



Professional Communication: Speak Up, Speak Well

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Purpose

The purpose of this course is to provide the healthcare professionals with tips and tools to improve oral communication, both with patients and with other health team members. This course showcases the regulatory agencies expectations surrounding effective communication among healthcare works and with patients.

Objectives

After successful completion of this course, you will be able to:

1. Define verbal and nonverbal communication and the impact of nonverbal messages such as posture, eye contact, attitude, and personal appearance.
2. Identify barriers to communication, including attitude, language, and disability.
3. Explain HIPAA requirements concerning confidentiality and disclosure of personal health information.
4. Define privileged communication.
5. Define slander.
6. Explain why assertiveness is an important characteristic of professional communication.
7. Identify legal implications of spoken communication.
8. Describe the SBAR framework for communicating with a provider.
9. Explain what is meant by the chain-of-command and state examples of when to use it.
10. State the steps in the process of crucial conversations.
11. Describe initiatives of the American Association of Critical Care Nurses (AACN) and the Joint Commission (TJC) related to communication in healthcare facilities.
12. Identify the relationship between communication and selected aspects of The Joint Commission (TJC) requirements, including:
 - Patient identifiers
 - Ambiguous terms
 - Rapid response team
 - Verbal and telephone orders and reports
 - Hand-off of responsibility
 - Reconciliation of medications
 - Active involvement of patient and family in safety
13. State important considerations when communicating about errors, urgent situations, and safety risks.
14. Describe communication concerns in special situations involving patients such as:
 - A patient's non-conforming behavior
 - Offering opinions to patients
 - Patient teaching
 - Delivering bad news

Introduction

"If you don't want to be sued, don't be rude." (Helm, 2003)

Good interpersonal rapport and clear communication prevents lawsuits. Beyond the rapport-building effect of courtesy, when staff members clearly communicate what the patient may anticipate in care and outcomes, the patient has more realistic expectations.

Suspicious patients sue. When a patient complains, discuss the issue with the patient. Involve other staff members such as your manager in an attempt to deal with the issue and defuse the complaint. Dismissing a complaint CAN lead to a lawsuit.

Focus on Oral Communication

Professional communication is critical to safe, effective patient care. Communication is a basic concept, yet communication failures result in disastrous outcomes for both patients and nurses. Both written communication such as documentation and oral communication such as hand-off reporting play important roles in patient safety. This course focuses on oral communications within the healthcare team and with patients and families.

The Joint Commission and Sentinel Events

The Joint Commission (TJC) defines sentinel events as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome. Sentinel events are identified under TJC accreditation policies to help aid in root cause analysis and to assist in development of preventative measures. The Joint Commission tracks events in a database to ensure events are adequately analyzed and undesirable trends or decreases in performance are caught early and mitigated (The Joint Commission [TJC], 2014). It is important for the nurse to recognize that sentinel events are not usually caused by a single action; both system and individual issues are often found to be causative agents.

The Joint Commission and Root Cause Analysis

The Joint Commission defines a Root Cause Analysis (RCA) as a comprehensive systematic analysis for identifying the causal and contributory factors. Root cause analysis, which focuses on systems and processes, is the most common form of comprehensive systematic analysis used for identifying the factors that underlie a sentinel event (TJC, 2015).

This RCA process results in an action plan that identifies the strategies that the healthcare facility intends to implement to reduce the risk of similar events happening in the future. These action plans should include strategies for revising system issues along with individual issues and should not be punitive in nature.

Communication, Sentinel Events, & Root Cause Analysis

Why focus on oral communication? The Joint Commission has identified communication as a leading root cause of sentinel events. The Joint Commission defines the communication root cause to include oral, written, and electronic communication among staff, with/among

physicians, with administration, and with patient or family. During the time period 2004 through second quarter 2015, communication ranked third overall as a root cause of sentinel events. Communication ranked:

- First in events related to delay of treatment, elopement, or fire that resulted in death.
- Second in maternal and perinatal events, operative and post-operative events, restraint-related events, suicide, and transfer-related events resulting in permanent injury or death.
- Third in wrong-patient, wrong-site, wrong-procedure events regardless of the magnitude of the procedure.

(TJC, 2015)

What We Have Here is a Failure to Communicate

- Effective and safe health care depends on effective communication. A patient who is able to clearly express his complaint, symptoms, history, and his comprehension is an equal partner with a physician or nurse who is trying to help.
- Between 2006-2010, over 1100 medical malpractice suits were instituted against Controlled Risk Insurance Company insured clinicians. Communication breakdown was a component of 42% of the cases (Hoffman & Raman, 2012).

Did You Know?

That 69% of communication cases allege that the patient did not receive information that he or she needed to understand their health issues, make informed decisions about treatment options, or manage their long-term care (Hoffman & Raman, 2012).

Importance of Comprehensive Documentation

Conversations and oral reports are often not documented. Therefore, when lawyers investigate allegations of malpractice and gather evidence, often years later, those involved in the situation may have to rely on memory. Experts recommend documenting all conversations related to patient care in the patient's medical record, or if concerning a disagreement about care, in whatever reporting system organizational policy and procedure specifies (Reising, 2012).

Verbal and Nonverbal Communication

Communication involves giving information, and very importantly, **exchanging** information. To exchange information effectively, the person who receives communication must validate that he understood what the communicator intended.

The validation process is required in some situations, such as reading back verbal and telephone orders for confirmation. Validating and clarifying the meaning of another's communication prevents errors, problems, and misunderstandings.

The Importance of Non-Verbal Communication

The nonverbal component that accompanies spoken words influences interpretation more than the words themselves. When someone makes a sarcastic comment, nonverbal inflections or gestures change the meaning of the spoken words. Nonverbal communication conveys attitude, sometimes in a way that the communicator does not intend.

Cultures differ not only in the meaning attached to certain words, but also in the meaning of nonverbal communication. When communicating with someone whose culture differs from your own, it is especially important to validate meaning.

Communicate with a self-confident attitude to convey professionalism and competence and to encourage others to feel confident and trusting of your capabilities.

Clues to Interpret Nonverbal Interpretation

Consider the following when interpreting nonverbal communication:

- Observe for incongruent behavior, that is, words that don't match nonverbal actions, such as gestures, tone of voice, frowning, or eye rolling.
- Concentrate on tone of voice and how it affects others. This can express interest, enthusiasm, sadness and a range of other emotions.
- Observe for eye contact, which may come across as confrontational or avoidant. Some cultures, like the Asian culture, may consider eye contact inappropriate in certain situations.
- Ask questions whenever nonverbal behavior is confusing.
- Be aware that signals can be misread. For example, a weak handshake doesn't necessarily mean a weak personality; the individual could have an injury or disease process such as arthritis.

