acute care situation effectively, reports study co-author **David Mehr, MD, MS,** of a study reported in the Journal of the American Medical Directors Association. The study looked at how well nursing home staff and physicians managed residents with acute infections. And among the list of obstacles resulting in lack of timely management: Physicians who feel like they can't count on nurses' assessments when the nurses call to report their concerns about a resident. Part of that mistrust on physicians' part stems from the way physicians and nurses approach the same problem, says Mehr. "The nurse wants to help the resident feel comfortable and treat symptoms as they arise, like fever," says Mehr. "So the nurse calls the doctor to report a fever and ask for an antipyretic. But the physician is saying, 'hold on, we don't even know the cause of the fever.'"

**Two more communication stoppers:** The physician who expresses annoyance with a nurse who calls with incomplete assessment information creates a chasm in the nurse-physician relationship. The study found, in fact, that nurses who had a bad experience with a particular physician were reluctant to call him or her again to report information about a resident, says Mehr. In addition, nurses with a track record for over-reporting concerns without appropriate assessment can create a "cry wolf syndrome" where physicians come to ignore their reports, cautions Mehr. Based on the study findings, Mehr recommends physicians "swallow their annoyance" when they don't get the assessment information they need from nurses. Instead, they might say, "Before we address an order for the fever, I need x, y and z information," Mehr counsels. The facility could develop a "structured assessment for phone reports or faxing information," says Mehr. For example, nurse practitioner **Clare Hendrick** has developed a set of faxable assessment templates to address common conditions in nursing homes, including fever, dehydration, pressure ulcers, behavioral changes, etc. The nurse uses the assessment template to gather pertinent data and lab values to organize a phone report to the physician (see the next page for a sample form for reporting aggression and combative behavior).

**The bottom line:** "When you give the physician more complete assessment information about a resident's problem, you're going to get a better answer," says Hendrick, a consultant in San Clemente, CA.

**Making the Leap From Sx To Illness Identification**

To detect and report acute changes in condition effectively, the nurse has to take a "conceptual leap to go from a symptom to conclude that it's more than a single or simple problem or to interrelate several seemingly unrelated symptoms," says Mehr.

**Proactive strategy:** In nursing homes where physicians are on site only about 10 percent of the time, asa "crude estimate," physicians need to work with nurses more closely to help them learn to make that conceptual leap, suggests Mehr. Or tap nurse practitioners to educate staff in that way. Also consider implementing "mentoring programs where more seasoned nurses work with licensed staff and CNAs to help them recognize meaningful symptoms and changes in condition."

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