Know the Plan, Share the Plan, Review the Risks: A Method of Structured Communication for the Emergency Care Setting


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0099-1767/$34.00
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doi: 10.1016/j.jen.2007.11.008

Mrs J, suffering from a headache of intolerable proportions, arrives at a level I trauma center with the “worst headache of my life.” The triage nurse is worried about a subarachnoid hemorrhage (SAH) and immediately assigns a bed. Mrs J is evaluated by a veteran ED physician-nurse-technician team, who noted the following information:

**Situation.** The patient is a 53-year-old female secretary, the mother of 5, who was driven from work by a friend. She presents with a 4-hour history, sudden onset, “crushing, worst headache of my life.”

**Background.** The patient denies trauma or another precipitating event. Her head and neck pain is reported as 10 on a scale of 10, unrelieved by acetaminophen × 6 in the past 16 hours.

**Assessment.** The patient is curled in a side-lying position on a stretcher, her coat over her head, her eyes closed. She arouses with difficulty in response to her name, is slow to answer, is confused regarding time and place, cannot state the names or ages of her children, and is intolerant of light. Her blood pressure is 140/90 mm/Hg; her temperature is 98.2°F; her pulse is 88 beats per minute; her respirations are 22 breaths per minute and shallow; arterial oxyhemoglobin saturation is 92% on room air.

**Recommendation.** Perform a work up to rule out SAH.

Mrs J is sent for a computed tomography scan without contrast. Despite the working diagnosis and the lack of a fever, the ED attending physician has a “gut instinct” that Mrs J has meningitis and orders a retake temperature. No additional discussion occurs between the nurse and the attending physician, who is called to another case. A
nursing assistant retakes the patient’s temperature and notes it in the chart but is pulled to transport another patient to radiology before she sees the nurse. Mrs J’s care is picked up by another physician who performs a quick review of the chart and notes Mrs J’s retake temperature of 103.8°F. Unable to determine if antibiotics were started, the relieving physician seeks out Mrs. J’s treating team. However, this physician is met by another critical patient and is consumed by this case before further investigation into Mrs J’s case can occur. Ultimately, meningitis is confirmed with delayed administration of antibiotics.

Errors, slips, and lapses occur all around us in emergency care. Medical errors are human errors that often involve cognitive activities and the inadequate processing of information.1-3 When information is inadequate, as in Mrs J’s case, medical plans of care will be under-informed, leading to faulty thinking, flawed decisions, and/or errors of execution.4 An under-informed plan or a plan unknown to the team may mean every action taken thereafter could be an incorrect action. Recent research cites cognitive errors—how we think and what we decide—to be the foundation of most ED diagnostic errors.5-7 Cognitive errors are distinct from procedural errors and inextricably linked to the conditions of ED care.

Anchoring, or bias, is one type of cognitive error. Bias describes the common tendency to rely too heavily upon one pattern or piece of information when making decisions and is an example of how humans use simplifying strategies and “rules of thumb” to ease the burden of decision making in complex circumstances. Often the way to proceed is time compressed and unclear because of the ambiguity created by information overload.8 To ensure outcomes, the time-stressed professional relies on experience to facilitate the “subconscious mental procedures for processing information.”8 To ensure outcomes, the time-stressed professional relies on experience to facilitate the “subconscious mental procedures for processing information.”8 Research specific to ED triage decision making indicates that triage decisions are non-analytic and based on intuition and experience.9 The anchoring or bias that occurs during times of rapid fire triage may later be corrected as data are gathered and analyzed during the ongoing ED assessment and care. However, without knowing the plan and updating the plan, the anchor, once set, will result in a predictable drift toward the bias with the potential to err.8 Precisely because anchoring is common and specific to triage, caution must be exercised when care is delivered under conditions of fast-moving, incomplete, time-compressed information and communication and when tasks are delivered in high-stress, high-stakes arenas where volume and turnover are high.

Engaging in formal, evidence-based, team training educates caregivers to recognize unfolding error and provides the skills and practice necessary to exercise the team tools and strategies critical to trapping, managing, and/or mitigating error and its impact.10 In operation, staff take specific actions to form or join a team where they use structured communication to plan and problem solve; to balance workload; and to manage and monitor care for a population of patients over time, while performing regular event debriefings as an ongoing mechanism for improving team performance and care.

Knowing the plan improves outcomes.10 In one study, after implementing an ICU “Patient Daily Goals” form, the percentage of staff who knew the plan increased from 10% to 95%, and ICU length of stay was reduced by half (2.2 to 1.1 days).11 ED teams meeting to know the plan also may improve outcomes by conducting interdisciplinary “rounds” and sharing information using the structured communication tool of “Know the Plan; Share the Plan; Review the Risks.” Verbalization of the plan alerts the team to potential risks or bias and provides new information or the opportunity to develop contingency plans to mitigate or negate flawed reasoning or decision making.

In a team-trained setting, Mrs J’s physician would have stated the plan and the risks: “This might not be a SAH, but, with ‘worst headache’ of her life and no fever, we have to continue to rule out the SAH. If, however, a fever develops, we should think about meningitis, and I need to know immediately so we can start antibiotics.” The team briefing should be conducted with all pertinent members of the team, including the nursing assistant, who, in Mrs J’s
case, was the team member who ultimately had the key piece of clinical information. In addition, the authors suggest that planning briefings be conducted with use of standardized critical communication techniques such as the Situation-Background-Assessment-Recommendation (SBAR) method used to describe Mrs J’s condition at any patient hand-off.

**KNOW THE PLAN, SHARE THE PLAN, REVIEW THE RISKS IN ACTION**

At 11 AM at a community hospital, the charge nurse takes a call from an incoming EMS agency regarding D, a long-time alcoholic well known to the department. Today, however, D is found “down in the bushes,” and after initial care by the EMS professionals, is transported to the emergency department awake, confused, and uncooperative. Prior to arrival, the charge nurse pulls the treatment team together to discuss the plan for D’s care, and using an SBAR format, describes the plan:

**Situation.** Patient D is en route to the emergency department via EMS after being “found down.”

**Background.** D has a history of alcohol abuse and is well known to the emergency department (no assumptions are made that the team is aware of D’s history).

**Assessment.** D’s behavior is different than usual, and trauma cannot be ruled out.

**Recommendation.** Direct EMS is to bring D to the resuscitation room.

The charge nurse then briefs the triage team using the same information. As EMS enters, they note that the triage area is overwhelmed and they move to the “detoxification” area, as they have countless times in the past with D. The triage nurse observes EMS wheeling D toward the detoxification area and shares the plan for evaluation for D. After the evaluation, D is found to have acute and chronic subdural hematomas and is scheduled for surgical intervention.

Bias—in this case, that the patient smells of alcohol—is well known to EMS and the emergency department, and that he “always goes to detox” was at work as well. However, a brief team discussion that included the correct team members, the charge nurse, the ED physician, and the care team, reflected that the team “knows the plan and reviews the risks” prior to the patient’s arrival. In addition, sharing the information with others who could affect the decision-making process, such as the triage nurse, was critical to timely and correct intervention for the patient. If the plan is known at the time of communication, it also can be shared with the transport team prior to the patient’s arrival.

Formal, structured communication tools are essential to safe and effective emergency care. “Know the Plan, Share the Plan, Review the Risks” is a good place to start to better manage or mitigate the potential for error in the emergency department.

**REFERENCES**


**Clinical questions** from nurses are welcome, as are names and addresses of clinicians who are interested in answering questions. Submit to:

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