Personal Appearance

Your appearance begins to communicate before you have a chance to speak! Present a competent and professional appearance. Important aspects of appearance include:

- Attire
- Eye contact and facial expression
- Gestures and movement
- Grooming
- Pace of walking
- Physical characteristics
- Posture
- Sounds

Enhancing Personal Appearance

When you begin to speak, your appearance is complemented by your tone of voice, pace of speaking, and other nonverbal components. Enhance your professional appearance by:

- Using proper grammar
- Speaking with a clear voice
- Listening carefully
- Embodying a helpful attitude
- Organizing your thoughts
- Preparing in advance with pertinent information

Did You Know?

Research shows 55% to 93% of the message in a face-to-face interaction is communicated in nonverbal body language? The percentage is dependent on the circumstances and the message.

Courtesy

In world class organizations, courtesy underpins every interaction and everyone practices courteous behavior. A culture of courtesy which treats employees with respect and honor leads to employees giving that same treatment to those they serve – in our case, patients and their families (Gore, 2001).

Courtesy in Nursing Practice

What does courtesy look like in nursing practice?

- Introducing yourself
- Asking the person how he or she prefers to be addressed
- Addressing the person to whom you are speaking by name
- Referring to patient by name and not a room number or disease condition
- Saying *"Hello"* and *"Good bye"*
- Saying *"Please," "Thank you,"* and *"You're welcome"*
- Saying *"Excuse me"* when you interrupt someone or bump into someone
- Stating your purpose
- Apologizing for any inconvenience or error
- Knocking on doors before entering a room
- Avoiding defensiveness when you receive a complaint or corrective feedback
- Acknowledging compliments with a *"Thank you"*

Principles at Work in a Culture of Courtesy

- Always work as a team
 - Share knowledge
 - Listen and communicate
 - Keep it simple
 - Participate and contribute
 - Live the "golden rule" and treat each other with respect
 - Exceed expectations of patients and co-workers
- (Adapted from Gore, 2001)

Barriers to Communication

The following are barriers to communication.

Language differences

Language barriers can be a barrier to communication. To avoid misunderstandings:

- Obtain confirmation from the person you are addressing that you are understood.
- Make use of organizational resources such as translators, quick references for languages frequently spoken, and Internet resources.
- Access printed patient education materials written in the patient's own language.

Most facilities require that staff members speak and write in English while on the job. Speaking in a language not understood by all can interfere with communication, safety, care, supervision,

and can create dissension among staff.

Health Literacy

Health literacy limitations interfere with communication in the healthcare setting. The Institute for Health Improvement (IHI) has identified lack of health literacy on the part of many patients in the U.S. healthcare system as a major threat to patient safety (Institute for Health Improvements [IHI], 2012). Assure that your patients understand the terminology, meaning, and implications of oral communications concerning their care.

Disabilities

Disabilities may also create barriers. Americans with Disabilities Act (ADA), TJC standards, the American Hospital Association (AHA) Patient Bill of Rights, and state laws require facilities to offer communication means to persons with disabilities that impair communication.

Aids may include:

- Interpreters of various languages, including sign language.
- Large print reading materials, telephones, text-type telephones, or other devices.
- Various aids for the patient who has aphasia or is unable to speak.
- When your patient uses an interpreter, document by full name the person who served as interpreter and how you validated the patient's understanding.

Expressing a Positive Attitude

Specific verbal and nonverbal techniques can express a positive attitude.

- Clarifying by asking questions
- Using open-ended questions
- Paraphrasing or restating to assure that you received the intended message
- Asking the other person to restate what you have told him
- Being specific and tentative as opposed to general and absolute
- Using silence and allowing time to put thoughts into words
- Facilitating communication with statements or questions

English-Only Policy

The Equal Employment Opportunity Commission (EEOC) identifies two types of English-only policies:

1. An English-only policy that defines certain times and places in which English must be spoken in order to assure clear communication between employees and with patients and members of the public is not discriminatory.

2. An English-only policy enforced by the employer at all times, in all places, and in every circumstance in the work environment is considered discriminatory.

Employers can assess English proficiency prior to hire and have the right to determine the circumstances in which English must be spoken to assure patient safety and rapport among healthcare team members (The U.S. Equal Employment Opportunity Commission [EEOC], ND) .

Interpreters for Patients

The Americans with Disabilities Act (ADA) requires medical facilities to accommodate a hearing-impaired patient's disability. A person who is hearing-impaired is entitled to communicate with caregivers as effectively as a hearing person. The healthcare organization must provide necessary auxiliary aids and services to promote communication with hearing-impaired patients (American Disability Act National Network [ADANA], 2014).

Examples of common auxiliary aids and services include:

- Qualified sign language interpreters in person or through video remote interpreting (VRI) services
- Note takers or exchange of written notes
- Real-time computer-aided transcription services
- Written materials
- Telephone handset amplifiers
- Assistive listening devices and systems
- Telephones compatible with hearing aids
- Closed caption decoders
- Open and closed captioning, including real-time captioning
- Voice, text, and video-based telecommunications products and systems, including text telephones (tty), videophones, and captioned telephones or equally effective telecommunications devices
- Videotext displays
- Qualified readers
- Taped texts
- Audio recordings
- Brailled materials and displays
- Screen reader software
- Magnification software
- Optical readers
- Secondary auditory programs (sap)
- Large print materials
- Accessible electronic and information technology

(ADATA, 2014).

Sign-Language Interpreters

Public entities and private businesses cannot require an individual with a disability to bring someone to interpret for him or her. They also cannot rely on an adult accompanying an individual to interpret or facilitate communication except:

- In an emergency involving imminent threat to the safety or welfare of an individual or the public where there is no interpreter available; or
- When the individual with a disability specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and relying on that adult is appropriate under the circumstances.

The new regulations permit the use of video remote interpreting (VRI) services which uses video conference technology to deliver sign language interpretation over the internet. Entities using VRI must ensure that the service is always available, that the technology meets performance standards, and that someone is always available who can set up and use the VRI system (ADATA, 2014).

