Communication and Teamwork for Patient Safety

1.0 Contact Hour

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Communication and Teamwork for Patient Safety

By Rene' Jackson, RN, BSN, MS, LHRM

Objectives:

1. Discuss the communication process that Joint Commission requires of healthcare organizations to help eliminate errors.
2. Discuss the World Health Organization's strategies for effective communication.
3. List the problems that may occur with hand-off communication.
4. Discuss the behaviors and actions that are necessary for effective teamwork performance.

Humans are prone to error. In 1999, the Institute of Medicine (IOM) reported in *To Err is Human: Building a Safer Health Care System,* that 48,000 to 98,000 Americans die each year in the hospital, because of mistakes and oversights in medical care. Therefore, allegedly, since humans are prone to error and are not perfect, they can't be depended upon to keep patients safe. The report raised public awareness of the need for change if we are going to keep patients safe. It also presented vocabulary necessary to better understand the problem:

- Errors – failures of planned actions to be completed as intended, or the use of wrong plans to achieve what is intended.

- Adverse events are injuries caused by medical intervention, as opposed to the health condition of a patient. A large proportion of adverse events are the result of errors. When the adverse event is the result of an error, it is considered a ***preventable adverse event***.

An error may or may not lead to detectable adverse events. Errors can also temporarily or permanently harm the patient or cause death.

Communication and teamwork go hand in hand with regard to patient safety. One of the goals on the list of the Joint Commission's (JC) National Patient Safety Goals is i*mprove the effectiveness of communication among caregivers.* Joint Commission requires healthcare organizations to establish processes the will help eliminate errors:

- For verbal or telephone orders or reporting critical test results, the individual must verify the complete order or test result by reading it back.

- Abbreviations, acronyms and symbols that are not to be used throughout the organization must be standardized.

- Measure, asses and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

- Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.[1]

Communication is a two-way street. Differences in knowledge, perceptions, and decisions frequently surface when people communicate. This can cause disagreement, misunderstanding, and conflict. However, the communication process is not harmed if disagreement is managed constructively. Breakdown in communication was the leading root cause of sentinel events reported to the Joint Commission in the United States between 1995 and 2006.[2]

While the contributions of technology should not be discounted, patient care leaders recognize that substantial reductions in healthcare errors will not come until more attention is given to human solutions, such as improving teamwork and communication in healthcare teams.[3] Interdisciplinary communication and teamwork is extremely important in fostering patient safety.

Other industries, such as the military and commercial airlines, have long employed structured communication styles as a routine part of their daily normal communications. To make communication more effective, healthcare has looked to these industries for clues. Dr. Robert Helmreich from the University of Texas at Austin is one of the leading experts in aviation safety. He and his team have been studying human error and teamwork in high-risk areas environments for more than 20 years. The key is to learn to contain the consequences of mistakes (because we are human) and to train teams to work more effectively to detect and recover from errors. The medical industry is following the aviation industry's shift of a reactive to a proactive approach to errors. Instead of waiting for an error to occur, they are trying to identify problems before something happens. They take the proactive approach and analyze a system before it fails and put into place measures that prevent the anticipated failure.

The World Health Organization (WHO), in conjunction with the Joint Commission, suggests the following strategies for effective communication:

1. Ensure that healthcare organizations implement a standardized approach to hand-off communication between staff, at change of shift, and between different disciplines and units in the course of patient transfer by:

- Use of the SBAR – Situation, Background, Assessment, and Recommendation – technique. In 2001, Michael Leonard of the Kaiser Permanente of Colorado Group introduced the SBAR to the healthcare industry. SBAR is a technique that provides a framework for communication between members of the healthcare

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[1] *Facts About the 2008 National Patient Safety Goals*. The Joint Commission, OakBrook, IL. Retrieved February 10, 2008 from http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/08_npsg_facts.htm

[2] *Root causes of sentinel events, all categories.*. The Joint Commission, Oakbrook, IL. Retrieved February 10, 2008 from http://www.jointcommission.org/SentinelEvents/Statistics/

