CHAPTER 2

Communication: Speak Up to Prevent Unfavorable Events

Sentinel Events

The Joint Commission recommends "careful investigation and analysis of patient safety events (events not primarily related to the natural course of an individual's illness or underlying condition), as well as evaluation of corrective actions is essential to reduce risk and prevent patient harm" (Joint Commission, 2020). The Joint Commission refers to these events as sentinel events (SE) and has identified the most frequent root causes. Inadequate communication has appeared as the third most frequent cause of these events since 2009 (Joint Commission, 2020).

Examples of Failure to Communicate

Incident 1

When a student performs a catheterization, contaminates the catheter, and inserts it into the individual anyway.

Cause: Failure to communicate the need for assistance or the need to stop and start the procedure again. This event increases the risk of infection for the individual.

Incident 2

An individual's condition is declining, and the physician/NP/PA does not respond to the nurse's assessment and need for evaluation. The lack of response must be addressed, and the nurse must notify the next in the chain of command (i.e., manager or chief of staff).

Incident 3

A nurse observes a protocol violation that will increase the risk of infection (e.g., contamination of venous access during dressing change). Does the nurse stop the or ignore it? Would it matter if the individual receiving the dressing change were the nurse's relative?

Incident 4

An individual falls while trying to access the bathroom. Were safety measures instituted to prevent the fall? Were the individual's risk factors for a fall clearly communicated during the handoff report?

Barriers to Speaking Up

What prevents a nurse from calling a physician/NP/PA when needed, reporting on negligent staff members to management, asking for help, or discussing poor prognoses or end-of-life care with a family?

- Fear
- Inexperience
- Belief that they will not be taken seriously
- Retaliation
- Intimidation
- Disruptive response

In 2008, the Joint Commission issued a sentinel event alert regarding behaviors that undermine a culture of safety (*Joint Commission, 2008a). "Reporting raises the level of transparency in the organization and promotes a culture of safety" (Joint Commission, 2020).

Intimidating and disruptive behaviors can foster medical errors, contribute to poor satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. Safety and quality of care are dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, healthcare organizations must address the problem of behaviors that threaten the performance of the healthcare team.

Intimidating and disruptive behaviors include overt actions, such as verbal outbursts and physical threats, as well as passive activities, such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. These behaviors are often manifested by healthcare professionals in positions of power. Such behaviors include reluctance or refusal to answer questions or return phone calls or pages; condescending language or voice intonation; and impatience with questions. Overt and passive behaviors undermine team effectiveness and can compromise the safety of individuals. All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

CARP'S CUES

According to the survey by the Institute of Safe Medication Practices, 17% of respondents had felt pressured to accept a medication order despite concerns about its safety on at least 3 occasions in the previous year; 13% had refrained from contacting a specific prescriber to clarify the safety of an order on at least 10 occasions; and 7% said that in the previous year they had been involved in a medication error where intimidation played a part (Vaida, Lamis, Smetzer et al., 2014).

Most nurses can relate numerous incidents when during morning report (handoff) the nurse reports a change in an individual's condition during the night that was not reported to the physician because of "fear of the response."

Disruptive Behavior

Hospitals are mandated to have a policy that (Joint Commission, 2008b. 2016):

- Defines disruptive and inappropriate behavior
- Outlines a process for managing disruptive and inappropriate behaviors.

Everyone is entitled to have a "bad day" on occasion within limits. Disruptive behavior is a pattern of inappropriate, abusive conduct that harms and intimidates others. In healthcare settings, this behavior compromises the quality of care and/or safety for individuals.

Any member of the healthcare team can be disruptive (i.e., a nurse, manager, administrator, medical assistant, physician, nurse practitioner, etc.). It is unacceptable at any level and there needs to be a culture of zero tolerance. Even in an atmosphere where disruptive behavior is expected and tolerated, individual nurses can choose to speak up. Everyone can develop the skills to communicate effectively while preserving his or her dignity.