Attitudes That Interfere With Communication

Some attitudes interfere with creating an atmosphere of trust and open communication. These include:

- Defensiveness which closes off communication and may evoke a defensive response in return
- Judgmental attitudes which interfere with an unbiased view of each situation
- Stereotyping which interferes with respect for each individual
- Condescending attitudes which may create safety risks if one staff member is reluctant to communicate with another because of that person's attitude
- Uncooperative attitudes which sabotage teamwork
- Hostile attitudes which lead to angry outbursts and abusive behavior
- Passive-aggressive attitudes which interfere with honest, open communication and teamwork

TJC and the American Association of Critical Care Nurses (AACN) both have launched initiatives to address inappropriate attitudes and behaviors in the workplace. These are discussed later in this course.

Confidentiality

The nurse's role in protecting patient confidentiality is expressed in the American Nurses Association (ANA) Standards of Practice (ANA, 2010a) Code of Ethics (ANA, 2010b)

Follow your organization's policies and procedures to protect patients' privacy. These policies include measures to protect personal health information (PHI) in compliance with the Health Insurance Portability and Accountability (HIPAA). Only those who need to know PHI to provide care have access to PHI.

- Verify another's need to know before discussing PHI. Conduct your conversation outside of the hearing of others.
- Be cautious about identifying a patient if you may be overheard by someone who does not have the need to know.
- The patient must give written permission to the medical records department for family and significant others to receive PHI.
- Healthcare workers may not access their own records or the records of their children or other family members without written permission to the medical records department.
- Patients must give consent for their PHI to be disclosed, including admissions to the healthcare facility.
 - If consent is not given, no information may be given out
 - Respond to any inquiries with "I have no information about that patient"

The Health Insurance Portability and Accountability Act (HIPAA)

The HIPAA Privacy Rule protects all "*individually identifiable health information*" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "*protected health information (PHI)*" (US Department of Health and Human Services [DHHS], 2003). 1

The Privacy Rule covers a health care provider whether it electronically transmits this information directly or uses a billing service or other third party to do so on its behalf. Health care providers include all "providers of services" (e.g., institutional providers such as hospitals) and "providers of medical or health services" (e.g., non-institutional providers such as physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care (DHHS, 2003).

Legal Issues Regarding Communication

HIPAA prohibits staff members from confirming certain diagnoses including pregnancy, psychiatric treatment or observation, sexual abuse, and rape.

HIPAA permits the reporting of certain events to authorities according to policy. These events include abuse, certain infectious diseases, and gunshot wounds. In some states, the patient's permission is required for reporting domestic violence or abuse.

Privileged Communication

In **privileged communication** the speaker intends that the communication remain private between the speaker and the listener. Privilege doctrine protects privacy within the fiduciary relationship, including relationships between patients and providers.

Privileged communication may include nurse-patient relationships, though few states specifically recognize it as such. The courts cannot force either party to disclose privileged communications, unless the party who would benefit from protection agrees. **Clarify with the patient that you may need to disclose information pertinent to his care or safety.**

Allegations of Slander

Speaking negatively about co-workers or patients undermines the work environment and can lead to allegations of slander. Slander occurs when information damaging to one's reputation is shared orally with malicious intent or in circumstances in which it is irrelevant. Written communication of this nature is considered libel. The truth of the information constitutes an absolute defense, unless the information is shared maliciously.

Did You Know?

If a patient sues a healthcare organization, the patient waves his right to privileged communication.

Assertiveness

Assertive communication is essential to fulfilling your professional role and keeping patients safe.

Assertive communication requires that you identify your needs in a situation and interact respectfully with others to satisfy your legitimate needs.

When To Be Assertive

On the unit you may identify needs to:

- Obtain orders in an urgent situation
- Complete patient care by delegating to others
- Notify a provider of a change in a patient's status
- Clarify an order that seems inappropriate
- Intervene to prevent unsafe behavior by a patient or staff member
- Report an error to your manager or to a provider

- Gain support from a supervisor to address staffing situations
- Confront a co-worker about unethical behavior
- Confront another team member about bullying behavior

In these situations and others, it is your professional responsibility to speak up clearly, objectively, and assertively. You may find it necessary to pursue the chain-of-command to resolve the situation, but the FIRST step is to assertively raise the concern directly with the person involved.

Assert Thyself as a Patient Advocate

Your most important role is that of patient advocate. You enact this role by upholding standards in your practice, monitoring patients carefully, and reporting your observations and judgments appropriately. At times, it takes an extra measure of assertiveness to explore issues with a patient, question an order, or convince a provider of the urgency of your concerns.

Speak Up!

Assert your need to eliminate distractions when receiving information in spoken and telephone communication. Take the time to use the proper process for documenting orders or reports.

If you are new to a healthcare organization, attend to the language and communication culture. Clarify any unclear communication. Misunderstandings can easily arise based on word usage, not only medical terminology, which is unique to an organization.

Question orders that seem inappropriate, unclear, or incomplete (a dosage too high, or too low, a potential drug interaction, or a patient's condition that contraindicates a medication order).

Take action:

- Follow organizational P&P
- Look up the medication in a credible current reference or credible Internet resource
- Explain your concern to the charge nurse
- Explain your concern to the hospital pharmacist
- Explain your concern to the prescriber
- If necessary, pursue the chain-of-command. Document all of the actions you have taken and the responses you received

Verify that the Message is Received

When you report information, assure that the person to whom you are reporting acknowledges your report. Use words that call attention to your intention. For example, “I want to be sure you’re aware that Mr. Johnson has not voided since he came back from PACU.” Be sure to document what, when, and to whom you reported, and that individual’s response to your report.

Preventing Legal Risk

Failure to communicate may lead to legal problems. Specifically, allegations of malpractice may arise from:

- Incomplete or unclear interdisciplinary communication
- Incomplete or unclear report between shifts of nursing staff
- Poor rapport with family and significant others
 - Consider family members and significant others as part of the interdisciplinary team
 - Secure the patient’s permission to communicate with significant others
 - Communicate clearly and frequently to the extent desired by the patient
 - Include family and significant others in decision-making
- Good rapport often prevents misunderstandings that lead to allegations of negligence or malpractice
- Failure to keep the provider informed of pertinent changes in a patient’s condition.
- Failure to pursue the chain-of-command to obtain resolution of a problem.
- Failure to clarify written orders and documentation.

ALWAYS DOCUMENT ORAL REPORTS TO PROVIDERS AND THE PROVIDER’S RESPONSE (Reisling, 2012).

Communication breakdown between RNs and providers and between shifts of RNs is a leading cause of lawsuits against nurses (Reising, 2012). Reporting on the effectiveness of treatment is critically important.

CASE STUDY

Failure to Report Leads to Judgment

A neurologist assessed a patient in the emergency department, but was not able to differentiate the diagnosis between a cerebrovascular accident (CVA) and a seizure. The patient was admitted to a medical-surgical floor.