[3] Kaissi, A., Johnson, T., Kirschbaum, M. (2003). Measuring Teamwork and Patient Safety Attitudes of High-Risk Areas. *Nurse Econ* 21(5):211-218. Jannetti Publications, Inc.

team about a patient's condition. It is an easily remembered mechanism useful for framing any conversation, especially critical ones, that require a caregiver's immediate attention and action. It allows for a focused way to set expectations for what will be communicated and how, which is essential for developing teamwork and fostering a culture of patient safety

- Allocating sufficient time for communicating important information and for staff to ask and respond to questions without interruptions wherever possible (repeat-back and read-back steps should be included in the hand-over process).

- Providing information regarding the patient's status, medications, treatment plans, advance directives, and any significant status changes.

- Limiting the exchange of information to that which is necessary to providing safe care to the patient.

2. Ensure that healthcare organizations implement systems which ensure – at the time of hospital discharge – that the patient and the next healthcare provider are given key information regarding discharge diagnoses, treatment plans, medications, and test results.

3. Incorporate training on effective hand-off communication into the educational curricula and continuing professional development for healthcare professionals.

4. Encourage communication between organizations that are providing care to the same patient in parallel (tradition and non-traditional providers).[4]

Hand-off communication is the process of passing patient-specific information from one caregiver to another, from one team of caregivers to the next, or from caregivers to the patient and family for the purpose of ensuring patient care continuity and safety.[5] Hand-off communication also relates to the transfer of information from one type of healthcare organization to another, or from the healthcare organization to the patient's home.[6]

Problems with hand-off communications can occur, however, if:

- The patient is being treated by a covering physician instead of his/her own physician.

- Communication is hindered between specialist services outside the hospital and inpatient system.

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[4] The Joint Commission and World Health Organization. (May, 2007). Patient Safety Solutions. *Communication During Patient Hand-Overs.* 1(3), Solution 3.

[5] *2006 National Patient Safety Goal FAQs*. The Joint Commission, Oakbrook, IL.

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- There is lack of team training and/or communication skills.
- There is lack of good role models
- The healthcare system promotes and rewards autonomy and individual performance.
- There are language problems.

Improvements in patient safety related to clinical handoffs may occur when:

- Training is provided or specialist roles are created to facilitate communication between clinicians.
- Structures are in place to facilitate joint decision-making, such as multiprofessional handoffs with doctors, nurses, and in some cases, pharmacists.
- There is a documented care planning process and medication management through charting and completion of records. [7]

Another important aspect of care delivery is including the patients and their families in the caregiving process because they play a critical role in ensuring continuity of care.

Opportunities for patient and family involvement include:

- Providing information to patients about their medical conditions and treatment care plan in a way that is understandable to them.
- Make patients aware of their prescribed medications, doses, and required time between medications.
- Inform patients who the responsible provider of care is during each shift and who to contact if they have a concern about the safety or quality of care.
- Provide patients with the opportunity to read their own medical record as a patient safety strategy.
- Create opportunities for patients and family members to address any medical care questions or concerns with their healthcare providers.

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[7] Australian Council for Safety and Quality in Health Care, March 2005.

- Inform patients and family members of the next steps in their care, so they can if necessary communicate this to the care provider on the next shift, or so they are prepared to be transferred from one setting to the next, or to their home.

- Involve patients and family members in decisions about their care at the level of involvement they choose.[8]

Potential barriers to patient/family involvement include:

- Resistance of caregivers to change behaviors.

- Time pressures from patient care needs and other responsibilities.

- Training and time cost of implementing new hand-off processes.

- Cultural and language differences among patient population and workforce.

- Low health literacy.

- Lack of financial resources and staffing shortages.

- Failure of leadership to require implementation of new systems and behaviors.

- Lack of information technology infrastructure and interoperability.

