Communication Counts

When it comes to communication across our healthcare organizations, it's often what's not being said that could save lives.

As a healthcare professional, it's a story you can never forget hearing. During an invasive procedure, a highly experienced nurse was too intimidated to speak up to a cardiovascular surgeon who had grabbed the wrong size catheter. Despite how seemingly easy it should have been to prevent, that one error proved to be fatal for the patient. It's one of the most powerful examples of how what's left unsaid is often more important than what's being said — and how essential creating a culture of strong teamwork and communication is in saving lives.

We'd like to think, as healthcare professionals, we're past the point of having internal cultures where our team members are too afraid to step forward to correct errors. We'd like to think we've built effective teams where everyone feels empowered to speak — and, when they do, it's with the same language.

Research shows we still have significant room for improvement

Research shows we still have significant room for improvement. According to OECD, Health Data 2011, approximately 150,000 patients (or seven per cent) admitted to acute care hospitals in Canada experience an adverse event during their hospital stay. Most alarmingly, approximately, 60,000 of these cases are preventable. Certainly, we've all heard horror stories or witnessed them firsthand. Some are near misses, such as a nurse misreading a word within a physician order and monitoring a vital sign less frequently than intended.

Others have caused patient harm, like when an anesthetist unknowingly gave a second dose of a high risk preoperative medication because of a miscommunication with the pre-op nurse. She had already given the dose herself and, unfortunately, in that instance, the result for the patient was severe blood loss, hematoma and a complicated prolonged recovery with risk of a potentially second,

unnecessary surgery.

A recent review of malpractice claims by the Hospital Insurer Reciprocal of Canada (HIROC) found that inadequate inter-professional communication of the changing clinical status of a patient is among the leading causes of malpractice claims.

Critical aspects of communication and teamwork aren't occurring on many teams

Whether it's the fear of speaking assertively, not speaking the same language or not asking for additional information to make the appropriate clinical decision, as healthcare leaders we need to take a serious look at how best to usher in culture change. Because if we don't, patients and families — as well as our healthcare teams themselves — will continue to pay a high price for this failed communication and teamwork.

We know that the provision of high quality patient care is a complex process dependent on effective teamwork and communication. The challenge for hospital leaders is to create and foster a culture of patient safety. This includes removing the barriers within the system and setting the expectations of a collaborative culture.

No healthcare provider comes to work to create harm

Failure by any inter-professional team member to recognize the interdependency of colleagues in achieving a safe patient culture is potentially harmful.

> *"Effective leaders need to support the work of creating a safety culture by defining the goals and values of the organization, and making them live and breathe within the process of caring for patients. Healthcare leaders have to clearly and relentlessly communicate that safe care is a primary, non-negotiable goal. Leaders need to be able to clearly articulate the behavioral expectations that create value for the patient, clinicians, and the organization. They need to communicate in concise, simple fashion." (M Leonard, A Frankel - May Issue. London: The Health Foundation, 2012 - hsj.co.uk)*

When leaders communicate the expectations for a culture that values effective teamwork and communication, they need to manage the disruptive behaviors and influences that negate the organizational values.

Changing process in isolation is not sufficient

Successful change needs to incorporate three important components: content of the change, process implications and, most importantly, the people component of the change. Some refer to this as a three legged stool model where all three of these legs are essential for stability.

Implementing successful change requires interaction, exploration and a high level of engagement to ensure that the changes and their implications are felt and understood. Ongoing guidance, mentorship and support for leadership teams to meet this challenge is critical and effective.

The Canadian Patient Safety Institute notes, "Organizations that embrace the value of teamwork and communication as a 'must have' rather than a 'nice to have' will ultimately strengthen their ability to provide safe patient care."

Implementing a change in culture isn't an easy task. It takes consistency, clarity and incredible persistence — and, often, guidance from a third-party to achieve but for those leaders who succeed in helping their inter-professional teams work better together, the results are better clinical, economic and operational outcomes.

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