“Late deceleration:

- Visually apparent usually symmetrical gradual decrease and return of the fetal heart rate (FHR) associated with a uterine contraction.
- A gradual FHR decrease is defined as from the onset to the FHR nadir of 30 seconds or more.
- The decrease in FHR is calculated from the onset to the nadir of the deceleration.
- The deceleration is delayed in timing, with the nadir of the deceleration occurring after the peak of the contraction.
- In most cases, the onset, nadir, and recovery of the deceleration occur after the beginning, peak, and ending of the contraction, respectively.”

At the depositions:

“She was having late decelerations and I really wanted him to come in.”
“She really did not seem that concerned about the tracing. She never asked me to come to see the patient.”

This hypothetical scenario is the result of a communications failure that could occur despite the standardized terminology and suggested management regimens agreed on at a consensus conference sponsored by the National Institute of Child Health and Human Development (NICHD) in April of 2008. The terminology was accepted and endorsed by both the American College of Obstetricians and Gynecologists and Association of Women’s Health, Obstetric, and Neonatal Nurses. Several commercial interests have initiated efforts to make these definitions and interpretations available to the perinatal community. There are, however, continuing concerns that this new approach will not necessarily result in improved teamwork, a collaborative approach to care, and improved responsiveness when intervention is needed.

Some organizations have recognized that even with mandatory certification of their medical and nursing staffs in the understanding of the new terminology, improved outcomes need to be associated with team training for all members of the perinatal team. So it can be said that although the standard definitions provided by the NICHD Consensus Conference provide a foundation for interpretation, it is the integration of all of the characteristics of the fetal tracing combined with the clinical picture of the patient that must be considered and discussed.

Despite the efforts of a few organizations’ attempts to improve teamwork and communication surrounding the interpretation of fetal heart tracings, this communications component of care has been largely unaddressed. The essential missing link centers on the process of effective communication between health care professionals that will eventually lead to a consensus-based management plan that results in the best outcome for the mother and her fetus. Recognition of patterns, the decision to call the patient’s provider, the nature of the call and the tenor of the conversation, reaching consensus of interpretation, and finally reaching a management plan are all part...
of the communication process that is necessary for appropriate care.

There have been some reasonable attempts to codify some components of this process by linking certain fetal heart patterns to the requirement that the physician is needed at the bedside. An additional relatively new layer of safety in obstetrical care, the introduction of the obstetric hospitalist or laborist, has made the need for accurate communication between multiple practitioners even more essential.

The purpose of this essay is to focus attention on the need to address this communication process between professionals associated with the NICHD terminology and to make recommendations of how individual labor and delivery units can implement, enculturate, and hardwire these communication strategies.

It is important to recognize that communication is a complex 2-way process, with a number of factors that can lead to miscommunication, or the lost-translation effect. Miscommunication can result from the choice of language made by the person sending the message and from the interpretation of the message by the receiver, both being steps in the communication process in which more than the words themselves (the facts) are attached to the actual material being transferred.

Said in another way, “Communication is often not simply about conveying factual information but often also contains components of self-revelation (an expression of the sender), the relationship between the sender and receiver, and an appeal aimed at influencing the receiver” (italics added).8

P.U.R.E. (purposeful, unambiguous, respectful, and effective) Conversations in obstetrics: a framework for enhancing communications on the perinatal unit

Structured communication as a way to improve the transfer of information between individuals is not new to health care and, in particular, perinatal medicine. One popular form of structured communication, situation, background, assessment, and recommendation (SBAR), has been widely introduced in the perinatal arena.9

P.U.R.E. Conversations was developed as a tool to enhance structured communications between health care professionals in the perinatal unit.10 The principles of P.U.R.E. Conversations are meant to complement and enhance any other form of structured communication that might be in use. The P.U.R.E. Conversations approach to communication seeks to refine the mental process of determining a purpose for the conversation; delivering the message in an unambiguous manner; making sure that the interchange is respectful (safe, balanced, and nonintimidating); and measuring, in real time whether the conversation is effective in determining the plan of action.

As a complement to the SBAR technique of structured communication, P.U.R.E. Conversations takes into account relationships of the individuals as well as allowing for an ongoing evaluation of the progress and eventual success of the interaction. P.U.R.E. Conversations is a particularly useful tool to help prevent miscommunications regarding fetal monitoring interpretation, clearly one of the most frequent, high-risk conversations that occur in labor and delivery.

We advocate using the P.U.R.E. Conversations approach that incorporates NICHD definitions, terminology, and category determination. Many of the conversations about category I and III tracings will be straightforward with respect to management; it is the broad definition and varied approaches to category II tracings that will require the most effective communication practices.

P.U.R.E. Conversations addresses the nature and structure of the communication that must take place between members of the perinatal team, be it nurses, midwives, residents, obstetricians, family medicine physicians, or maternal-fetal medicine specialists. In most cases, the communication begins with the nurse at the bedside and is directed toward house staff or the patient’s attending physician or midwife. Even in situations in which the fetal heart tracing is available for viewing by all parties through a number of alternate technologies, the elements of interpretation and subsequent management still require consensus to be reached by the patient’s nurses and physicians. It is the success of this communication component that is necessary to gain consensus and subsequent action, if necessary, based on the appearance of the fetal monitoring strip and the clinical status of the mother.

