MISCOMMUNICATION IN THE MASS COMMUNICATION AGE

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OBJECTIVES

• Review the elements of a communication process
• Communication Failures & Implications
• Translational Communication Elements and Skills
• Put it to the test
MASLOW'S HIERARCHY OF NEEDS


**Self-Actualization** - A person’s motivation to reach his or her full potential. As shown in Maslow’s Hierarchy of Needs, a person’s basic needs must be met before self-actualization can be achieved.
THE RELEVANCE

• 60% of Sentinel Events reports to TJC associated with communication failures
• Communication failures exceeded technical error by 2:1 among cause in 14,000 hospital deaths
THE RELEVANCE

• Multisite studies of ICU’s, poor collaborative communication among providers contributed to 1.8 fold increase in risk adjusted mortality and length of stay.

• 421 OR communication events
  • 30% prevalence of failures
  • 1/3rd jeopardized patient safety
THE RELEVANCE

• Among 444 surgical malpractice causes resulting in harm to patients, 60 cases (13%) were associated with communication failure.
  • 73% were associated with verbal breakdowns
  • 64% involved only 2 individuals
Опишите перспективы взаимодействия армии и флота в условиях массированного ведения боевых действий.

Первый в ряду таблиц — «Панцирь С».

Второй в ряду таблиц — «Куб».

Третий в ряду таблиц — «Фундамент».

Четвертый в ряду таблиц — «Восток».

Пятерой в ряду таблиц — «Крым».

Шестой в ряду таблиц — «Авангард».

Седьмой в ряду таблиц — «Ямал».
GRICE’S MAXIMS OF COMMUNICATION

• Quantity
  • Make your contributions as informative as is required (for the purposes of the exchange)
  • Do not make your contribution more informative than is required
  • *Season to flavor*

• Quality
  • Make your contribution one that is true
  • Do not say what you believe to be false
  • Do not say that for which you lack adequate evidence
  • *Hear no evil, see no evil, speak no evil*
GRICE’S MAXIMS OF COMMUNICATION

• Relation
  • Be relevant

• Manner
  • Avoid obscurity of expression
  • Avoid ambiguity
  • Be brief
  • Be orderly
  • *I said what I meant and I meant what I said*
FAILURE ANALYSIS

• Message
  • Language
  • Format
• Sender & Recipient
  • Prepared to communicate
• Conduit
  • Technology Interface

• Environment
  • Ambient noise
  • Stress changes EVERYTHING
• Timing
  • Context of events
• Sustainability
**Dominance**
*Person places emphasis on accomplishing results, the bottom line, confidence*

- Sees the big picture
- Can be blunt
- Accepts challenges
- Gets straight to the point

**Influence**
*Person places emphasis on influencing or persuading others, openness, relationships*

- Shows enthusiasm
- Is optimistic
- Likes to collaborate
- Dislikes being ignored

**Steadiness**
*Person places emphasis on cooperation, sincerity, dependability*

- Doesn't like to be rushed
- Calm manner
- Calm approach
- Supportive actions
- Humility

**Conscientiousness**
*Person places emphasis on quality and accuracy, expertise, competency*

- Enjoys independence
- Objective reasoning
- Worries the details
- Fears being wrong
CATEGORIES OF FAILURE

• Too late to be effective
• Exclusive of some relevant team members
• Incomplete/inaccurate content
• Did not convey clear and/or achievable goal
CONDUIT FAILURE

• “Failure to communicate: Inside the army’s doomed quest for the ‘perfect’ radio” by David Axe

• $6 Billion in outlay, $11 Billion to buy replacements
• $12 Billion to develop effective new radios
• Begins in 1997; brought to 1000 veterans in 2010

• “JTRS’ history is one of grand but naïve technological ambition colliding with the unbending laws of physics and the unforgiving exigencies of modern warfare.” One size fits none!
DYNAMIC BARRIERS

• Work is complex and unpredictable
• Variety of disciplines with individuals priorities and goals.
• Limited opportunity for synchronous interaction
• Hierarchical organization structure – Authority distance

COMMUNICATION IN CRISIS – THE GOOD
COMMUNICATION IN CRISIS – THE BAD
COMMUNICATION IN CRISIS

The message that was sent to Halsey was:

TURKEY TROTS TO WATER GG FROM CINCPAC ACTION COM THIRD FLEET INFO COMINCH CTF SEVENTY-SEVEN X WHERE IS RPT WHERE IS TASK FORCE THIRTY FOUR RR THE WORLD WONDERS

Since the padding at the end of the message, “the world wonders”, made sense to Halsey’s decoder he left it in. Admiral Halsey therefore received the message: Where is, repeat, where is Task Force Thirty-Four? The world wonders.

