125: Interprofessional Collaboration in Pediatric Acute and Critical Care: How to Cultivate Happy & Healthy Work Environments

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Disclosures
• Michelle M. Wilson has no financial relationships to disclose and will not discuss off-label use and/or investigational use of drugs/products in this presentation.
• Sarah A. Martin has no financial relationships to disclose and will not discuss off-label use and/or investigational use of drugs/products in this presentation.

Learning Objectives
• Define the concepts of interprofessional collaboration (IPC), teamwork, communication, professional resiliency and happiness within the context of their overall contribution to quality care in the pediatric acute and critical care settings.
• Recognize effective communication patterns for high-functioning pediatric acute and critical care teams.
• Identify self-care strategies to promote professional happiness and enhance provider resiliency to mitigate burnout and turnover for the pediatric acute care nurse practitioner.

Interprofessional Collaboration-Brief History
• 2009- Six national associations of schools of health professionals formed a collaborative to advance interprofessional learning experiences
  - Disciplines represented: Dentistry, Nursing, Medicine, Osteopathic medicine, Pharmacy, Public health
  - IPC Core Competencies published (IPEC, 2011)
• 2016- IPC Core Competencies updated (IPEC, 2016)
  - Core competencies: Values & Ethics, Roles & Responsibilities, Communication, Teams & Teamwork, Scope of Practice (SOP)
• 2016- 9 disciplines added: Podiatry, PT/OT, Psychology, Veterinary Medicine, Optometry, Allied Health, Social Work and Physician Assistants
• 2017- 5 more organizations added: Academy of Nutrition and Dietetics (ACEND); American Speech-Language-Healing Association (ASHA); Association of Academic Health Sciences Libraries (AHAHSL); Association of Chiropractic Colleges (ACC); National League for Nursing (NLN)

Interprofessional Collaboration-Significance
Why is this important?
• Patient safety
• Quality of care
• Enhanced communication & error reduction
• Deliver team-based care within SOP
• Achieve the Triple Aim of Healthcare (IHI, 2007)
  - Improve patient experience
  - Improve population health
  - Reduce health care costs
Interprofessional Collaboration-Definition

“When multiple health workers from different professional backgrounds work together with patients, families and communities to deliver the highest quality of care.” WHO, 2010

Interprofessional Collaboration-Implementation

• Work with individuals of other professions to maintain a climate of mutual respect and shared values.
• Use the knowledge of one’s own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations.
• Communicate with patients, families, communities and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.
• Apply relationship-building values and principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population centered care, programs and policy that are safe, timely, efficient, and equitable.

Interprofessional Collaboration-Team Dynamics

• Defined as: “a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable.” (IPEC, 2016)
• Composed of knowledge, skills & attitude
• Affected by climate & culture
• Influenced by leadership & level of role autonomy
• Failures of leadership, teamwork & communication contribute to preventable patient harm
• Similar to sports teams: role clarity, trust/confidence, overcome adversity & personal differences, collective leadership (Bosch & Manuell, 2015)

Interprofessional Collaboration-Team Roles & Responsibilities

• APPs: APRNs & PAs
• Child life
• Patient, parents, families
• Psychologists
• Attending physicians
• Fellows/Residents/Medical Students
• Medical directors
• Hospital administrators
• Respiratory therapy
• Pharmacists
• Dieticians
• Social Work
• Consultants
• Nursing leadership
• Staff nurses

Interprofessional Collaboration-Scope of Practice

• Legal implications
• Guidelines
• Practice setting
• Public protection
• Title protection
• Practice to full scope
• Contributions
• Limitations
• Perspective
• Unique knowledge
• Sharing
• Synergy

Interprofessional Collaboration-Effective Communication

(Stocker et al., 2016)

• Feedback
• Role clarity
• Overcommunicating?
• Risks and benefits
• Create culture of respect & trust
• Psychological safety
• Learning while working
• Bedside white boards with patient daily goals
• Shared mental models
• Accountability
• Transparency
• Dissemination
• Barrier reduction
• Difficult conversation simulation
• Parent empowerment
• Learning to learn from failure
• Coaching & mentorship
The work of a busy pediatric surgery service had commenced at 0530 AM. Three advanced practice providers (APPs) were rounding with the surgeon of the week (SOW) (the attending surgeon that manages the service from 6 AM to 5 PM) she seemed distracted and after seeing several patients stated she needed to leave. The remaining team members returned to the work room and were informed by the replacement SOW that the fourth-year surgical resident had taken his own life that morning. The immediate unrest was palpable.