- Insufficient generally accepted research, data, and economic rationale regarding cost-benefit analysis or return on investment (ROI) for implementing these recommendations.[9]

Through cooperative problem-solving, collaboration and communication help the healthcare team learn and grow and share different viewpoints, and find common ground. It fosters brainstorming. Teamwork is required if you want to get better results from less work and if you want to accomplish anything of value. Teamwork does improve patient safety and patient safety depends on teamwork.[10] Healthcare teamwork should focus on providing the highest quality patient care and working together toward this common goal. Teamwork combines the knowledge, skills, and attitudes of each of its individual members which allows for the team to be pro-active in catching errors before they occur, find the root cause of errors, and focus on the patient.

Solid teamwork is fundamental to achieving outcomes and increasing effectiveness.[11] Safety is all about relationships between the team members and their common goals: to

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[10] Salas, E., Sims, D., Klein, C., Burke, S. (July, 2003). Can Teamwork Enhance Patient Safety? *Forum,* Risk Management Foundation, Harvard Medical Institutions.
[11] Gonzales, C., Rotman, S. (Feb. 18, 2008). Building Block of Teamwork. *Advance for Nurses,* 9(5), 28-31.

reduce errors and provide quality patient care.[12] Effective teams function through collaboration among patients, families, team members and other teams throughout the healthcare system.[13] Collaboration involves analyzing situations and defining the conflict at a higher level where shared goals are identified and commitment to work together is generated.[14] Effective relationships and collaboration are built on trust, but without trust, team collaboration, along with patient safety, is compromised.[15] For example, the conversation and dialogue between the nurse and the physician establishes a safe care plan based on the current status of the patient.[16] When this, and other, important conversations about patient care are misinterpreted, incomplete, blocked, abbreviated, unclear, or absent, patient safety can suffer and an injury may follow.[17] Teamwork and communication enable healthcare professionals to safely and consistently delivery high quality patient care. Breakdowns in communication and teamwork are the leading contributors toward errors in medical treatment.

Effective teams have members who anticipate each other's needs and they can coordinate without the need to communicate overtly – this is vital in high stress, tim-restrictive environments.[18] Each member of the team recognizes his/her dependence on the other team members, and knows that together they will be able to solve problems. They also recognize problems before they occur and are able to adapt to change quickly depending on the need of the current situation. Teams should work well in everyday situations, so they can quickly react when crises occur. Effective teams have the ability to avoid or minimize potential for error. To facilitate effective teamwork the following behaviors and actions are necessary for effective performance. They must:

- Proactively and reactively adapt to changing circumstance.
- Use information collected from the task environment or situation to make adjustments in treatment plans or procedures.
- Demonstrate clear and concise closed-loop communication (verify sent messages are both received by the intended party and interpreted by the receiver correctly).
- Monitor their teammates and provide back-up behavior.
- Demonstrate strong leadership.
- Manage conflicts appropriately.
- Make informed decisions.

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[14] Yoder-Wise, P. (1999). *Leading and Managing in Nursing.* St. Louis, MO: Mosby, Inc. 2nd Edition, pg. 327.
[15] Reina, M., Reina, D, & Rushton, C. (2007). Trust: The foundation for team collaboration and healthwork environments. *AACN Advanced Critical Care*, *18*(2), 103-108.
[16] Veltman, L., Larison, K. (2007). Pure Conversations: Enhancing communication and teamwork. *Journal of Healthcare Risk Management*, *(27)*2, 41-44.
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[18] 10

- Promote coordinated action by synchronizing the team's task requirements, material resources, strategies, and responsibilities.[19]

- Have a shared understanding of how a procedure/plan should be carried out.

- Enlist the patient's participation as part of the team when appropriate.

- Anticipate the needs of others.

The report *To Err is Human* endorses the systems approach to understanding and reducing errors, and that failures are most often due to unanticipated events or factors occurring within multiple parts of the systems, though the human component is a large contributor. Improving patient safety requires more than relying on the workforce and well-designed work processes; it requires an organizational commitment to vigilance for potential errors and the detection, analysis, and redressing of errors when they occur.[20]

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[20] National Academies Press. Board on Health Care Services. Institute of Medicine. *Creating and Sustaining a Culture of Safety - Keeping Patients Safe: Transforming the work environment of Nurses* (2004).