Halsey read this message, as a stinging rebuke from Nimitz, of Halsey’s decision to pursue the decoy carriers and leave the landings unprotected. He later recounted that: “I was stunned as if I had been struck in the face. The paper rattled in my hands. I snatched off my cap, threw it on the deck, and shouted something I am ashamed to remember... I was so mad I couldn’t talk.”
COMMUNICATION IN CRISIS
SBAR

• Situation
• Background
• Assessment
• Recommendations
SBAR COMMUNICATION

• Universally applicable
• Bridges communication styles
• Bridges communication tools
• Effective for vertical and horizontal communications
• A/R recognizes expertise of professionals
• Requires respect of professional opinions
• Endorsed by ACHE
TeamSTEPPS

SITUATION
What is the situation?

BACKGROUND
What is the clinical background?

ASSESSMENT
What is the problem?

REQUEST/RECOMMENDATION
What do I recommend/request to be done?

Structured Communication Tool
ESCALATION PROCESS

- Ensure communicator satisfaction with outcome
- Ensure safe outcome
- Ensure institutional goals and standards are met
- Provide a ‘safety-valve’ outlet

- Failure to have standardized escalation process
  - Confusion in responsibility
  - Delay in definitive solutions
  - Provider frustration
Nurse wants to inform the surgery resident about non-access to IV on a patient. No call back from the resident. Orders entered are different, phone and pager nos. do not match. Nurse now wants to confirm the phone and pager nos. of the surgery resident but that does not work too. Gets another phone no. for the surgery resident but no response. Waits for call back from surgery intern. No response. Nurse receives call-back from surgery floor intern but has no information on patient. Surgery floor intern calls back again. Resolves issue for now.
TEAM HUDDLES

- Establish foundation upon which day or session is built
- Bring functional elements into alignment

- Standardize
  - Start time and Duration
  - Location
  - Structure
  - Agenda
  - Attendance
# ICU/IMC Daily Goals Checklist

**Attending:**

**MAJOR underlying comorbidities:**

**Admission diagnosis:**


<table>
<thead>
<tr>
<th>System</th>
<th>In detail</th>
<th>Initiative</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>Th</th>
<th>F</th>
<th>Sat</th>
<th>Sun</th>
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<tbody>
<tr>
<td>Cardiac</td>
<td>Rhythm? Hemodynamic stability? Vasoactive drugs?</td>
<td>Cardiac</td>
<td></td>
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<tr>
<td>Neuro</td>
<td>Pain control sufficient?</td>
<td>Pain</td>
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<td></td>
<td>CAM-ICU positive or negative/ RASS score</td>
<td>Agitation</td>
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<td></td>
<td>CIWA score (as appropriate)</td>
<td>Delirium</td>
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<tr>
<td>Pulmonary</td>
<td>Results after sedation vacation?</td>
<td>SAT</td>
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<td></td>
<td>Current oxygen / Hi Flow / CPAP / BiPAP / Vent settings?</td>
<td>Oxygenation</td>
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<td></td>
<td>Outcome of AM weaning trial?</td>
<td>SBT</td>
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<td></td>
<td>CLRT indicated/implemented?</td>
<td>CLRT</td>
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<td></td>
<td>HOB up &gt;30°? Oral care q 2-4 hr. (b.i.d. brushing)?</td>
<td>HOB/Oral</td>
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<td></td>
<td>Lung protective ventilation or BiLevel/APRV if ARDS?</td>
<td>LPV</td>
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<tr>
<td>Neuro</td>
<td>Mobility score? PT / OT?</td>
<td>Activity</td>
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<tr>
<td>ID</td>
<td>Lines: Can any lines be removed (central/art)?</td>
<td>Lines</td>
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<td></td>
<td>Foley catheter: Can Foley be removed?</td>
<td>Foley</td>
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<tr>
<td></td>
<td>Has duration of antibiotic been established? Is procalcitonin demonstrating a decrease? IV→PO Abx?</td>
<td>Abx Stewardship</td>
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<tr>
<td>Fluids/GU</td>
<td>Fluid balance? (+ or - )</td>
<td>Fluid Bal</td>
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<td></td>
<td>Weight up or down (since yesterday? Since admit?)</td>
<td>Weight</td>
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<td></td>
<td>Last BM ___________ Diarrhea?</td>
<td>GI</td>
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<td></td>
<td>Current diet / feeding / free water?</td>
<td>Diet</td>
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</table>
Table 4. Results of communications process analysis

