



Tool Tutorial

Role-Playing Case Simulations: A Tool to Improve Communication and Enhance Safety

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Introduction

This article discusses the use of role-playing simulations of patient cases to improve communication by and among clinicians to reduce medical error. The formal education of clinicians in schools and in continuing professional education has lacked interactive, interdisciplinary simulations of key clinical communication. Although technical simulations of certain clinical procedures are coming into popular use, nontechnical simulations of communication among clinicians are still rare. Role-play case simulations build the awareness of one's own communication patterns in difficult conversations and provide structured opportunities for the practice and critique of new behaviors.

Tool Description

Role-playing case simulations enact prepared scripts in an environmental context, focusing on clinicians' oral communications. The ultimate aim is to improve communication to prevent errors, to improve the identification of root causes of adverse events, and to improve the disclosure of adverse events.

Although errors are ubiquitous, most of them are intercepted before reaching the patient, making them "near misses." Of the errors that reach the patient, some—"adverse events"—injure patients and/or delay their recuperation.¹ Some of these adverse events are preventable; others, like an unanticipated adverse drug reaction to a medication never previously used for that patient, are not. Better oral communication can prevent errors, including adverse events, and increase interception rates. Miscommunication can be responsible for wrong-patient, wrong-route, wrong-dose, and wrong-time medication errors, in addition to surgical and other forms of clinical errors.

Use of simulations is an effective method to study, explore, teach, and improve communication to prevent errors. Simulations facilitate the assessment and improvement of the clinical competencies of patient care, practice-based learning and improvement, and medical knowledge, as mandated by the Accreditation Council for Graduate Medical Education (ACGME).²

Tool Application Settings

Simulations can be used in the classrooms of medical schools, nursing schools, and other schools that educate health care professionals. They are effective in continuing education settings in hospitals and nursing homes, either as off-site classroom instruction or as the topic of in-house departmental meetings, pharmacy and therapeutics committee meetings, adverse event committee meetings, morbidity and mortality meetings, grand rounds, and the like, or as part of patient safety fairs.

"Best" Applications

Any one of three types of clinical situations are most appropriate: (1) the setup of an adverse event during the communications among clinicians (for example, among physicians, nurses, and pharmacists); (2) the root cause analysis and identification of safeguards for an adverse event, (for example, by an adverse event committee); and (3) the disclosure of an adverse event to the patient or family member.

How To

The example on page 261 focuses on a simulation developed by the author addressing the setup of an adverse event. The facilitator leads all steps.

Step One

Establish the objective of the simulation.

The objective is to practice communication to prevent or detect errors before they reach the patient.

Step Two

Research and select or compile a realistic case from client files or published adverse events that illustrates the communication issues to be addressed.

A miscommunication involving a busy, brusque physician and a nurse deferent to the doctor's authority.

Step Three

Write the script:

- Identify the key players;
- Select an appropriate setting or context for the scenario;
- Write the dialogue that the key players would normally speak as Act I; and
- Write the dialogue that the key players would normally suppress as Act II.

The setting is an inpatient surgical unit. Key players are the surgeon, the nurse assigned to the patient, and a staff pharmacist. The dialogue for each of the first two acts should be no longer than a few minutes, only enough to set the scene and context.

Step Four

Write the facilitator guide:

- Develop scenario and character descriptions to orient those playing roles;
- Identify the key points to be discussed and explored after Act I ("What They Said"), Act II ("What They Didn't Say"), and Act III ("A Happier Ending");
- Identify the points between the acts and during the acts of the simulation where structured discussion and critique occur;
- Specify important open-ended and follow-up questions the facilitator should ask during the first and second debriefing segments;
- Describe what the facilitator should say about forcing functions and root cause analysis in light of the audience's knowledge;

- Describe the set-up for Act III, which participants will write; and
- Describe contingency plans for the simulation. For example, if few are eager to participate initially, the facilitator and/or an assistant should be prepared to play the role(s), preferably the smaller role(s). If the time allotted for the simulation is less than had been expected, the guide should describe how and where to shorten the simulation.

Step Five

Conduct the simulation:

- Introduce the simulation and recruit the actors from the audience.
- The actors read the script aloud. For the simulation of identifying root causes and disclosing an adverse event, actors are seated, as in a conference room. For the simulation of clinical communication, the actors stand, as they would in real life.
- Guide the actors, calling time-out as needed (for example, at points where the audience reacts strongly). The facilitator asks the audience why they reacted as they did and probes further, as appropriate.
- Act I shows the typical way that clinical communication leads to an error.
- The subsequent debriefing discusses the realism of the case and the suspected causes of the error.
- Act II reveals the key unvoiced thoughts of the actors. The facilitator calls time-outs as appropriate and engages in brief discussions with the audience and participants.
- The subsequent debriefing discusses the realism of the unvoiced thoughts and allows the group and facilitator to identify more effective communication.
- Act III, written by the actors, will likely require time-outs by the facilitator and perhaps retakes. Since it is more improvisational than the earlier acts, Act III gives the group an opportunity to practice alternative statements and observe their effects.
- The subsequent debriefing critiques the effectiveness of the communication presented in Act III.
- Act IV ("In the Coffeehouse") leads the audience to critique the overall production, as theater critics.

Output

Complete production, with a program including the script and facilitator guide for use in educational sessions or in groups analyzing errors and working to improve safety.

Results and Lessons to Date

Participants' feedback has been highly favorable. The most frequent positive comments applaud the simulation's realism and the open discussion of sensitive topics that it stimulates. The most frequent comments about improvements in the simulation call for lengthening the simulation to allow additional time for discussion and practice and for simulating additional scenarios.

Our first lesson to date is that, to support objectivity and maximize insight and learning, the simulation facilitator should come from outside the organization. Second, it is a good idea to conduct a dress rehearsal to improve the script and sharpen the facilitator's treatment of the debriefing. Third, if you want to use a scenario from your own organization, be sure to alter key details in light of the sensitivity of the subject.

Conclusion

Simulation allows the learner to observe from a distance familiar communications among physicians, nurses, pharmacists, and patients that reveal the shortcomings of common patterns of miscommunication. The simulation then places the learner in the driver's seat, allowing him or her to safely test more effective ways to talk and behave.

Contact Us

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The author is grateful for the insight of Dr James Grant of Theravision Institute on the design of the simulations.

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