CARP'S CUES "So, for most nurses, the first step in addressing disruptive behavior is internal. It starts with an absolute belief that nobody deserves to be yelled at for making or witnessing a mistake, much less while doing their job correctly and competently" (Lyndon et al., 2012).

Effective Communication

In 2004, communication failure was the leading cause of inadvertent patient harm in over 70% of the 2455 sentinel events reported to the Joint Commission for Hospital Accreditation (JCAH, 2004, quoted in Leonard et al., 2004, p. i86). Ten years later in 2014, communication failure has caused less than 24% of sentinel events (Joint Commission, 2020). Thus, the focus on effective communication was successful.

Delivering high quality, safe patient care is impossible without effective communication and teamwork, and too often communication failures cause inadvertent patient harm. The complexity of medical care, coupled with the inherent limitations of human performance, make it critically important that clinicians have standardized communication tools, create an environment in which individuals can speak up and express concerns, and share common 'critical language'" (*Leonard et al., 2004, p. i85).

As described earlier in this chapter, it is just as important to create a safe working environment where team members feel comfortable speaking up about safety concerns (*Leonard et al., 2004).

SBAR

The Situation, Background, Assessment, and Recommendation (SBAR) technique* has become the Joint Commission's stated industry best practice for standardized communication in health care (Joint Commission, 2012).

SBAR is used in the U.S. military, aviation, and law enforcement to improve communication during emergencies. Leonard et al. developed SBAR for use in healthcare centers (*2004). It is a framework for communicating pertinent information clearly and consistently among healthcare professionals. SBAR quickly organizes the briefing information in one's mind or on paper.

Predictable structures like SBAR offer a sense of familiarity in the communication process and allow healthcare professionals to easily and concisely transmit critical information. In addition, SBAR helps develop essential critical thinking skills. "The person initiating the communication knows that before they pick up the telephone that they need to provide an assessment of the problem and what they think an appropriate solution is" (*Leonard et al., 2004, p. i86).

Therefore, even if a nurse at the bedside cannot exactly identify what is clinically unfolding, they most likely know that something is wrong and a solution is needed. "Lowering the threshold to obtain help and treating the request respectfully and legitimately creates a much safer system" (*Leonard et al., 2004, p. i86).

This format is useful in handoffs (shift report), when an urgent response is needed and in conflict situations (*Leonard, Graham, & Bonacum, 2004). SBAR examples are found throughout the plans.

Table 2-1 outlines the format of SBAR with examples.

If one is reluctant to act, prior to notifying or discussing an individual with a physician/NP/PA, discuss the situation with the manager or coordinator.

CARP'S CUES

Avoid having experienced colleagues call instead of yourself, which will only continue your fears and inexperience. Students can be assisted with a clinical nurse or faculty listening while the student talks. The faculty person can add data if needed. This is an invaluable lesson that must be practiced as a student.

Consider the following prior to making the call:

- Select the appropriate physician/NP/PA
- Assess the person yourself before calling
- Open the electronic health record of the person
- Relate allergies, pertinent medications, per os (PO) status fluids, lab results
- Report vital signs, focus on changes
- Clarify code status if it is unknown

---

* Michael Leonard, MD, Physician Leader for Patient Safety, along with colleagues Doug Bonacum and Suzanne Graham at Kaiser Permanente of Colorado, developed this communication tool, which was adapted from the U.S. Navy. The SBAR technique has been implemented widely at health systems, such as Kaiser Permanente.

