Team Reassessment Communication

Adapted from Team STEPPS training course; any similar communication program is also recommended.

Communication is a key factor in early recognition and treatment of sepsis. Learning to use effective communication techniques between disciplines will enhance perinatal patient outcomes and decrease maternal morbidity. The goal is to advocate for early recognition and treatment of sepsis. As with any new practice, you may encounter resistance in establishing a treatment plan for early recognition of sepsis in the perinatal population. Empower your teams to advocate for the patients by asserting a corrective action in a ***firm*** and ***respectful*** manner. Standards of effective communication include being: ***Complete, Clear, Brief*** and ***Timely***.

ENCOURAGE A CULTURE OF BEING PROACTIVE, AND NOT REACTIVE. This can be done by performing briefs and debriefs. The brief is a way to plan ahead, while debrief is more of a means of process improvement. Anyone can request a brief or debrief.

Briefs: Planning

A key part of everyday practice is to encourage a shared mental model, which provides a shared understanding of what needs to be done.

- Know the Plan
- Share the Plan
- Review the Risks
- Encourage input from all

Debrief: Process improvement

Teams participate in brief, informal information exchanges and feedback sessions following an event to enhance future patient outcomes and improve teamwork skills.

- Reconstruct key events
- Analyze why the event occurred
- Reflect on what could be done differently next time

Communication techniques that will assist with prompt recognition and treatment

✓ Time out
✓ SBAR (situation, background, assessment, recommendation)
✓ CUS (concerned, uncomfortable, safety issue)
✓ Closed loop communication
✓ Handoff

Time Out and SBAR

Any team member who wishes to regain situational awareness and express concern can call a 'time out.' When a time out is called, include all multidisciplinary members of the team and provide an SBAR report to ensure every one is on the same page with the treatment plan.

A time out is key in the early recognition phase of sepsis. It can be called as needed to assist the team in "touching base" and to regain situational awareness. It can be used to discuss critical issues and emerging events as well as anticipate outcomes and likely contingencies. The time out can also be used to assign resources and express concerns. A SBAR report can be used to communicate the following information:

- *Situation*–What is going on with the patient?
- *Background*–What is the clinical background or context?
- *Assessment*–What do I think the problem is?
- *Recommendation*–What would I recommend?

Example of an SBAR for a perinatal patient with sepsis

- *Situation*–Patient Jane Doe has met sepsis screening criteria.
- *Background*–Jane is G4P2 EGA 39.6 weeks admitted for SROM > 24hrs. Patient has been augmented with oxytocin and is making appropriate progress in her labor. GBS is negative and she has no other known risk factors.
- *Assessment*–Jane's vital signs are Temp 38.4°C, Pulse 120/min, BP 110/68 mm Hg, pO_2 96% on room air, Category 2 tracing. Jane appears to meet the initial sepsis screening criteria.
- *Recommendation*–"My recommendation is to initiate test for confirmation of sepsis, including laboratory tests 1 L of fluid and increased monitoring. Would you like to start antibiotics? I will report back results for further orders."

Use CUS words to advocate: CUS (concerned, uncomfortable, safety issue)

Use CUS words if there is resistance for sepsis screening and you receive a response similar to the following examples:

- "It is not sepsis, it is chorio. We will treat for chorio."
- "We will continue to monitor her; sepsis screening is not necessary."
- "It is normal in pregnancy to have those vital sign changes; it is not sepsis."

Examples of CUS

- "I am **concerned** that the patient might become septic from the chorioamnionitis/intraamniotic infection. Early recognition and treatment is important and I would like to initiate the sepsis screening process"
- "I am **uncomfortable** with waiting to initiate the sepsis screening and I would like to activate the order set so that we can promote early recognition and treatment if indicated."
- "Although vital signs are elevated in pregnancy, her current vital signs meet sepsis screening criteria. This is now a **safety issue** we must address."

Closed loop communication

When initiating treatment for sepsis, it is essential that all members of the team use clear and precise communication regarding tasks completed and those that are still pending. At the bedside, closed loop communication is key to ensure the message has been clearly heard and received.

Example 1 of closed loop communication

- **Nurse to charge nurse**: "The patient has 2 vital signs that meet sepsis screening criteria. We need to draw sepsis screening labs and notify the physician."
- **Charge nurse to nurse**: "I will find a staff member to help you draw sepsis screening labs, and I will page the physician so that you can provide report."

Example 2 of closed loop communication

- **Nurse to physician**: "Initial lactic acid result is 3.2 mmol/L. We are requesting your prompt presence at the bedside for assessment. What orders would you like me to initiate at this time?"
- **Physician to nurse**: "I am on my way in to the hospital to assess the patient and about 20 minutes away. Please initiate fluid resuscitation of 30 mL/kg. I will order antibiotics when I arrive after evaluating the source."
- **Nurse to physician**: "We will initiate fluid resuscitation now. We will expect you at the bedside in the next 20 minutes."

Handoff

The handoff defines the transfer of information during transitions in care across the continuum; it includes an opportunity to ask questions, clarify, and confirm. Applying a standardized approach to handoff communication is recommended to ensure that tasks that have been completed in sepsis treatment have been adequately reported, as well as next steps.

Example of handoff

RN to RN: "Patient Jane Doe met criteria for the sepsis screening order set. We drew labs, lactate, and blood cultures. Her lactic acid result was 3.8 mmol/L. We notified the physician and he is on his way in to assess the patient, and we expect him to arrive in the next 10 minutes. He ordered a fluid bolus of 30 mL/kg that we have initiated. The physician stated that he will order antibiotics after assessing the patient.

The charge nurse is aware of the situation, and I have also given report to the rapid response team regarding the patient's status. Jane is on continuous fetal monitoring, continuous pulse oximetry, and will need Q30 min BP and Temp until her lactic acid level is above 2.0 mmol/L. She will need a repeat lactate 2 hours from the first draw. Do you have any questions?

Simulation of maternal sepsis to emphasize communication techniques

Multidisciplinary simulation of maternal sepsis is an ideal way to reinforce the workflow and interventions when sepsis screening criteria is met. Focus your simulation on communication approaches and the immediate actions of the bedside team. Pause the simulation as necessary to emphasize educational elements. If possible, use an actual patient scenario as your simulation storyboard, with actual vital signs. Make sure to disclose this during debriefing of the simulation. This gives the team participating insight into areas of improvement. The following is an example of a storyboard for maternal sepsis simulation as well as a debriefing tool that can be used after simulation or after an actual patient case.