REDUCING RISK
THROUGH STRONG COMMUNICATION SYSTEMS

Strengthening clinical communication mechanisms across the healthcare continuum can help reduce malpractice risk.
COMMUNICATION FAILURES HAVE BEEN IDENTIFIED AS THE ROOT CAUSE OF THE MAJORITY OF BOTH MEDICAL MALPRACTICE CLAIMS AND MAJOR PATIENT SAFETY VIOLATIONS IN HEALTHCARE (SCALISE, 2006).

This includes errors resulting in patient death. Risk managers in the US and many other countries such as Canada and England agree that up to 80% of malpractice claims can be attributed to failures in communication and/or a lack of interpersonal skills (Andrews & Miller, 2005). In addition, studies confirm that dysfunctional communication among healthcare providers leads to medication errors, patient injuries, and even death (Kohn, Corrigan & Donaldson, 2000; Leape, 1994; Page, 2004; Tammelleo, 2001; 2002).

The Joint Commission (TJC) performed an extensive 10 year review of sentinel events in the acute care setting. They found over 60% of the sentinel events in the time period studied could be traced in some way to poor communication (The Joint Commission, 2006). The graphic representation in Figure 1 shows communication far exceeds other common causes of sentinel events such as patient assessment, staffing, procedural compliance or organizational culture.

FIGURE 1.

From “A Case for Strengthening Nurse-Physician Relations” The Advisory Board Company, Washington, D.C.
As expected, most sentinel events have a mixture of causes. The astounding discovery is the extent to which poor communication led to a sentinel event or poor outcome. This would indicate that communication and communication patterns should be considered in all sentinel event investigations in healthcare settings.

Several communication risk points are found in the care continuum in many residential healthcare settings. Communication processes across the organization and among team members have been implicated in clinical error. In addition, information exchange with outside services such as lab work, diagnostic tests or special treatments are vulnerable, as are specialty care visits.

HANDOFFS ACROSS ORGANIZATIONS

Resident handoff in any area of healthcare is a risk point, but handoffs are particularly frequent in fragmented settings, where residents regularly move between areas of diagnosis, treatment and care and encounter multiple shifts of staff. This increases safety risk. Gaps in communication can cause serious breakdowns in the continuity of care, inappropriate treatment and potential harm to the resident. The following are some handoff points to consider:

**Facility to Facility:** Care may be started in one setting while the resident is awaiting assignment in another setting. Once admitted to the next healthcare setting, medical orders and continuation of healthcare treatments started previously may be in jeopardy.

**In-System Transfers:** Residents can be moved from place to place within the healthcare system for a variety of reasons including change in level of care required, staffing, a need for a different type of service or activity. For example, residents can be moved from an acute care facility to skilled care.

**Housing:** Changes can take place within a continuum of care when an resident is reassigned to a different level of care such as assisted living to long term care.

**Admission and Discharge:** Residents move to and from acute care or an outpatient short procedure unit.

All of these areas of potential risk should be considered as you evaluate clinical communication in your setting.
Verbal Communication

Verbal communication is a primary way resident care is managed among clinical team members. Ineffective communication can risk resident injury. Several key areas are worthy of attention in seeking to reduce communication risk.

- Within Discipline: Nursing shift reports can be missed in the confusion of resident movement. For example, a resident might depart for an off-site treatment during one shift and return during another.
- Across Disciplines: An example of a common weakness is communication between medical and rehab health staff. Complex resident treatment plans require frequent updating across disciplines.
- Clinician Availability: Key issues can be missed when key staff members are only available periodically. For example, a small facility may only have medical staff onsite certain hours or days of the week. At other times or on other days calls must be made and return calls awaited. This leads to frustration and missed information, especially when staff from one shift initiate communication but another shift is onsite when a return call is made.

In a review of research on patient safety in clinical handoffs, two key areas of increased concern were identified (Scalise, 2006). These interactions are of particular issue in more fragmented healthcare delivery systems:

- Treatment by a covering physician rather than a primary physician
- Communication between an outside specialty service and the resident care team

Attention should be given to the communication loop between on-call physicians and the resident’s primary physician in many fragmented, residential or outpatient settings. Orders provided in an emergency situation need to be integrated with the resident’s medical record. A communication process should be in place for alerting the primary physician to any emergency care provided on off hours and weekends.

In addition, a system is needed to assure that specialty consult information returns to the ordering physician and arrives to the resident’s medical record. Delays in treatment initiation or missed diagnoses can result from ineffective communication in this channel.

Team verbal communication has been found to improve with the following efforts:

- Specific communication and handoff training is provided to clinical staff
- Structures in place such as multi-professional handoffs with doctors, nurses, and in some cases, pharmacists.
- There is a documented care planning process and medication management through charting and completion or records (Scalise, 2006)
Using a standard communication process can strengthen clinical communication (Manning, 2006). Structured verbal communication systems such as SBAR have been used for some time in high reliability organizations which need to make quick informed decisions such as nuclear power, NASA and mission control, aviation, air traffic control and dispatch services (Doucette, 2006). More recently, structured communication has been advocated by the Joint Commission for use in resident handoffs as a part of their National Patient Safety Initiatives. Documented benefits of SBAR include streamlined communication processes where critical information is communicated effectively. This improves resident safety, reducing medical errors and improving relationships within the healthcare team. Structured communication minimizes confusion and saves time.