After bedside X-rays, the nurse was unable to arouse the patient with a deep sternal rub. She documented the finding but did not notify the physician.

During the next 10 hours, the patient awoke and had difficulty moving his limbs, complained of right-sided numbness, could not lift his right arm, and could not squeeze with his right hand.

There was no record of communication between the nurses and the patient's physicians concerning the patient's neurological status.

The physician was notified that the patient was unable to swallow, nearly 12 hours after admission to the medical-surgical floor.

The following morning, the neurologist diagnosed a CVA; however, due to the delay in communication, the stroke protocol which indicates antiembolytics be given within the first hour after symptoms appear, could not be followed. The patient sustained permanent disabilities as a result of this delay in care.

This scenario could lead to a malpractice suit citing delay of care with significant injury because of the lack of communication between the nurses and the provider.

Case Study 2

Timely Notification of a Provider

Labor and Delivery nurses were slow to confirm and respond to variable late decelerations. By the time the physician was called, the fetal heart rate had dropped to 60 beats per minute.

The nurses failed to anticipate an emergency Cesarean section and did not summon a pediatrician and a neonatologist. These MDs did not arrive until 8 minutes after the birth.

In the interim, one of the nurses attempted to intubate the newborn. She inserted the endotracheal tube into the newborn's stomach by mistake, causing further oxygen deprivation.

The newborn was ventilated with a bag mask and airlifted to a neonatal intensive care setting.

The child suffered from cerebral palsy, mental retardation, and spastic quadriplegia. **What are your concerns about this scenario?**

Were the nurses sufficiently trained? Was there an issue that kept the physician from getting his messages? Was his pager working? Was he near a phone? How long had the heart rate been at 60? Why was best practice not followed? Why did it take so long for the neonatologist and pediatrician to get to the bedside? Were they not in house? Was it protocol for the nurse to intubate?

The final outcome of this scenario is dismal, lack of communication may have played a part in the final outcome.

Reporting to the Provider and Others

Clear, effective reports are essential in building rapport among team members and in assuring patient safety during patient hand-off, transfer, critical events and provider notification. Many nurses find reports to providers especially challenging. Using a standardized reporting system has been demonstrated to enhance effective communication. Many tools have been developed, SBAR is one such tool developed by the IHI.

SBAR is an easy-to-remember tool for any conversation, especially critical ones, which may require a provider's immediate attention and action.

Situation: What is happening at the present time?

Background: What are the circumstances leading up to this situation?

Assessment: What do I think the problem is?

Recommendation: What should we do to correct the problem?

SBAR card tool can be found at: <https://rxschool.adobeconnect.com/sbar/>

[Your institution should have a standardized approach for delivering information between and among caregivers. If there is not one or if there are several reporting approaches, review the options available and advocated for standardization.](#)

Chain-of-Command

The chain-of-command is a sequence of persons to contact when you need help to protect patient safety, ensure quality patient care, and ensure your own safe practice.

The chain of command begins with your direct supervisor and defines whom you contact next if the issue is unresolved. Pursue the chain-of-command when:

- A provider responds with extreme anger, hostility, or inappropriate behavior
- A provider is reluctant to respond to your concerns
- You are not successful in reaching the provider in a timely manner
- You are concerned that the provider's orders are unsafe or inadequate to manage the situation or deviate from standards of care and the provider persists with the current orders
- You are concerned about patient safety or your own safety, including dangerous staffing levels and violent behavior

Persist in obtaining the assistance you need to resolve your concerns. You have an ethical and legal responsibility to advocate for your patients.

Continue to pursue the chain-of-command until the situation is resolved. The chain does NOT end when you notify your immediate supervisor. If you fail to pursue the chain-of-command and a patient suffers because of ineffective medical action, or no medical action, the courts will hold you responsible.

Comply with organizational procedure. Document the circumstances and your actions.

Nursing malpractice suits frequently allege that nurses have inadequately identified, communicated, and/or documented significant changes in the patient status. Assure that your documentation reflects your efforts to obtain the care your patient requires.

Silence Kills

Research findings link the healthcare worker's ability to discuss emotionally and politically risky topics with indicators such as patient safety, quality of care, and nursing turnover.

- Fewer than 10% of healthcare clinical staff confront colleagues about their concerns
 - One in five MDs said they saw harm come to patients as a result
- Healthcare workers who raised concerns observed better patient outcomes, worked harder, and were more satisfied and committed to their jobs

The American Association of Critical Care Nurses (AACN) partnered with a management consulting company to conduct the research (Maxfield, Grenny, Lavanderso, & Groah, 2011)). The findings identified 7 categories of essential and difficult conversations that require confrontation when the stakes are high:

- Broken rules
- Mistakes
- Lack of support
- Incompetence
- Poor team work
- Lack of respect
- Micromanagement or bullying

Crucial Conversations:

The first step for a successful crucial conversation is to prepare. In a 2012 publication, Patterson, Greeny, McMillian & Switzer, delineated how to hold a crucial conversation with a colleague without confrontation. The authors identified key behaviors and attitudes that could assist in having a conversation that brings about the expected outcome..

Single Incident

Is this a single incident you need to address? Suppose you asked a new nurse to assist you with a complicated dressing change and were appalled when she violated basic principles related to clean, soiled, and sterile items. You corrected the situation to protect the patient and complete the procedure correctly, but now must address the issues with her.

Before you begin, think through your purpose and your approach. Limit your conversation to this specific situation and ask yourself the following questions:

- What was supposed to happen?
- What actually happened?
- What caused the discrepancy? Lack of knowledge? Distraction? Lack of psychomotor skill? Some other difficulty?
- What are the consequences, or potential consequences, of her actions?

- What assistance, practice, or resources can this nurse use to correct the problem?

It is important to address single incidents to prevent bad habits or patterns of incompetence from developing. Plan to keep the focus on this incident.

Patterns

Have you recognized that a new nurse's poor performance in assisting you with the dressing change is part of a larger pattern? Perhaps you have observed other examples of her lack of attention to infection control precautions, details of patient care, and documentation. In that case, the problem is a pattern of behavior. Plan to focus your conversation upon the pattern rather than the particulars of this latest incident or other specific incidents.

In this case, plan to begin the conversation by stating that you are noticing a pattern that concerns you. This is a delicate situation because the new nurse might quickly become defensive if you seem to be reciting a laundry list of her deficiencies.