Case Scenario A Sad Morning

• Trajectory of the day
  • All division debriefing
  • Psychiatrist from NMH Physician Wellness Program
  • If have experienced suicide in the past the act will have a more profound impact on affected individuals
  • EAP counseling made available
  • I wished...
  • Discussion

Physician Suicide

• Driver for many of the wellness initiatives in health care organizations
  • Fortunately, many of the resources for physicians are being expanded to nurses
  • Many initiatives aimed at mitigating burnout
• National Violent Death Reporting System (CDC)
  • Female physicians 2.27 more likely than females in the general population
  • Male physicians 1.41 more likely than males in the general population
• Second leading cause of death for physician trainees (Hu et al., 2019)

• Suicide occurs when stressors exceed coping abilities of someone with a mental health issue
• Usually associated with a major depressive episode
• Resident stressors
  • See a lot of death
  • Exposure to vast human tragedies
  • Physical challenges
  • Responsible 24/7
• Lots of life stressors (personal injury or illness, family illness or death, relationship break ups, divorce, marriage, childbirth)
• Challenge of working in teams if not in a good culture
• Harassment from patients, staff, faculty and toxic teams
Nurse Suicide

- No current incidence data for nurses in the U.S.
  - 10th leading cause of death in the United States
- Australia nurse incident rate ratio of 2.65 for female and 1.5 for male (Andersen et al., 2010)
- Risk factors for nurse suicide (Davidson et al., 2018)
  - Past attempts
  - Past or current mental illness
  - Factors related to those in the caring professions
    - Access to means
      - Knowledge of how to enact lethal means
    - Exposure to work related stressors and demands
    - "Resident factors"
    - Witnessing or being involved in a medical error

Nurse Suicide-The HEAR Program (Davidson et al., 2018)

- Pilot expansion of physician program to nurses due to nurse suicides
  - Present at more than 60 medical teaching campuses and 8 medical schools
- Healer Education, Assessment and Referral (HEAR) programs detect at risk providers and facilitates referral to mental health care
- Two-pronged approach
  - Didactic educational presentations: burnout, depression, suicide, membership and function of HEAR
  - Encrypted web-based screening and assessment, confidential, to identify at risk individuals
  - Referral to mental health professional

Nurse Suicide-The HEAR Program (Davidson et al., 2018)

- First 6 months of the program
  - 7% of the nurses completed the screening questionnaires
  - N=12 (7%) current active thoughts of self-harm and N=19 (11%) had previous suicide attempts
  - N=44 (26%) received counseling and 17 accepted referral for continued treatment
  - Many nurses contacted HEAR counselors without doing the screening

Nurse Suicide-The HEAR Program (Davidson et al., 2018)

- Next steps
  - Increase program marketing
  - Adapt lectures to facilitate attendance: shorter sessions, provide protected time, huddles
  - Provide requested resiliency lectures
  - Offer emotional critical incident debriefings following serious clinical events

A Closer Look at Surgical Residency Training

- Paucity of APP data on work environments
- Cross-sectional national survey of general surgery residents administered with the 2018 American Board of Surgery In-Training Examination (ABSITE) assessed mistreatment, burnout (evaluated with the Maslach Burnout Inventory), and suicidal thoughts in the last year (Hu et al., 2019)
  - 7409 (99.3%) of the eligible residents completed the survey
  - 31.9% reported discrimination based on their identified gender
  - 16.6% reported racial discrimination
  - 30.3% reported verbal or physical abuse or both
  - 10.3% reported sexual harassment
  - 4.5% reported suicidal thoughts
  - Patients and patients' families most frequent source of gender discrimination
  - Attending surgeons were most frequent sources of sexual harassment (27.2%) and abuse (53.9%)

A Closer Look at Surgical Residency Training

- Most comprehensive study to date, previous studies had low response rates
- After adjustment for higher prevalence of maltreatment among women, the differences between genders did not persist
- Considerable program variability related to incidence of maltreatment and duty-hour violations
- Sources of mistreatment differs by type of mistreatment which may help guide interventions
  - Training on how to respond if direct recipient versus witness to maltreatment
  - Although overall prevalence concerning, a substantial number of programs had very low prevalence suggesting benefit with training
  - Lack of concordance-training needs to be tailored to the program
A Closer Look at Surgical Residency Training

- **Study Limitations**
  - Concurrent administration with ABSITE may influence results (exam-related distress and post-exam relief)
  - Concerns about confidentiality of data as ABSITE performance tracked
  - Recall bias as date collected for tenure of residency
  - Mistreatment terms not defined
    - Potential underestimation
  - Unable to determine causality of mistreatment with burnout and suicidality
  - Applicable to APPs?

Case Scenario-Stuff Happens

You are getting ready to sign out and leave after a busy Saturday shift that you have worked as the sole APP. You receive a call from a nurse about a child that you had removed a JP drain from earlier in the day that there appeared to be some mucosa protruding from the wound site. Upon your assessment it is determined it is omentum. Later that evening, the child was taken to the operating room.

