



Communication: Patient Safety and the Nursing Work Environment

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Today's Health Care Environment

Providing safe patient care is a challenge in today's health care environment. Even with the many advances in technology, basic, effective, interpersonal communication remains essential to the provision of safe patient care. Ineffective communication is a major factor in adverse events — it leads as a contributing cause in sentinel events reported to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Ineffective communication is also implicated as the leading cause in medication errors, delays in treatment, perinatal deaths and injuries, and wrong site surgery, and is the second leading cause for patient falls (JCAHO, 2006a).

Communication Issues

At the 2006 Agency for Healthcare Research and Quality Patient Safety and Health Conference, Elizabeth Dayton and Kerm Henriksen identified five factors that impede effective communication. First, interruptions can disrupt work flow and cause a negative impact on the safe, effective completion of tasks. Second, physicians and nurses are educated in separate silos. This can hinder effectiveness of communication between the two disciplines because of differences in the “implicit assumptions” of the two professions. Third, authority gradients may exist in which health care providers are afraid to “speak up.” This is particularly evident in a hierarchical structure that impedes both upward communication and dissemination of critical information that could prevent an error from occurring. Fourth, given the complexity of today's health environment, it is not always clear who is responsible for what. This adds to the confusion and places patients at risk for needs not being addressed in a timely manner. Fifth, the multiple transitions (also known as handoffs) that occur across the health care continuum are a high-profile factor that increases the risk of miscommunication. Handoffs occur during shift changes, transfers and discharges. During each handoff there is risk of loss of critical information (Dayton & Henriksen, 2006).

Ineffective communication processes are receiving attention in many health care venues. A major study titled *Silence Kills* (Maxfield et al., 2005) identifies a number of issues related to communication, including incompetence, poor teamwork and disrespect. Whereas 53 percent of nurses and other health care providers had concerns with colleagues' competence, the majority were reluctant to discuss their concerns. Roughly three out of four nurses and other health care providers expressed concern regarding poor teamwork and disrespect (for example, verbal abuse and bullying) they experienced. Nurses and other health care providers experience lack of teamwork and significant disrespectful communication from their peers and physicians, which seems ironic in a profession focused on caring.

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Despite these challenges, new innovations and strategies are emerging to support a culture that allows and promotes open and effective communication among all health care providers. The American Association of Critical-Care Nurses (AACN) developed the *AACN Standards for Establishing and Sustaining Health Work Environments*. The first standard addresses the importance of effective communication, stating that “Nurses must be as proficient in communication skills as they are in clinical skills.” (American Association of Critical-Care Nurses, 2005). Another important standard calls for collaborative relationships, centered on mutual respect and zero-tolerance policies. This position is also emphasized by The Texas Nurses Association’s Nurse-Friendly Criteria, which focus on the importance of improving interdisciplinary relationships and requiring zero tolerance of abuse of nurses. Unfortunately, as the problems with communication are complex and involve all disciplines, resolution of these issues requires a multifaceted, comprehensive approach and organizational commitment.

Educational Needs

The need to improve collaboration and communication among health care providers has implications for the education of future nurses, physicians and other health care providers. Educational strategies must be developed to better prepare students to collaborate effectively in the future, not only to build “bridges rather than silos” but to rethink what and how students are taught to better meet the needs of the future (Miller, 2004). Inter-professional communication and collaboration are key to improving patient care delivery and effective care. Barriers to interdisciplinary education exist but these barriers can be “managed and overcome” (McPherson et al., 2001, p. 46).

Organizational Efforts

Organizations need to promote the kind of culture and structure that facilitates communication among all members of the team, and encourages nurses to speak up and address all concerns that place — or may place — patients at risk. Several organizations are reporting success with communication models that enhance communication

and allow all members of the team to be heard. One such model, the Situation, Background, Assessment, and Recommendation (SBAR), provides health care providers with a method for improving communication. Organizations that have used SBAR (Haig et al., 2006; Leonard et al., 2004) report a number of successes. St. Joseph Medical Center in Indiana reported a decrease in adverse events and fewer occurrences of missing information during patient handoffs (a time when many communication errors occur). Kaiser Permanente reported improvement in the patient transfer process and a decrease in wrong site surgeries (Leonard et al., 2004).

To successfully use a tool such as SBAR, organizational support and commitment from the leadership are essential and must include provision of education, technical support, monitoring and feedback. The style and effectiveness of communication reflect the culture within the organization. If the culture is very hierarchical and not supportive of patient safety, communication errors will occur and patients will be harmed. St. Joseph’s reports that flattening the hierarchy facilitated communication among physicians and nurses (Haig et al., 2006).

Techniques employed in other industries to reduce risk associated with communication (read backs) are being adopted in health care (Barenfanger et al., 2004; Hanna et al., 2005), and in fact are JCAHO patient safety goal expectations (JCAHO, 2006b). Other strategies to improve communication processes include the Sentara system in Virginia, which uses behavior-based expectations to improve communication processes. The Department of Defense developed a tool kit to improve patient safety that includes a number of tools improving communication (Davis, 2005; Department of Defense Patient Safety Center, 2005).

These challenges in health care communication today require strategies to address deficiencies in communication, both at the organizational level and at the individual practitioner level. As a profession we need to move forward in addressing problems with communication. We need to promote collaboration with all members of the health care team and develop systems to enhance communication and safeguard patients.



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