Imagining the situation: A patient lies in a steadily deteriorating condition in a general ward. His nurse has noticed that he has taken a turn for the worse and is worried. She picks up the phone to call a senior doctor for help but is unable to get across the seriousness of the situation. Anyway, the doctor is busy elsewhere and does not prioritise her request. The patient’s condition continues to deteriorate and he ends up in an intensive therapy unit.

**Case Study: Communication**

Ward staff often know instinctively if a patient is deteriorating, but sometimes aren’t able to make clear how serious the situation is when calling a senior colleague for help. Peter Featherstone, Consultant Physician at Queen Alexandra Hospital in Portsmouth, describes a communication scheme to overcome this challenge.

Recent reports from the National Patient Safety Agency (NPSA) (tinyurl.com/4t38tj) and the US-based Joint Commission (tinyurl.com/bct6oz) have highlighted the importance of communication failures in this type of situation. In an NPSA analysis of the 1,804 serious incidents in the NHS in England that were reported to have resulted in death in 2005, 425 occurred in acute and general hospitals and were interpreted as related to patient safety issues. Some 64 of these related to patient deterioration not recognised or not acted upon. Ward staff need to identify why their patient is sick even before communication becomes an issue.

Physiological deterioration is difficult to detect in the early stages, so nurses often rely on subtle changes in their patient’s condition, such as visual changes in colour or mood. By what has been called ‘intuitive knowing’ (see Further reading), nurses detect that patients need medical attention, but at this stage the patient may just be described as ‘not right’.

It has been reported that calls for help from inexperienced ward doctors and nurses are often long and include too much irrelevant information. Rightly or wrongly, quantifiable changes are used by doctors to prioritise their workload. They need to be persuaded to stop what they are doing to redirect their attention to a new problem. More experienced nurses are aware of this, one staff nurse commenting: “You couldn’t ring up the doctor and say, “Their ‘resp’ rate is a bit funny.” You need other numbers and physical things to tell them.”

Clearly, the person taking the call can have a big influence on the outcome. It is good practice for the listener to clarify points with the caller. It is not helpful to interrupt him or her unnecessarily, to ‘put down’ the caller or to carry on another conversation at the same time. Nitpicking, emotional responses and arguments are undesirable, as is the use of overly technical language and using a patronising or dismissive tone.

Our team in Portsmouth developed the Acute Life-threatening Events—Recognition and Treatment (ALERT) course, which emphasises that attempts...
Case Study: Communication

Typical scenario of RSVP in operation

A 50-year-old female patient on a general ward was admitted eight hours ago. She has a 24-hour history of wheezing, cough and becoming breathless. The patient has had asthma for ten years. She has never smoked. The admitting doctor thought the patient had an asthma flare and prescribed oxygen, two-hourly nebulised salbutamol and oral steroids. The patient had been improving on this treatment, but the nurse looking after the patient notices that she has now become tired and unwell and is breathing very fast and shallowly. The nurse is not very experienced, but has recognised that the patient seems unexpectedly acutely ill. The nurse checks the vital signs and discovers that the patient has a rapid, thready pulse, low oxygen saturations and a raised rate of breathing. There is neither a doctor nor a more experienced nurse on the ward but the nurse feels that she needs urgent help as she feels out of her depth. She decides to telephone the doctor on call. At this point her chance of getting an appropriate, helpful response is increased if she gives a structured call for help. She decides to use the RSVP tool, as it is imprinted on the ward telephone, as follows:

R Reason: ‘Hello is that doctor A? This is nurse B on ward C. Mrs D in bed two came in yesterday with a flare-up of her asthma. Over the past half an hour she has become agitated and unwell and is struggling to breathe.’

S Story: ‘She is a thin 50-year-old woman who developed a head cold a few days ago. She lives alone since her husband died and doesn’t go out much. She was in intensive care last year with a bad asthma attack and she isn’t very good at remembering to take her steroid inhaler.’

V Vital signs: ‘She has a respiratory rate of 28, a pulse of 110, and blood pressure of 95/65. Her oxygen saturations are 94% on 15 litres of oxygen through a non-rebreath mask. She is alert on the alert-voice-pain-unresponsive scale, but her oxygen saturations have gone up from two to five since the vital signs were checked three hours ago.’

P Plan: ‘She seems really sick and I’m very worried about her. Please come and see her straight away.’

Further reading