Peer Support (Shapiro & Galowitz, 2016)

- Peer support program at Brigham and Women's Hospital (Shapiro & Galowitz, 2016)
  - Mission to encourage a culture that values and promotes mutual respect, trust and teamwork
  - One-on-one support to individuals following a stressful event with a trained peer
  - If group involved, peer support facilitated by a licensed clinical social worker (EAP or Center for Professionalism and Peer Support director)
  - Defendant program-peer support from colleague that has been a defendant in a lawsuit

Peer Support

- **“Debriefing”**
  - Lack of respect amongst team members
  - Engage the attending physician
  - Phone a co-worker or friend
  - Engage patient relations
    - Staff includes Registered Nurse
  - The “Ps”
    - Personalization: you are solely responsible
    - Pervasiveness: single mistake impacts all areas of professional and personal life
    - Permanence: consequence of mistake will last forever
- Discussion

Peer Support (Shapiro & Galowitz, 2016)

- **Peer support “conversation”**
  - Initiated with a brief email stating they are reaching out as a peer supporter asking the peer to call or page them
  - Peer accepts and mutual time for a conversation determined
  - Opening: “What happened?”
  - Listening: “How are you doing?”
  - Reflecting, reframing, coping
  - Closing: “I really appreciate your sharing your thoughts with me. This happened because you’re human, not because you are a bad clinician.”

Peer Support

- Referrals from leadership, EAP, risk management, quality
- CPPS director matches the clinician to suitable peer
- Peer support reaches out directly to the peer
  - Matches based on if interventionalist needed, faculty level, profession, personality style
  - Peer decides if they want to access support
Colon CA Awareness Month

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Burnout

- Incidence
  - 35-54% U.S. nurses and physicians (National Academy of Medicine, 2019)
- What is it?
  - Response to chronic emotional and interpersonal stress at work
  - Syndrome of emotional exhaustion, cynicism, depersonalization, and reduced effectiveness at work
  - Takes everything you can muster to get to work
- What causes it?
  - Long work hours, burdensome documentation, emotional distress, insufficient technology tools, moral distress, involvement in an adverse event especially if it involves a medical error

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Burnout: 9 Organizational Strategies (Shanafelt & Noseworthy, 2017)

- Mayo clinic initiatives
- Acknowledge and assess the problem
- Harness the power of leadership
- Develop and implement targeted interventions
- Cultivate community at work
- Use rewards and incentives wisely
- Align values and strengthen culture
- Promote flexibility and work-life integration
- Provide resources to promote resilience and self-care
- Facilitate and fund organizational science

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Professional Resiliency

- What is it?
  - The ability to maintain physical and emotional well being in the face of adversity
  - The absence of burnout/preventing burnout?
  - Present in environments and individuals
- What contributes to resiliency?
  - Personal traits (e.g., grit)
  - Process of coping or adaption (e.g., mindfulness)
  - Embracing resiliency resources

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Professional Resiliency

- How can it be achieved?
  - Leader empowering behaviors (LEBs) (Conger & Kanugo, 1988; Hui, 1994)
    - Enhancing the meaningfulness of work
    - Opportunities to participate in decision making
    - Confidence in high performance and recognizing accomplishments
    - Facilitating the attainment of organizational goals
    - Providing autonomy
  - TJC
Professional Resiliency - Professional Associations

- American Association of Critical Care Nurses
  - Strong commitment to promoting a healthy work environment since 2001
- Developed 6 standards
  - Skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition and authentic leadership
  - Benefits patients, nurses and the health care team
- ANA
  - Workplace violence prevention
- NAPNAP
  - Possible role of the Acute Care SIG

Professional Self-Care: Evidence Based Strategies

- Code Lavender
- Resiliency training
  - APRN with Oncology background offers periodic workshops
- Dedicated mental health provider for providers at the organization
- Personal wellness education
- Wellness assessments & apps
  - Well-being index offered at Lurie
- Annual Wellness Survey, Sleep app, EAP app with self-help topics at CC

Interprofessional Collaboration - Happiness

- Happy & healthy work environment not something to just “check off”
- Comes from your values and having a purpose and meaning
- Contentment or sense of positive well-being
- Subjective assessment of how much we like the life we live
- The pursuit of happiness (Geddes, 2019):
  - Embrace nature & bright light; increase activity & exercise; get adequate sleep
  - Improve executive function (plan, organize & complete tasks) through music
  - Volunteering
  - Reduce alcohol consumption, stop late-night snacking & overconsuming in general
  - Stop being so hard on ourselves; adjust expectations

Interprofessional Collaboration - Cost

- Staffing ratios
  - Do they exist for APP’s?
- PTO
  - Ensure culture supports using
- Part-time & PRN positions
- Burnout
- Turnover
- Lack of protected time

Interprofessional Collaboration - Key Takeaways

- New generation trained in IPC
- Patients first mentality
- Conflict resolution & negotiation skills
- Emotional intelligence
- Empathy & compassion for others
- Diversity & inclusion: create a culture of acceptance
- Team is only as strong as its weakest link
- “Competent individuals may not necessarily be competent interprofessional team members” Stocker et al. 2016

References

References


Questions?

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