Crucial Conversations:

Plan to:

- Focus the conversation on the gap between what you have observed and what is expected competent practice.
- Identify consequences of her behavior pattern related to patient safety and rapport with fellow staff members.
- Help her to identify the causes of this pattern and what she can do to change it.
- Present yourself as someone who cares about this nurse and her practice, and wants to help her solve the problem.

Relationships

Have you observed that a new nurse seems to make mistakes and overlook details only when you are working closely with her? Or perhaps you observe that she seems to be reverting to previous roles of a nursing student or nurse extern rather than accepting the responsibilities of the RN role.

Relationship problems may be about an interpersonal relationship or may be because person is unclear about her role as it relates to other team members.

Plan to:

- Begin the conversation with your observations and specifically identify the relationship element.
- Investigate:
 - Specifically how what you have observed differs from what you expect.
 - The consequences of the problem
 - The causes of the problem

- Direct the conversation toward what this nurse and others can do to resolve this problem. If the problem is an interpersonal one between you and this nurse, it is likely that there are ways in which each of you can contribute to resolving the problem.

The Process of Crucial Conversation

An effective crucial conversation begins with clearly identifying the problem **BEFORE** confronting the other person. Additional important preparations are to:

- Identify what each of you will accomplish by solving this problem. How will things be better for each of you when you achieve a solution?
- Clarify for yourself the outcome you desire from this conversation.
- Remind yourself of why you respect the other person.

Next:

- Create a safe environment for the conversation: privacy and an attitude of problem solving, rather than attack.
- State your purpose to the other person.
 - “I’d like to talk with you about . . .”
 - “My goal is to . . .”
 - “Can we talk?”
- Explain the gap between what has happened and what needs to happen.
- Engage the other person in identifying the causes and consequences of the problem.
- Make a specific action plan for improvement.
- Commit to following up with the other person on progress toward solving the problem

(Patterson et al., 2012))

Healthy Work Environment: An AACN Initiative

Since 2001, The American Association of Critical Care Nurses (AACN) has actively promoted the creation of healthy work environments that support and foster excellence in patient care wherever acute and critical care nurses practice.

Intimidating behavior and poor interpersonal relationships lead to mistrust, chronic stress, and dissatisfaction among nurses. Ineffective communication also threatens patient safety. To create a healthy work environment, nurses must gain proficiency with effective communication skills to complement their clinical skills (AACN, 2005).

AACN Standards for a Healthy Work Environment

The AACN Standards for establishing and sustaining a healthy work environment include:

- Skilled communication
- True collaboration
- Effective decision making
- Appropriate staffing
- Meaningful recognition
- Authentic leadership

More information about AACN's Healthy Work Environments Initiative can be found at:
<http://www.aacn.org/wd/practice/content/publicpolicy/workenv.pcms?pid=1&&menu=>

Safe nursing practice demands zero tolerance for ineffective communication and for rude and intimidating behavior.

The Code of Conduct: A Joint Commission Standard

The Joint Commission has established Hospital Culture and System Performance standards. The standards require a culture of teamwork, open discussions of concerns about quality and safety, and the encouragement of and reward for internal and external reporting of safety and quality issues (TJC, 2012a). TJC identifies communication as one of the key systems that influence performance of a hospital. The standards require a healthcare organization to create:

- A code of conduct with definitions of acceptable, disruptive, and inappropriate behaviors.
- A formal process for managing disruptive and inappropriate behavior.
- An environment in which all individuals who work in the hospital are able to openly discuss issues of safety and quality.

National Patient Safety Goals

The Joint Commission annually updates both accreditation standards and National Patient Safety Goals (NPSG). National Patient Safety Goals address prevention of specific untoward outcomes and the factors which contribute to them. TJC requires TJC accredited facilities to develop policies to assure compliance with NPSG. Often NPSG established in one year are refined into standards in future years. One NPSG formerly focused on communication which has now become incorporated into the Hospital Culture and System Performance standard.

Zero Tolerance for Ineffective and Rude Behavior

Both the AACN Healthy Work Environments Initiative and the TJC disruptive and inappropriate behaviors identify the importance of:

- Education for all staff concerning effective professional communication.
- Individual accountability for respectful, effective communication.
- Zero tolerance for rude and ineffective behavior, regardless of the power or position of the person who engages in it.
- A specified process for reporting incidents and protecting those who report.
- A disciplinary process for violators.
- An approach for addressing the effects of inappropriate behavior on patients and their families.

Consider using the crucial conversations approach to address inappropriate behavior. Follow organizational P&P in reporting violations of the code of conduct.

Zero Tolerance for Bullying

Bullying interferes with morale and can jeopardize patient safety.

Common bullying behaviors involving nurses include:

- Innuendo
- Verbal affront
- Undermining
- Withholding information
- Sabotage
- Infighting and scape-goating
- Backstabbing
- Failing to respect confidences
- Breaking confidentiality

Bullying behaviors are often directed toward new nurses, leading to the often repeated phrase that “nurses eat their young.”

Bullying behaviors may include:

- Eye-rolling
- Gossiping
- Silence
- Exclusion
- Humiliation

(Townsend, 2012)

ANA has compiled many resources at its website to address bullying behavior:
(<http://www.ana.org>)

Addressing Bullying Behavior

Breaking the cycle of bullying and changing a culture which accepts bullying is challenging. Leadership plays a key role in creating the culture and establishing expectations. However, the individual nurse also has accountability for ending these destructive behaviors. Vow to treat others with respect and address instances of bullying with the bully and if needed, with management or the chain-of-command (Townsend, 2012).

A study by Maxfield colleagues, identified that a culture of bullying and intimidation interferes with implementing safeguards to prevent errors (Maxfield, et al, 2011). The study highlights the problem of risks that are known, but not discussed. Nurses described situations in which serious errors were made in perioperative and critical care settings because no one demanded that proper protocol be followed.

Only a small minority spoke up in situations when they observed dangerous shortcuts, incompetence, or disrespect. However, several nurses in the study reported positive outcomes using specific techniques (Maxfield, et al, 2011):

- When the issue wasn't urgent, they collected facts, ran pilot tests, and worked behind the scenes
- They assumed the best and spoke up, providing a model for others
- They explained their positive intent – how they wanted to help the caregiver as well as the patient
- They took special efforts to make it safe for the caregiver – to avoid creating defensiveness
- They used facts and data as much as possible, often taking the other person into the actual situation
- They avoided telling negative stories or making accusations
- They diffused or deflected the person's anger and emotion

Bullying Examples from RNs

"The surgeon was marking the wrong foot, while talking to the patient about something social ... I opened the chart to the permit and lightly reminded him we were doing the other foot today ... Presenting the issue to the surgeon in a nonthreatening manner saved face in front of the patient and made him grateful that I spoke up when I did."