Using the P.U.R.E. Conversations structure, a typical approach to the communication process regarding a given fetal heart tracing would entail the following factors:

P: purpose
1. The nurse (or whoever is at the bedside) would make a clear determination of the elements of the tracing based on the NICHD terminology. Using a mental or a written checklist format, baseline rate, variability, the presence or absence of decelerations or accelerations, the type of decelerations defined, and the characteristics of uterine activity would be noted.
2. The next step would be to put this information together in a SBAR format. SBAR is a form of structured communication that has been widely introduced in many professional settings as a method to organize, prioritize, and deliver information that is to be communicated.
3. Before the call is placed, the mental process of determining the purpose of the call should be formulated. The purpose of the call may be to ask the patient’s physician to come to the bedside, to give a progress report, or to ask for a medication change or addition, but the purpose of the call should be clear in the caller’s mind before the call is made. Without a clearly established purpose, it is difficult to construct the necessary elements of the conversation and even more difficult to evaluate the success of the interaction.

U: unambiguous
1. The call should be made and the transfer of information and request for action should be presented in an unambiguous manner with respect to
the following issues: first would come an SBAR report as to the nature of the tracing; second would be a request from the caller to the recipient to view the tracing, if available, off site (home, office, or cellular device) during the discussion. Third, there should be a clear statement of whether the physician is requested to come to the bedside. This latter point, on occasion, especially at night, may produce resistance, negotiation, and even anger when the request to come to the bedside is hesitant, ambiguous, or unsupported by evidence from the tracing.

2. Because many studies have shown that there is never going to be 100% agreement in monitor tracing interpretation, there should be a unit policy that addresses when the physician should come to the hospital. This policy might address the following:
   a. When the physician must come. For example,
      i. If the nurse is not sure about the tracing or the conditions of the mother or fetus.
      ii. If the doctor is not sure about the tracing or the conditions of the mother or fetus.
      iii. If the nurse and doctor cannot agree about the tracing, the category or the plan of care.
      iv. If the category is clearly II or III.
   b. What the physician is expected to do when he or she comes to the unit:
      i. Write a progress note in the patient’s record.
      ii. Have a minibriefing to establish the category of the fetal tracing, the plan of care, or the next check-in point.
   c. Have a method to resolve any conflicts or disagreements that might occur. (See additional discussion in the following text regarding the evaluation of the effectiveness of the conversation.)

3. When requesting the physician to come to the hospital, an unambiguous request might be, “I would like you to come to the hospital now to evaluate the fetal tracing.” This should be followed by the question, “When can I expect you to arrive?”

**R: respectful**

1. It is well established in the literature that disruptive and intimidating behavior is a potent inhibitor of communication. There is also ample evidence that this behavior is associated with a significant proportion of near misses and adverse outcomes.

2. It should be clear to the professionals on the entire unit that there is a zero tolerance for unprofessional behavior, and there should be policies and procedures that are effectively designed to deal with such behaviors. These policies should stress the importance of reporting such behaviors and, as importantly, address the prohibition of retaliation when unprofessional behavior is reported.

3. The “R” in P.U.R.E. Conversations standing for respect is unique as an adjunct to the concept of structured communication because it focuses on the relationship of the individuals who are communicating with each other. An example that occurred at our institution was as follows: a nurse called a physician with what she thought was a well-structured SBAR report of a situation. The physician was not satisfied with the style and the content of the report and remarked, “You call that an SBAR!?” By utilizing the principle of respect during the response to the SBAR message, the comment from the physician would have been different, and the overall effectiveness of the conversation in terms of what was needed for the patient would have most likely been enhanced.

**E: effective**

1. As part of the real-time evaluation and debriefing of the communication process, the parties should ask themselves and/or each other where applicable:
   - Were the requests clear and understood?
   - Was the response reasonable? Respectful?
   - Were other measures necessary to help resolve conflicts that arose from the conversation? What techniques were used and how effective were they?

2. Part of the communication training process for staff on any perinatal unit should be dedicated to conflict resolution. There are a number of tools to assist with this training. A particularly effective tool is the TeamSTEPPS program developed by the Department of Defense in conjunction with the Agency for Healthcare Research and Quality.

3. To have a successful communication strategy, it is critical for the entire department to agree on a prescribed approach for conflict resolution. The use of scripts, key phrases, elevation policies to the chain of command, implementation of a 2-challenge approach to stop the line, second opinion teams, and departmental leadership can all provide effective tools and personnel to help resolve conflicts, should they occur.

At this time, preliminary data are available regarding the effectiveness of using P.U.R.E. Conversations. After training sessions with physicians and nurses practicing the principles of structured communication, immediate participant satisfaction was high. For example, of 121 participants in one system’s series of workshops, 121 of 121 found the training useful and rated the importance and quality of the subject matter and the materials at 4.8 of 5. For many it was the first time that physicians and nurses actually practiced talking with each other.

Additional data obtained 6 months after the training reflected that 81% of participants felt that they used the principles of P.U.R.E. Conversations in their daily practice, 83% felt that communications were improved on their perinatal unit, 69% felt that the unit had hardwired P.U.R.E. Conversations and the culture of the unit had changed, and 61% felt that the changes in communication practices were permanent rather than temporary.

Fetal monitoring is more than identifying elements of the tracing with the
appropriate terminology. The critical phase of care involves the care plan and the actions that result from the monitor strip interpretation and subsequent integration of the elements of the tracing with the clinical status of the patient. If communications are inadequate in any of the elements described in the aforementioned text, without purpose, ambiguous, disrespectful, and ineffective, there is a good chance that the patient will not receive the safest care that she should. Combining proper understanding of the NICHD terminology with communications policies and training in the utilization of a structured communication tool will benefit patients and increase satisfaction among members of the perinatal team.

REFERENCES