<table>
<thead>
<tr>
<th>Time for resolution of communication/issue</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>P-value (1-sided)\textsuperscript{a}</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MICU</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time for communication (min)</td>
<td>(N = 112)</td>
<td>(N = 112)</td>
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</tr>
<tr>
<td>Mean</td>
<td>7.19</td>
<td>3.69</td>
<td>0.007</td>
</tr>
<tr>
<td>Range</td>
<td>1 - 312</td>
<td>1 - 51</td>
<td></td>
</tr>
<tr>
<td>Adjusted mean</td>
<td>4.52</td>
<td>3.37</td>
<td>0.01</td>
</tr>
<tr>
<td>Adjusted range</td>
<td>1 - 55</td>
<td>1 - 51</td>
<td></td>
</tr>
<tr>
<td><strong>ACU</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Time for communication (min)</td>
<td>(N = 135)</td>
<td>(N = 136)</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>8.29</td>
<td>6.51</td>
<td>0.27</td>
</tr>
<tr>
<td>Range</td>
<td>1 - 136</td>
<td>1 - 61</td>
<td></td>
</tr>
<tr>
<td>Adjusted mean</td>
<td>6.63</td>
<td>5.27</td>
<td>0.31</td>
</tr>
<tr>
<td>Adjusted range</td>
<td>1 - 135</td>
<td>1 - 60</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resolution and satisfaction</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>P-value (2-sided)\textsuperscript{b}</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MICU</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Positive nurse responses (%)</td>
<td></td>
<td></td>
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<tr>
<td>(N = 99)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pre-intervention</td>
<td>67.7</td>
<td>80.2</td>
<td>0.04</td>
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<tr>
<td>Post-intervention</td>
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<tr>
<td>Satisfied/very satisfied nurse responses (%)</td>
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<tr>
<td>(N = 103)</td>
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<td></td>
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<tr>
<td>Pre-intervention</td>
<td>85.5</td>
<td>92.8</td>
<td>0.08</td>
</tr>
<tr>
<td>Post-intervention</td>
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</tr>
<tr>
<td><strong>ACU</strong></td>
<td></td>
<td></td>
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<tr>
<td>Positive nurse responses (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N = 135)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pre-intervention</td>
<td>66.7</td>
<td>75</td>
<td>0.13</td>
</tr>
<tr>
<td>Post-intervention</td>
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<tr>
<td>Satisfied/very satisfied nurse responses (%)</td>
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<tr>
<td>(N = 136)</td>
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<tr>
<td>Pre-intervention</td>
<td>77.1</td>
<td>80.1</td>
<td>0.53</td>
</tr>
<tr>
<td>Post-intervention</td>
<td></td>
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</tbody>
</table>

\textsuperscript{a} t-test
\textsuperscript{b} chi-square
Variation in Communication Loads on Clinical Staff in the Emergency Department

Study objective: We determine whether there are differences in role-related communication patterns in the emergency department (ED).

Methods: This was an observational study of a metropolitan ED. Four medical officers and 4 nurses were observed for 19 hours and 52 minutes. Communication load was measured by proportion of observed time in communication, proportion of concurrent communication events, and proportion of interruptions.

Results: Eight hundred thirty-one communication events were identified, an average of 42 events per person per hour. Eighty-nine percent of clinicians' time was spent in communication. Synchronous communication channels, involving face-to-face or telephone conversations, were used in 84% of events. One third of communication events were classified as interruptions, averaging 15 interruptions per person per hour. Senior medical and nursing staff experienced higher rates of interruption than junior medical staff and registered nurses with an allocated patient load.

Conclusion: There was considerable variation in communication loads on clinical staff occupying different roles in the ED. Medical registrars had a high proportion of interruptions and spent the most time dealing with interruptions. These new data suggest some clinical roles may be at higher risk of communication overload than those of the general clinical population.

