Amid the incredible advances, discoveries, and technological achievements in healthcare, one element has remained essential—clear and complete communication between caregivers.

Communication is simply one of the most important components of the delivery of care and ensuring the safety of patients. Not only is effective communication a prerequisite for attaining quality-of-care goals, it is also a critical ingredient in reducing preventable medical errors. Despite this fact—as well as the many articles, strategies, and toolkits that focus on effective communication, with support from organizations like the Agency for Healthcare Quality and Research, The Joint Commission, and the Institute of Medicine—ineffective communication continues to be a leading factor in, and often times is the root cause of, adverse clinical events.

**Communication and Patient Safety—Data and Analysis**

Good communication is not only an essential element to help ensure positive clinical outcomes, but it is also vital in preventing harm to patients. A review of published information relative to serious medical adverse events in the care of patients confirms that ineffective communication is one of the leading contributing factors that affect patient safety. When medical errors occur, it is often the result of multiple factors that precede an event. Of errors that were initiated by multiple factors (i.e., cascades), 80 percent involved informational or personal miscommunication.² Despite efforts to utilize standardized approaches to address either hand-off communications or breakdowns in communication, miscommunication continues to be a significant contributing factor affecting the safety of patients.

The Joint Commission publishes data trends based on information provided by participating healthcare facilities for significant adverse events. The most serious of these events are termed sentinel events, which are defined by The Joint Commission as “unexpected occurrence(s) involving death or serious physical or psychological injury, or the risk thereof.” Based on the Summary Data of Sentinel Events Reviewed by the Joint Commission, the organization reviewed more than 11,660 such events between 1995 and the second quarter of 2015. Table A below displays the top four contributing factors for significant sentinel events as identified by submitted root-cause analysis factors over the past three years.

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²Woolf, Steven H.; Kuzel, Anton J.; Dovey, Susan M.; Phillips, Robert L. "A String of Mistakes: The Importance of Cascade Analysis in Describing, Counting, and Preventing Medical Errors." Annals of Family Medicine, Vol. II, No. 4 (July/August 2004)
The contributing factors that lead to communication challenges are well documented. Given that communication among caregivers has been an area of focus for more than two decades (journal articles emphasizing the importance in terms of patient safety date to the early 1990s\(^2\)), it is somewhat perplexing why communication continues to be a leading root cause for medical errors, delays in treatment, and medication errors.

In this article, three key factors related to communication’s impact of the delivery of care will be explored in further depth:

1. Complexity of the healthcare environment
2. Inherent communication obstacles associated with multiple caregivers and multiple sources of information
3. Behaviors of individuals involved in the communication stream

The Complexity of Healthcare

Healthcare is a unique and evolving delivery system. Incredible breakthroughs in medical science and technology as well as improvements in clinical practices, healthcare quality, and patient safety have led to significant improvements in the treatment of medical conditions. Along with clinical improvements and innovations, there has also been a significant increase in regulatory oversight, clinical documentation requirements, and the risk of penalties for poor-performing healthcare entities that participate in federally funded programs.

The Institute of Medicine (IOM) discovered that patient safety is dependent upon the internal systems and organizations within the healthcare environment—the more complex the environment, the greater the potential for mistakes that affect the safety of patients.\(^3\)

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Healthcare has been described as a system that functions as a “complex adaptive system.” A complex adaptive system is a group of diverse and independent individuals whose behaviors are not always completely predictable and whose actions (or inactions) are interconnected with others in the system. What has resulted is a sophisticated yet somewhat fragmented healthcare delivery system. This complexity adds to the current challenges of communication that caregivers experience.

The Challenge of Effective Communication

Effective communication is also influenced by a number of individualized factors. Caregivers have diverse knowledge levels and varied interpretations and perceptions of care settings. Team member diversity also includes a range of personality types, styles, and skill sets with respect to communication. Additionally there are often multiple decision-makers involved in the care plan, and, as a result, a variety of different messages may be conveyed in the delivery of services.

Because care is provided across a continuum, changes in personnel who function within the delivery system can introduce the possibility of human error. When there is a change in personnel involved in the care of a patient, the system relies heavily on the “hand-off” (i.e., the process of transferring responsibility for care), including exchange of information, that occurs during the transition. This hand-off plays an important role that can impact both quality and safety of care. Changes in personnel occur routinely with both internal staff (e.g., nurses) and external associates (e.g., physicians or allied health professionals). The result is that there are any given number of transitions that occur, and these changes are often conducted independently and do not include all members of the care “team.” The Joint Commission has determined that hand-offs played a role in an estimated 80 percent of reported serious preventable adverse events.

Additional factors come into play when we consider the various sources of clinical and administrative information that are essential in the communication process, including content in the medical record—some may be electronic, while some may be paper-based. Communication may also include electronic messaging, phone calls, or in-person discussion between multiple caregivers. In essence, the multiple methods employed to capture and communicate information add to the complications presented by the aforementioned individual and relational challenges.