"I spoke up and stated, 'This patient is fully anticoagulated right now. Do you think it is wise to

start a central line when we are okay with PIV [peripheral intravenous] for now?' All the surgeons turned to me and stated, 'Wow, we forgot. Thanks for making a good point.'"
(Maxfield, et al, 2011)

Preventing Sentinel Events

TJC Requirements and Communication

TJC requirements address many aspects of spoken communication including:

- Using patient identifiers, including 2-person identification before administering blood
- Following universal protocol prior to procedures, including time out to assure accurate identification of the patient, the procedure, and the site
- Taking precautions to communicate clearly regarding look alike/sound alike medications and abbreviations, symbols, and acronyms which may be ambiguous
- Obtaining accurate information concerning patient allergies
- Adhering to fall-prevention protocol
- Activating the rapid response team
- Identifying and communicating about patients at risk for suicide
- Reading back verbal and telephone orders, and critical test results; obtaining confirmation from the person giving the order or test result
- Communicating with the nutrition department concerning any patient who is receiving anticoagulant medications
- Standardizing hand-off communication, including an opportunity to ask and respond to questions
- Reconciling medications at critical points in the process of care
- Actively involving the patient and family in safety
- Labeling all containers of medications and solutions on and off the sterile field

Patient Identifiers and Verification

To assure that the patient is correctly identified and correctly matched with each procedure, treatment or service, TJC requires use of 2 independent patient identifiers and verification processes.

Identifiers include only information uniquely associated with the patient, such as hospital ID, social security number, or other identifiers that your organization has designated. Patient identifiers DO NOT include room numbers, asking the patient his name, or asking another staff member or visitor to identify a patient.

Universal Protocol

TJC specifies the use of the Universal Protocol, also known as a procedural pause or time out, before commencing surgery and other special procedures. The Universal Protocol includes a verification process to assure that *“all relevant documents, related information, and equipment are (TJC, 2012b):*

- *Available prior to the start of the procedure.*
- *Correctly identified, labeled, and matched to the [patient]’s identifiers.*
- *Reviewed and are consistent with the [patient]’s expectations and with the team’s understanding of the intended [patient], procedure, and site.”*

Importance of Verification

The Universal Protocol requires a time out before beginning the procedure during which team members complete the verification process which includes at minimum (TJC, 2012b):

- Correct patient identity
- The correct site
- The procedure to be done

Inform patients and family members to insist that healthcare workers use the patient’s name before any procedures.

Inform patients and family of how they can help reduce medical errors by asking questions.

Ambiguous Terms Are Dangerous

TJC requires each healthcare organization to designate a list of:

- Medication names which look alike or sound alike
- Do not use abbreviations, symbols, and acronyms
- Acceptable abbreviations, symbols, and acronyms

TJC endorses the *Do Not Use Abbreviations List* and the *Confused Drug Names List* developed by the The Institute for Safe Medication Practices (ISMP). The Institute for Safe Medication Practices issues alerts regarding specific sound alike/look alike medications and recommended safety procedures such as the use of **TALL MAN LETTERS** for greater clarity. The use of **TALL MAN LETTERS** is also recommended by the Federal Drug Administration (FDA) to distinguish sound alike/look alike medication names such as diphennydr**AMINE** and dimenhy**DRINATE**;

DOBUTamine and **DOPAmine**, and many other medication names which appear or sound similar.

Comply with your organization's lists in spoken communication as well as in written documentation. In oral communication, emphasize the TALL MAN portions of medication names.

A list of confused drug names (2011) compiled by the ISMP can be found at <http://www.ismp.org/Tools/confuseddrugnames.pdf>

Rapid Response Team

TJC requires facilities to develop plans to identify early and respond promptly to signs of a patient's deterioration. Hospitals have created teams of specially trained nurses, providers, and others such as respiratory therapists to respond.

If the rapid response team is to work effectively, it must be summoned promptly when the situation warrants.

Some nurses can be reluctant to activate the rapid response team, fearing that their assessment may be incorrect and wanting to avoid embarrassment. Prepare yourself with a thorough understanding of the protocol, including with whom to consult if you are uncertain of the need to call the team.

Remember that a nurse may be held liable for failure to obtain assistance for a patient, if the nurse should reasonably have known that the patient required special intervention.

Verbal and Telephone Orders and Reports

Verbal orders are reserved for emergency situations ONLY. When accepting a verbal order or test result, follow organizational P&P strictly.

To assure safe care and legal protection, follow these guidelines for all verbal orders, test results, and reports received orally or by telephone, while always following your organization's P&P.

1. Receive the order or report directly and not through a third party.
2. Read back the information to the other person. Assure that you have the same understanding. For example, state, "five-oh" rather than saying "fifty" which could be misunderstood. If there is any question, spell, or ask the prescriber to spell medication names. When spelling, assure that sound-alike letters are correctly interpreted (e.g.,

“B” as in “ball”).

3. Obtain confirmation that the information is correct as you have read it back.
4. Document the order or report per P&P. Document the order as a verbal order.
5. In an emergency, administer the ordered medication at once. After the emergency is over, document completely.
6. Comply with prohibitions on verbal and telephone orders, such as prohibition on Do Not Resuscitate or Allow Natural Death orders. TJC standards prohibit accepting orders via voicemail.
7. For test results, notify the provider, take any needed actions, and document.

Case Study

Verification of a Receipt of a Report

A report from the labor and delivery floor regarding the results of a non-stress test on a laboring patient was faxed to a physician’s office at 5:48 P.M. Nurses did not attempt to verify the physician’s receipt of the report which indicated that the patient and fetus needed emergent care. The nurse faxing the report was an inexperienced labor and delivery nurse and had not been trained on how to interpret the report. The physician did not get the fax until the next morning.

A US district court ruled that faxing a test result to a physician’s office without verifying that the physician has been made aware of the report fails to fulfill a hospital’s standard of care. The court also ruled that the test result should have been read by an experienced labor and delivery nurse and that a decision should have been made at the hospital as to whether or not an emergency existed.

What could have been done to mitigate this issue?

If the nurse did not know the proper protocol, she should be educated on the policy and procedure to notifying physicians of results. If possible, she should have shown the report to an experienced nurse to ascertain the urgency of the results. During office hours and especially after office hours, the physician should be paged to verify receipt of the results..