Table 2-1 SBAR Guidelines

When calling the physician/nurse practitioner, follow the SBAR process:
(S) Situation: What is the situation you are calling about? What is going on with the individual?
■ Identify, self, unit, the individual, room number
■ Briefly state the problem/situation, what it is, when it happened or started, and how severe.
(B) Background: Pertinent background information related to the situation could include the following:
■ The admitting diagnosis and date of admission
■ List of current medications, allergies, intravenous (IV) fluids, and labs
■ Most recent vital signs
■ Lab results: provide the date and time test was done and results of previous tests for comparison
■ Other clinical information
■ Code status
(A) Assessment: What is your assessment of the situation? What do you think the problem is?
(R) Recommendation: What is your recommendation or what do you want?
Examples:
■ "I need you to come now and see the individual."
■ Order change
■ Notification that the individual has been admitted
■ Need to transfer to intensive care unit (ICU)
■ Any tests needed?
■ Need to talk to individual's family about code status

"Medical care is extremely complex, and this complexity coupled with inherent human performance limitations, even in skilled, experienced, highly motivated individuals, ensures there will be mistakes" (*Leonard et al., 2004, p. i86).

"Effective teamwork and communication can help prevent these inevitable mistakes from becoming consequential, and harming individuals and providers" (*Leonard et al., 2004, p. i86).

The Handoff Process or Shift Report

The handoff is a term used to describe the transfer of information (along with authority and responsibility) during transitions in care across the continuum

Table 2-2 Tips to Increase the Effectiveness of Handoffs

1. Establish that the dialogue will be limited to that which will improve the care to individuals.
   - Avoid negative discussions of family, visitors, individuals
   - Avoid socialization
   - Avoid criticizing staff, personnel, etc.
2. Relate to the priorities of care for the individual.
   - Frequency of vital signs
   - Changes in condition
   - Physician/NP/PA involvement
   - Last PRN medication dose, time
   - Risk status for falls and pressure injuries
3. Report what has been done or needs to be addressed to prepare for transition.
   - Teaching, referrals, individual/family involvement
   - Individual/families understanding of condition, home care

Data from Joint Commission (2020) Sentinel Events (SE) accessed at https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/joint-commission-online/march-24-2021/sentinel-event-statistics-released-for-2020/

(*Friesen et al., 2008). This handoff, also known as shift report, transfer report, or sign over, is utilized at:

- Change of shift on a unit
- Transfer to another care facility
- Discharge to a community agency

Effective handoffs support the transition of critical information and specifically identify high-risk and clinically unstable individuals. Unfortunately, the literature describes adverse events and safety risks occurring when the handoff process is compromised, incomplete, and/or missing (*Friesen et al., 2008).

All healthcare facilities have a format/process for handoffs; however, the quality and accuracy of the handoff are primarily dependent on the involved clinicians. Nurses engaged in handoffs can increase the accuracy and clarity of the dialogue. Refer to **Table 2-2** for strategies to increase the effectiveness of the handoff. The usual data, name, room, age, medical diagnoses, medicines, and treatment will also be presented.

CARP'S CUES

Nursing care is 24 hours a day/7 days a week. Care of an individual is not completed when a shift is over. The care continues and thus, it is a handoff.

Sometimes, a treatment may have to be handed over to the next nurse. Working as a 24-hour team is less frustrating than working independently. Nursing is a difficult profession with huge responsibilities. Lend a hand to your nursing colleague because it is the right thing to do. Note: Nurses, who habitually hand off incomplete care without cause is a management problem. Wagner, Patow, Newton et al. reported that 69 percent of clinical learning environments did not have a standardized handoff process, and only 20 percent had some standardization (2016).

Students are strongly encouraged to refer to The Joint Commission Center for Transforming Healthcare. Targeted Solutions Tool® for Hand-Off Communications. Oakbrook Terrace, Illinois: The Joint Commission, 2017, access at https://www.centerfortransforminghealthcare.org/improvement-topics/hand-off-communications/

Summary

Despite the explosion of technology as electronic medical records, invasive lines with alarms, bed alarms, cardiac alarms, and patient-controlled analgesia (PCA) pumps, the safety and comfort of individuals and their families depend primarily on the expertise of the bedside nurse. The expert nurse knows when something is not right or when wrong is wrong, and one must step up, speak out, and intervene.