

Lessons Learned, 2005 #02 -- "Say What?" Verbal Communication Among Team Members

The Case

Early in the evening, Dr. Steve Adams, an attending physician, berated Dr. Johnson, the junior resident, at the nursing station regarding his care decisions for a patient on their service. Dr. Johnson was often intimidated by Dr. Adams, but was particularly embarrassed this time, as several of his fellow residents witnessed this public interaction.

During the night, Dr. Johnson was called regarding abnormal laboratory test results on a different patient on the service. Despite his uncertainty regarding how to follow-up on the labs, and recalling the incident from earlier in the day, Dr. Johnson decided not to call Dr. Adams for assistance. Shortly thereafter, Dr. Johnson received an urgent page from the nurse on the unit that the patient's vital signs were worsening. Dr. Johnson called the ICU resident and the patient was transferred to the intensive care unit where she was stabilized and ultimately was discharged to home.

Commentary:

Although the case described above is fictional, it is representative of what can occur when communication between members of a health care team is compromised.

Ineffective communication among team members is the most frequently identified root (underlying) cause of sentinel events, both here at VCUHS, as well as nationally.

- Ninety percent (90%) of errors committed in ALL industries, including healthcare, involve communication.
- Ineffective communication contributes to medication errors, mistaken identities (wrong patient), wrong site surgery and other medical mishaps. In addition to contributing to untoward outcomes, these errors cost hospitals and patients billions of dollars annually.
- Multiple factors can contribute to ineffective communication:
 - o In this case, intimidation led to a failure to communicate information and to ask for assistance
 - o Hierarchical relationships may lead to failed communication due to lack of willingness to challenge the decision making of someone in a position of higher authority (this was a factor in some airline crashes prior to the aviation industry's changes in culture and communication standards).
 - o Other human factors, such as fatigue, distractions and interruptions also contribute to failed communication.

Discussion Points:

1. Be aware of factors that might impair clear communication with a colleague:

- o background noise
- o multi-tasking
- o working relationships
- o interruptions
- o time pressure

2. Tips to communicate clearly:

- o Take time to organize your thoughts first; this will help you communicate information efficiently and effectively, in addition to helping the person receiving your information understand it
- o Minimize distractions by stopping other tasks and moving to a quieter area
- o Be sure that you have the full attention of the person you are speaking to when you have important information to relay
- o **Learn to "CUS"**, a communication technique developed by aviation to denote concern for a situation -- it centers around shared "critical language," or words that should trigger everyone to stop and evaluate the situation:
 - "I am **C**ONCERNED about..." -- indicates a concern that requires attention
 - "I am **U**NCOMFORTABLE with..." -- indicates a concern that requires attention
 - "I think we have a **S**AFETY issue..." -- requires immediate attentionAll of these words mean, "We potentially have a serious problem, stop and listen to me now."
- o When you have a concern that is not resolved, elevate it through the chain of command.

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- o Senior staff and managers should respond respectfully to all patient-centered concerns. Misguided concerns should be used as educational opportunities.
- o Avoid intimidation and address performance issues in a constructive manner away from public settings (i.e., private office rather than nursing station).
- o **Verbal order readback** -- When accepting any verbal order or critical test result, write them down, then verbally read back the entire order/results (including patient name) for confirmation.
- o **Final Verification** -- Perform final verification before any invasive procedure, an active, verbal exchange between at least two caregivers confirming correct patient, site and procedure.
 - Note: If you are performing a procedure alone, and another caregiver is not available for this exchange, pause before the procedure to verify right patient, procedure, site, etc.
- o Perform hand-off reports, including change of shift & “sign-outs” in a quiet environment, minimizing distractions and interruptions, whenever possible.