Hand-Off Responsibility

Errors and threats to safety often arise from unclear or incomplete communication at the time of hand-off of responsibility. Hand-off of responsibility refers to transferring coverage at any time, as well at change-of-shift or at the time of transfer to another level of care, such as from an intensive care unit to a step-down unit.

TJC recommends:

- Using a standardized protocol for giving and receiving reports that includes the opportunity to ask and answer questions
- Including up-to-date information regarding the patient's condition, care, treatment, medications, services, and any recent or anticipated changes
- Using a method to verify the received information, including repeat-back or read-back techniques

Giving an opportunity for the receiver of the hand-off information to review relevant patient historical data, which may include previous care, treatment, and services. Limiting interruptions during hand-offs to minimize the possibility that information fails to be conveyed or is forgotten.

TJC guidelines discourage the use of a taped or written report unless an opportunity to ask questions and clarify information is provided.

Temporary Coverage

Going to lunch? Need coverage while you're tied up with one of your patients? Think through the safety risks, needs, preferences, and peculiarities of your patients for the time period to be covered. Give a full report to the nurse who will cover for you. By doing so, you will protect patient safety, preserve good professional rapport, and reduce your risk of liability.

If you are receiving a hand-off report for temporary coverage, ask questions to assure that you understand the patient's status, risks, and anticipated needs during the absence of the assigned nurse.

P&P and the particular situation dictate the content of the report, but relevant pieces of information usually include:

- The patient's current status
- Recent changes in condition
- Potential changes to watch for
- Resuscitation status
- Recent laboratory values
- Allergies
- A problem list
- A To-Do list for the nurse who is covering

Did You Know?

That each state has regulations that determine how many patients one nurse may oversee,

even during a temporary coverage situation such as going to lunch? Be sure to investigate your state's regulations as some are much more restrictive than others.

Accepting New Assignments

Whenever a RN accepts a new patient assignment, it is his or her responsibility to be accountable for that patient's safety at all times during the shift. If an RN is assigned to a patient but decides to leave the unit at any time (including before the shift actually begins), the RN must communicate immediately with the Charge Nurse to discuss the situation and review alternative options for patient care.

In addition, RNs should only accept nursing assignments that are commensurate with the nurse's educational preparation, experience, knowledge, and physical ability.

It is considered unprofessional conduct to leave a nursing assignment without notifying the proper personnel. RNs must communicate any discomfort with a particular nursing assignment directly to the nursing supervisor immediately. It is also recommended that the RN complete and submit a written report of the situation by the end of the work period to the direct supervisor, and retain a copy of the report for the nurse's own records.

Reconciliation of Medications

A time of potentially great safety risk is the time of transfer of a patient to another setting, service, level of care, or practitioner within or outside of the hospital. TJC requires healthcare organizations to maintain and communicate accurate patient medication information. Lack of reconciliation can result in the failure to re-order critical medications post-operatively and the risk of ordering duplicate medications, and medications that interact with one another. Medication reconciliation procedures have reduced adverse drug events in many healthcare settings (Evans, et al, 2011). However, the process of medication reconciliation can be quite complicated and challenging, especially in the absence of suitable electronic support.

Reconciliation of Medications: TJC Requirements

TJC requires (TJC, 2012b):

- On admission, documenting a complete list of the medications, including over-the-counter products, herbal supplements, and all routes of administration that the patient is taking at home, including dose, route, and frequency.
- Comparing the medications that patient was taking prior to admission to those ordered for the patient.
- Reconciling and documenting any discrepancies, such as omissions, duplications, adjustments, deletions, or additions while the patient is under the care of the hospital.

- Providing complete medication information to the patient and if indicated, the family. Include the need for communication with the all providers about the medication profile and necessary administration information, precautions, and monitoring information.

Recommendations for Reconciliation Procedures

TJC recommends:

- Use a medication reconciliation form as a template for gathering information about current medications. The form should allow staff members to see that medications have been reconciled.
- Include reasons for changes in medications so that the next provider understands the rationale for the change.
- Include over-the-counter medications, herbals, and dietary supplements when constructing the patient's medication profile. Commonly missed medications include eye drops, inhalers, patches, and contraceptives.
- Involve the pharmacist in compiling the medication profile when the patient is taking a large number of medications (number to be defined by P&P).
- Include medication reconciliation information in the change-of-shift procedures as well as in the provider's progress note.
- Improve the effectiveness of interviewing the patient concerning medications. For example, ask open-ended questions about health and specific diseases in addition to questions about medications.
- Establish time frames for reconciling different types of medications – for example, within 4 hours, within 24 hours, before the next dose, or other pertinent time frame.

Active Involvement of the Patient and Family in Safety

TJC requires facilities to (TJC, 2012a):

- *"Identify the ways in which the [patient] and his or her family can report concerns about safety and encourage them to do so."*
- Communicate with the [patient] and family about all aspects of care, treatment, and services. When the [patient] knows what to expect, he or she is more aware of possible errors and choices. The [patient] can also be an important source of information about potential adverse events and hazardous conditions.
- Provide information to patients and families concerning infection control measures for hand hygiene practices, respiratory hygiene practices, and contact precautions according to the patient's condition within 24 – 48 hours of admission. Confirm and document the patient's understanding.
- Educate patients and families concerning available reporting methods for concerns related to care, and instruct them to report any concerns.

- Describe to surgical patients the measures that will be taken to prevent adverse events in surgery including, but not limited to, patient identification practices, prevention of surgical infections, and marking of the procedure sites.

Patient and Family as Safety Net

TJC takes patient advocacy one step further by directing caregivers not only to advocate for patients but to teach patients to advocate for themselves. Begin by establishing rapport with patients and family. Maintain ongoing communication that clarifies all aspects of care and encourages patients and families to ask questions. Patients' involvement in their own care is an important patient safety strategy.

The Patient as a Safety Check

The patient can be a final safety check in preventing errors and assuring that the right patient is receiving the right care at the right time. Advise patients of the risks pertinent to their care. Gain their assistance in your assessment by letting them know what to look for as indicators of improvement or of a potential problem. Some of the communications that assist in this effort include:

- What has your provider told you about this test?
- Which of these medications you have been taking at home?
- When do you usually take this medication? This medication is most effective on an empty stomach.
- Are you experiencing any unusual effects related to this medication?
- Because you have fallen previously, we want to be certain we are doing all we can to prevent another fall. How can you help us prevent another fall?

The Speak-Up Initiative

TJC's Speak-Up Initiative is designed to enlist patients and their families in the effort to improve safety.