COMMUNICATION UNDER STRESS

- Hypothesize that certain communications loads associated with specific work patterns
- Expect communication load to vary with clinical roles
- Identify which roles are at risk for high loads and thus, communication failures
COMMUNICATION UNDER STRESS

- 4 physicians and 4 nurses monitored for 20 hours in ED
- 831 distinct communication events
  - 42 events/person/hour
  - 1/3 of events classified as interruptions
  - 10% of time carrying out ≥ 2 overlapping conversations/tasks
Communication Systems in Healthcare

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Abstract
The care of patients now almost inevitably seems to involve many different individuals, all needing to share patient information and discuss their management. As a consequence there is increasing interest in, and use of, information and communication technologies to support health services. Yet, while there is significant discussion of, and investment in, information technologies, communication systems receive much less attention and the clinical adoption of even simpler services like voice-mail or electronic mail is still not commonplace in many health services. There remain enormous gaps in our broad understanding of the role of communication services in health care delivery. Laboratory medicine is perhaps even more poorly studied than many other areas, such as the interface between primary care and hospital services. Given this lack of specific information about laboratory communication services, this paper will step back and generally review the components of a communication system, including the basic concepts of a communication channel, service, device and interaction mode. The review will then try and summarise some of what is known about specific communication problems that arise across health services in the main, including the community and hospital service delivery.
Figure 1. The number of possible conversations increases combinatorially with the number of individuals who need to communicate (after Lang and Dickie, 1978).\(^1\)

\[
\text{number of conversations} = \frac{n!}{r!(n-r)!}
\]

where \(n\) is the number of individuals, and \(r\) is the number of individuals involved in a single conversation.
CONVEYING A MESSAGE

• Define the intended audience
  • Attention span
• Understand the media being utilized
• Account for barriers to understanding
  • Language
  • Profession
  • Priorities
  • Education
The Health Information Management Department has begun a process to improve the verbal order process throughout our hospital.

Approximately 250,000 verbal orders are given annually in this institution.
A survey recently completed among 8NE nurses indicated that:

- 32% of RNs were dissatisfied with the current verbal order policy.
- 45% found it difficult to identify the ordering provider.
- VO process was completed only 55% of the time.
VERBAL ORDER PROCESS

1. All verbal orders must be signed, dated and time stamped by the ordering practitioner within forty-eight (48) hours after order is given.

2. Deferred verbal orders are reviewed, managed and monitored by Nursing and Ancillary Services.

3. New verbal order reports have been developed to monitor compliance.
SER PROVIDER LOOKUP PROCESS

• Physicians and APP's will be asked by RN's for their SER (unique provider) number to ensure accurate identification of the person giving the order.

• Second identifier will ensure your name is selected correctly (i.e. a provider with the same/similar last name).
Beginning May 20, 2015 providers will now use the New Sign Off feature to sign Codes, Rapid Responses or RSI. This update will eliminate the need to sign the Code Documentation Note.

How to Sign Off

There are two methods available for Sign Off – it is your choice which method you want to use:

Method 1: A reminder will automatically be sent to the provider’s In Basket to sign when the end time has been entered by the Recorder.

Method 2: The provider can sign the Code or Rapid Response prior to leaving the patient’s room.

How to Sign Off with this method

1. Go to the Recorder’s PC - immediately after the event has ended.
2. Click the Sign Off link next to your name and enter your password, a comment section will be available from here also.

Staff Sign Off

- [ ] Sign Off
- [ ] Sign Off
- [ ] Sign Off
- [ ] Sign Off

This is the view from the Recorder’s PC in Code Narrator immediately after the Code and Rapid Response has ended.

With this method you are immediately finished with signing the Code or Rapid Response. The Recorder should remind the provider(s) to sign prior to leaving the patient’s room. Any provider(s) whose name is linked to any order, or linked to any medication given during the event will receive an In Basket reminder to sign or Sign Off link next their name (see above screen shot for Sign Off hyperlink).

Physician Code Blue Documentation Specifics

- New Note Type: 'Code Documentation' in top left corner of note (Blue Arrow)
- Change note time (Red Arrow) to match time code event was completed (ask RN scribe or review event under Epic Patient Summary Tab and Code/Rapid Timeline screen under reports)
- Use 'codemdt' to document your presence and supervision of code/rapid response
- Necessary to link your presence and supervision for medications/procedures during code event.
- Contact Julie Nist with questions @ nistj@wvhealthcare.com
PUTTING IT ALL TOGETHER

- Teach a simple skill
- Exchange communications inventory
- Teach a similar skill
- Feedback on effectiveness