Within healthcare systems, there are pockets of variability based on the type of care and services rendered. For example, in the long-term care environment, communications are primarily held via telephone. Further, these communications often occur after hours or on weekends between staff and on-call physicians rather than the resident’s direct caregiver.

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In the acute care environment, there is a combination of direct communications as well as internal and external conversations via telephone, with more of these communications (depending on the department and setting) occurring during the day shift. The variability also depends on the complexity of the care delivered within a specific department. In the operating room, where there is a requirement for multiple checks and validations for each specific procedure, it is difficult to verify that all elements are addressed without the use of checklists and validation protocols that are cross-checked similar in fashion to a preflight checklist in the aviation industry.

**Behavior Considerations**

Thus far we have explored the complexity of the healthcare system coupled with the diversity of individual members of the care team, and that by design the system functions across a continuum. However, this requires constant personnel changes, resulting in the increased likelihood of either incomplete or ineffective communication. Further, information is stored in multiple areas and formats, which affects the efficiency and effectiveness of accessing information. The complexity described can also lead to particular individualized behaviors, including anxiety, frustration, and anger—all of which can influence the effectiveness of communication. Recently published literature evaluates behaviors and how they impact communication among members of the care team.

The Institute for Safe Medication Practices (ISMP) identified intimidation as a barrier to effective communication. In October 2013, the ISMP released survey results showing that “bullying, intimidation, and other types of disrespectful behavior” continue to be a problem in the healthcare environment, with a direct impact on communication. This survey was a follow-up to a 2003 survey with the same focus, albeit with more than double the number of 2003 participants. The survey consisted of nurses (68 percent), pharmacists (14 percent), more than 200 physicians, and roughly 100 quality/risk management staff. From this survey, the most frequent disrespectful behaviors reported include:

1. Negative comments about colleagues
2. Reluctance or refusal to answer questions or return calls
3. Condescending language or demeaning comments
4. Impatience with questions or hanging up on colleagues
5. Reluctance to follow safe practices or work collaboratively

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Understanding personal behavioral elements is important because it not only affects the ability of the care team to communicate with one another—it also affects the culture of safety within an organization.

Establishing an infrastructure that supports a culture of safety and accountability to address these issues promptly is crucial, recognizing that they not only affect morale and strength in teamwork but also directly impact patient safety and effective communication. Developing and maintaining an effective and accepted culture of safety that is embraced throughout the organization is often one of the greatest challenges that organizations face.

**Tools That Support Effective Communication**

It is fortunate that the patient safety movement has produced sound and effective patient safety strategies that focus specifically on communication among caregivers.

The Joint Commission has established specific guidelines within its National Patient Safety Goals that outline ways to enhance the communication process. These guidelines include:

- Interactive communications
- Availability of up-to-date and accurate information
- An environment free of interruptions and distractions
- A standardized process for verification of information
- Reviewing relevant past medical information

The aforementioned general recommendations are well established in patient safety literature, and organizations have implemented aspects of these elements within policies and procedures as well as staff training programs. There are a number of risk management and patient safety fundamentals that are incorporated into healthcare operations by highly reliable organizations.

The following are important components of improving communication within an organization, with a focus on patient safety:

1. Establish a strong culture of safety that includes individual accountability, aligns behaviors with goals and values, and promotes teamwork and a unified approach to patient-centric care
2. Implement recognized best practices that support communication within patient safety programs (e.g., AHRQ TeamSTEPPS process)
3. Hardwire practices to:
   a. Appropriately identify resource needs
   b. Clearly outline expectations and build them into processes
   c. Establish tools that ensure consistent, reliable, reproducible results

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4. Establish sound risk management and patient safety systems to anticipate, recognize, evaluate, and manage occurrences and adverse events. Utilize data collection and analysis for proactive assessment and to feed Quality Improvement initiatives.

5. Utilize Continuous Quality Improvement (CQI) and utilize process-improvement techniques to identify inefficiencies and improve systems and processes

**Conclusion**

Because ineffective communication has such a significant impact on the safe delivery of care, a strong understanding of the challenges of communication among caregivers and its associated complexities is necessary for both individual caregivers and organizations to understand so they can move forward in the development of improvement initiatives. Healthcare leaders and patient safety organizations will continue to focus on communication, and continued development of new and innovative tools and best practices to support the delivery of care can be expected. The recommended strategy and examples of evidence-based practices serve as a primer, with the goal of encouraging healthcare entities to build a framework of effective programs and to help individual caregivers reach a better understanding of the importance of communication.

In the opinion of this author, the two biggest challenges that are faced by an organization are the establishment of a strong and accepted culture of safety and the hardwiring of patient safety initiatives that focus on communication strategies. Organizations that make the commitment to performance excellence and patient safety, find ways to establish systems to improve patient safety based on best practices, and are able to "hardwire" and build a strong culture of safety are poised to make significant strides in reducing errors and harm associated with communication errors.

**References**


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