Visit TJC's website for further information about the Speak Up initiative and materials at <http://jointcommission.org>

Think About It

What communications are most important to the patient population with whom you work? Think about recent experiences with patients. Did any problems occur which might have been prevented by asking questions of the patient or family members?

Think of 3 or 4 questions that are especially pertinent for the safe care of patients on your unit.

Plan to ask these questions of your patients when you make rounds.

Errors

Report all errors whether or not you are the one who made the error. Safety initiatives emphasize that the system is more frequently at fault than any individual.

Reporting errors calls attention to system problems, the first step in improving a faulty system.

Prevent errors by assuring that your oral and written communication is clear. Clarify any uncertainties in communications you receive from other team members.

Communication Dilemmas

Communication dilemmas can be one of the most difficult issues for healthcare team members to handle. Take the time to learn to communicate effectively with the providers and other team members with whom you are working. The investment of time will create a more pleasant working environment and most importantly help protect patient safety and protect you from legal exposure. One successful strategy reported by a nurse in the *Silent Treatment* study was to consistently introduce yourself to members of the team (Maxfield, et al, 2011). Establishing a connection assists in cementing a relationship so that when the need arises to call attention to a potential error, there is a greater chance of a spirit of camaraderie on behalf of the patient.

Identifying and Reporting Risks, Urgent, and Emergent Situations

If you sense that something is wrong, you are probably correct. Investigate the situation and report your concern.

When reporting to others, explain fully why you are concerned. Don't assume that the person to whom you are reporting has all of the relevant information and repeat information if necessary.

If the situation requires further action by the person to whom you are reporting, be sure to make clear any actions needed - such as further assessment by a nurse to whom you report, or a formal reporting procedure by a charge nurse or manager.

Even in routine reporting, assure that you and the other person share the same understanding of terms that you are using. For example, a nurse who described vaginal bleeding as spotting misrepresented the amount of bleeding and failed to alert the physician to imminent uterine rupture. Describe rather than label and quantify amounts whenever possible.

Communicate your concerns with all pertinent team members as appropriate. This may include not only the provider but other nursing or ancillary staff. Some situations require reporting to risk management, the FDA, pharmaceutical company representatives, TJC, or others.

External Reporting

While external reporting is usually a management responsibility, there may be portions of the report that require statements of the nurse involved in a situation, for example in the case of a piece of equipment which fails.

Find the P&P regarding such situations so that you can complete documentation promptly and not be forced to rely on your memory at some later time.

Special Situations with Patients: Non-Conforming Patient Behavior

For safety reasons, most facilities forbid patients from possessing certain items in the hospital setting. Such items include alcoholic beverages, firearms and other weapons, certain electrical appliances, and other items.

If you discover that a patient has such items, FIRST communicate with the patient to clarify the policy and safety reasons for it. If you feel too threatened by the patient to confront him, involve your supervisor. You may need to call security personnel to raise the issue with the patient.

Your organization may have a specific P&P about dealing with and documenting such incidents. Report the incident in hand-off communication and to others as P&P indicates.

Special Situations with Patients: Communication Bad News

When you communicate bad news, be sure to document the date, time, with whom you communicated and the means of communication (i.e. by telephone or in person). Include the response of the person. Depending upon the situation, you may want another staff member to witness the communication.

Some healthcare organizations have developed policies regarding communicating with patients and their families about medical errors. Such disclosure is usually the realm of the provider. Follow your organization's P&P concerning disclosure of medical errors.

Offering Opinions

Remember that the patient views you in your professional role and that your opinions and advice imply professional endorsement. Avoid charges of practicing medicine without a license. When a patient asks you, avoid offering opinions on subjects such as:

- Possible choices of treatments or providers.
- Fault or error in the patient's care. Although disclosure of error is recommended, disclosure is not to be undertaken in an off-handed manner in response to a question. Instead, it should be a planned communication involving all pertinent team members, including administrative staff.
- Criticism of other team members.
- Malpractice insurance of yourself, other team members, or the healthcare organization.

Teaching Patients

When teaching a patient, give the patient printed material as reinforcement whenever possible. Do not let the printed matter substitute for a thorough explanation. Consider the printed matter as a reference piece for the patient. Document by title any materials that you gave to the patient.

Validate that the patient understands the teaching by asking him to repeat important points, rather than by asking, "*Do you understand?*" or "*OK?*" Document the patient understands.

Documentation and Spoken Communication: An Important Partnership

Effective spoken communication goes hand-in-hand with complete documentation. Good interviewing techniques are vital to accurate patient assessment:

- Ask the patient to describe more fully symptoms, complaints, history, medications taken, and other relevant information.
- Use this inquiring approach particularly when the patient describes symptoms or makes complaints seemingly unrelated to the major diagnosis or treatment.
- Such complete documentation is powerful evidence that you are meeting the standard of care.

Many aspects of spoken communication have corresponding documentation requirements. Comply with your organization's policies and procedures regarding documenting spoken communication.

Summary

Assertive, clear, spoken communication is absolutely key to patient safety and professional practice. Pay attention to the nonverbal component of communication. What do your appearance, your posture, and your gestures communicate?

Communicating assertively, verifying understanding, and seeking assistance when needed all contribute significantly to patient safety.

Communication failures have legal consequences. Document spoken communication completely and in a timely manner to provide evidence of meeting the standards of care.

Use the recommendations in this course to assure safety and practice professionally.

Conclusion

By studying this course, you have gained tips and tools to improve your oral communication, both with patients and with other health team members.

Specifically, you have learned:

- Definitions of verbal and nonverbal communication and the impact of nonverbal messages such as posture, eye contact, attitude, and personal appearance.
- Barriers to communication, including attitude, language, and disability.
- HIPAA requirements concerning confidentiality and disclosure of personal health information.
- Definitions of privileged communication and slander.

- Why assertiveness is an important characteristic of professional communication.
- Legal implications of spoken communication.
- The SBAR framework for communicating with a provider.
- What is meant by the chain-of-command, and state examples of when to use it.
- The steps in the process of crucial conversations.
- Initiatives of the AACN and TJC related to communication in healthcare facilities.
- The relationship between communication and selected aspects of TJC requirements including:
 - Patient identifiers
 - Ambiguous terms
 - Rapid response team
 - Verbal and telephone orders and reports
 - Hand-off of responsibility
 - Reconciliation of medications
 - Active involvement of patient and family in safety
- Important considerations when communicating about errors, urgent situations, and safety risks.
- Communication concerns in special situations involving patients such as:
 - A patient's non-conforming behavior
 - Offering opinions to patients
 - Patient teaching
 - Delivering bad news

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