Hear, hear!

By Suzanne C. Beyea, Ph.D., R.N.

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Remember the children's parlor games of "gossip" or "telephone"? A phrase is passed by word of mouth down a line of players, usually getting hilariously distorted along the way. Unfortunately, verbal communication among health-care providers can often resemble such parlor games—only the resulting distorted messages aren't at all funny.

Physicians, nurses, and other health-care providers are trained to communicate effectively with their patients. Yet they get surprisingly little instruction in how to communicate well with one another—especially verbally. Despite that fact, clinicians often rely on verbal communication to report on the status of patients, indicate changes in patients' conditions, clarify written orders, call in prescriptions to a pharmacy, notify other clinicians about laboratory test results, or report impending medical emergencies.

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Consistent: But according to patient safety experts, verbal communication is simply not a reliable way to transmit important information. There are few guidelines to ensure that spoken communication about health care is as consistent, complete, and accurate as written communication—such as a note in a patient's medical record.

Communication problems have long been associated with medical errors and adverse events, and they may be a leading cause of what are known within medicine as "sentinel events"—unexpected occurrences involving death or serious physical or psychological injury. Interruptions, distractions, and the frequency of clinician-to-clinician interactions can all interfere with the process of communication. The problems range from a clinician failing to record or pass along information received verbally—for example, about a patient's medication allergies or health condition—to a surgeon saying by mistake "*right* below-the-knee amputation" instead of "*left*." Such lapses must always be taken seriously, since sometimes they can result in an error as drastic as the wrong limb being removed.

Accuracy: Health-care organizations have begun to develop guidelines aimed at improving clinician-to-clinician communication. For example, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires hospitals to develop processes to ensure that spoken communications—whether in person or by phone—of orders or of critical laboratory test results are read back by the person receiving the information. JCAHO believes this step will help improve completeness and accuracy.

Differences in training and communication styles, as well as lack of teamwide training, play a role, too. Dr. Michael Leonard, an anesthesiologist and patient safety leader at Kaiser Permanente, has identified differences between nurse and physician communication styles: nurses tend to be narrative and descriptive, whereas physicians tend to focus on the exact problem or need. Leonard suggests using a briefing model that he calls SBAR (Situational, Background, Assessment, and Recommendation) to establish a shared framework for nurse-to-physician communication.

DHMC is using the SBAR model in its 12-week nurse-residency training program, which uses human-patient simulators that respond physiologically like real patients. The nurse residents practice providing data about a patient's current clinical situation, background information about the patient's condition, an assessment of the current problem, and a recommendation to meet the patient's needs. For example, the nurse would tell a physician, "Mr. Smith's blood pressure is 84/50 and his pulse is 140 [situation]. He underwent a gastrectomy this morning [background]. I think he may be actively bleeding [assessment] and I'd like you to come and see him now [recommendation]." Using these strategies, new nurses gain skills in effective communication and develop approaches that help promote patient safety. Safety experts say such assertive communication is crucial to patient safety.

Errors: The nurse residents get feedback from their trainers as well as from the patient simulators. So if, for example, the nurse resident forgets to use structured communication or forgets to "read back" an order or critical test result, nurse educators provide feedback about the potential for error. Sometimes the educators will allow the errors to play out so the nurse residents can see the consequences. So, say a verbal order is for "15" milligrams of a certain medication, but the nurse resident hears "50" milligrams and prepares and administers the wrong dose. If the dose is excessive, the simulator suffers the consequences that a real patient would in an actual clinical situation. The nurse therefore quickly realizes the hazards associated with not reading back the order. Strengthening communication skills helps new nurses develop reliable approaches to communicating pertinent information in a manner that promotes patient safety.

Communication is a complicated process, especially in health-care settings, where we face many challenges in our effort to keep patients safe. As the complexity of the health-care environment increases, clinicians will have to work together to identify and implement strategies that promote reliable verbal communication. Both patients and clinicians can improve the effectiveness of their communications by getting the intended recipient's attention; providing information in a clear, organized fashion; and repeating important information.

So remember those old games of "gossip" and "telephone"—and keep in mind that what is not written down may change its meaning very quickly and in a most unexpected manner. ■

"Grand Rounds" covers a topic of interest to the Dartmouth medical faculty. Beyea, who has an appointment as an associate professor of community and family medicine, is the director of nursing research at Dartmouth-Hitchcock Medical Center.