SBAR is an acronym for a four part verbal communication pattern – Situation, Background, Assessment, Recommendation (Table 1). It is a way to organize the information that must be shared rapidly in an urgent or emergent situation where communication can be scattered and disorganized. This framework provides hooks to hang important information while weeding out extraneous and unnecessary items.

**TABLE 1.**

<table>
<thead>
<tr>
<th>SBAR Structured Communication Process</th>
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<tbody>
<tr>
<td>S</td>
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<tr>
<td>B</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>R</td>
</tr>
</tbody>
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*Adapted from Haig, Sutton, & Whittington, 2006*

Several studies on the use of SBAR indicate the benefits of use. At St. Joseph Medical Center, the number of general adverse events and the number of adverse drug events decreased significantly with the addition of structured communication (Figure 2).
In another published study, mortality rates were reported to have reduced over time at Tallahassee Memorial Hospital with the addition of a verbal communication model along with multidisciplinary rounding (Figure 3). Research and application in the acute care setting suggest that structured communication can also reduce clinical error in the other settings.
Written Communication

Systems that help prevent communication failures are easy to understand, offer consistency and predictability and minimize reliance on human memory (Nadzam, 2009). These systems can range from written guidelines to checklists and protocols. Checklists are a common memory-jogger in healthcare. Some residential care examples include assessment, on-call reports, returns from other departments for treatments and transfers.

Another consideration in reducing risk in written communication is the elimination of unsafe abbreviations. The Joint Commission has published a list of the most frequently confused abbreviations used in healthcare (Table 2). Healthcare settings accredited by TJC are banned from using them in documentation. Other healthcare settings should also eliminate these confusing abbreviations.

The Joint Commission has published a list of the most frequently confused abbreviations used in healthcare.

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**Table 2.**

Joint Commission Official “Do Not Use” List

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “00”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.d, qod (every other day)</td>
<td>Period after the Q mistaken for “I” and the “O” mistaken for “I”</td>
<td>Write “every other day”</td>
</tr>
</tbody>
</table>

from The Joint Commission, 2010
Several communication culture factors have been found to hinder effective clinical communication (Wood, 2006). Evaluate these areas in various healthcare settings’ clinical communication in order to reduce risk. Awareness is key to overcoming communication culture issues.

**Culture and Ethnicity**

A staff member’s cultural background may affect how he or she interacts with other team members. Language barriers and accents can hinder understanding of the medical information that is being exchanged or the decisions being made. Inappropriate assumptions can easily result. Encourage staff to ask for clarification if information is not understood.

**Socioeconomics**

Levels of education and organizational power inequity can provide a communication overlay affecting interpretation of information. Hierarchical power within the care culture such as between physicians, nurses and nonclinical staff can lead to hesitancy to question or ask for clarification of ambiguous or unsafe treatment directions or task delegation.

**Personality/Behaviors**

Gruff communication, sexual overtone or dismissive/impatient vocal tones set up a risky communication dynamic. Tension develops among team members leading to avoidance and ambiguity.

**Relationship/Trust**

Lack of trust or lack of sufficient relationship can cause team members to question the communication message or be hesitant about judgments made. For example, an on-call physician may not know a nurse calling about a resident’s chest pain in the early hours of the morning. Because of the lack of sufficient relationship and possible attentiveness of the nurse, the assessment information provided by the nurse may not be trusted by the physician. This may result in an unnecessary testing in order to determine appropriate diagnosis and treatment.

In considering clinical communication, evaluating the organization’s communication culture in these key areas is a first step in reducing risk. A communication culture can be a difficult structure to change, requiring much time and effort. But, spending time to improve clinical communication will develop staff communication capacity and decrease malpractice risk.
UNDERSTANDING ROLES

In many settings, communication with nonclinical staff becomes important as spheres of responsibility often cross. All healthcare staff need to understand their roles, the roles of other care providers and what can be expected of nonclinical staff. Healthcare staff, at times, can be expected or requested to practice outside their licensure or job description. In those situations, staff must know how to communicate that a request is inappropriate for them to perform. They may also need to know an administrative recourse for how to resolve the issue.

SUMMARY

Communication breakdown is a leading cause of clinical error. There is great opportunity to reduce malpractice risk by strengthening clinical communication mechanisms across the healthcare continuum and among team members. Attention to vulnerable points in the communication chain such as resident transfers, off-site care delivery, and covering provider orders can reap major benefit. Adding structured verbal communication and reducing confusing documentation can contribute to error reduction. In addition, investing time in developing a conducive communication culture where every team member understands their role will contribute to resident safety and risk reduction.

NEXT STEPS

Follow these steps to effectively use this information in your healthcare setting, if appropriate.

- Evaluate the current clinical communication culture
- Test communication loops in vulnerable clinical processes
- Implement communication best practices
- Develop staff communication skills over time


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