Nurse Spotlight: Communication

Nurses Service Organization (NSO), in collaboration with CNA, has published our 4th Edition of the NSO/CNA *Nurse Liability Claim Report*. It includes statistical data and case scenarios from CNA claim files, as well as risk management recommendations designed to help nurses reduce their malpractice exposures and improve patient safety.

You may access the complete report, and additional Risk Control Spotlights, at: www.nso.com/nurseclaimreport.

This Spotlight provides an overview of common liability exposures related to communication issues and risk control recommendations to enhance communication skills and minimize potential loss.

Communication is an important element of nursing practice, including both verbal and written communication through documentation. Nurses are responsible for communicating with members of the patient healthcare team, navigating a variety of patient healthcare goals and responsibilities, and assisting with the coordination of patient care. Studies by The Joint Commission, among others, of the root cause factors that contribute to sentinel events in healthcare have shown that communication is one of the most common root causes of adverse patient events. Understanding how information is effectively communicated and heard can help promote positive patient outcomes and improve patient satisfaction.

Professional liability allegations related to the **failure to communicate pertinent health information** with providers, patients, or patients' family members occurred relatively infrequently in the 2020 nurse professional liability claims analysis. However, a breakdown in communication probably contributed to other nursing allegations in the *Nurse Professional Liability Exposure Claim Report*. Communication barriers may prevent or delay nurses from reporting changes in the patient's condition, invoking the chain of command, clarifying orders, or raising concerns about systems and processes.

Professional liability claims involving communication breakdowns can be difficult to defend. This is reflected in the fact that allegations related to communication had an average total incurred of $324,260, which is more than one and a half times greater than the overall average total incurred for all nursing professional liability claims of $210,513. An example of communication breakdown leading to a failure to invoke the chain of command, an adverse patient outcome, and professional liability action against an insured nurse follows.

Nursing Malpractice Scenario: Failure to report changes in the patient's medical condition; failure to act as the patient's advocate; failure to invoke the nursing chain of command

A 38 ½ weeks pregnant patient arrived at the emergency department (ED) at 8:29 p.m. with complaints of abdominal pain and decreased fetal movement. She presented to the ED because her mother (a registered nurse at the same hospital) instructed her to come to the ED in order to be seen faster. The patient's mother described the patient's symptoms as "*Continuous episodes of vomiting for the past three hours, left side abdominal pain. The pain is cramping that does not radiate, is aggravated by movement, and nothing seems to alleviate the symptoms.*" She stated that the patient had some takeout food earlier that afternoon and later began having abdominal pain and vomiting. Initially, there was confusion regarding if the patient should be sent directly to the Labor and Delivery (L&D) unit or evaluated first in the ED.

At 8:31 p.m, the patient was seen in the ED by a nurse. She reported her pain as an 8 on a 10-point scale. The health information record states that the patient was first seen by an ED nurse practitioner (NP) at 8:33 p.m. and then by an ED physician at 8:37 p.m. The NP documented a complete physical examination. Her differential diagnosis was: "*gastritis, cholecystitis, labor.*"

At 8:42 p.m., the insured L&D registered nurse (RN) came to the ED to monitor the mother and baby. The nurse applied a fetal heart monitor in the ED and noticed that the fetal heart rate was in the 130's with minimal variability, and no decelerations noted. The nurse started IV fluids and only infused 50 ml, as she wanted to see if the fluids would improve the fetal heart rate. After 20 minutes of monitoring the patient, the nurse determined that the contractions and fetal heart rate were unlikely to be reversed by hydration.

The patient was in the ED for less than 35 minutes when the decision was made to transfer and admit the patient to the L&D unit. The insured nurse disconnected the fetal heart monitor and transported the patient to the L&D unit. When the nurse and patient arrived at L&D, the monitor was reattached. At 9:18 p.m., the nurse documented that she had "*Reviewed the fetal heart monitor strip and the patient was being examined by OB*[1]."

At 9:20 p.m., the OB practitioner documented a progress note, "*Patient is G1 @ 37+ weeks2, presented to ED with nausea and vomiting, mild abdominal pain. Didn't feel well today. Decreased fetal movement, FHTs*[3] *130s NR*[4]*, decreased LTV*[5]*. Assessment/Plan: probable GI*[6] *virus, hydrate with IV fluids – monitor FHTs.*"

At 9:25 p.m., the insured nurse documented that she turned the patient on her right side "*due to minimal variability.*" At 9:30 p.m. an entry was made by a second L&D nurse, "*The contractions are moderate. The FHR*[7] *baseline was 125 and the variability was minimal with no accelerations or decelerations.*"

At 9:55 p.m., the insured documented that "*Contractions are mild to moderate and the FHR baseline are 120 with minimal variability and no accelerations or decelerations.*"

At 10:16 p.m., the insured documented, "*The FHR baseline is 115 with minimal variability and no accelerations. OB performed an ultrasound and a biophysical profile.*"

At 10:35 p.m., the OB called for an operating room team in order to perform a C-section[8]. The last note by the OB prior to the C-section stated: "*C-section was performed due to non-reassuring fetal testing. The patient had felt movement earlier that morning, but it had decreased throughout the day and the biophysical profile after IV hydration showed an AFI*[9] *of 5, no movement, no breathing. Since patient is only 1 cm and remote from delivery she will proceed with C-section.*"

At 11:21 p.m., the delivery was accomplished Apgar scores were 1 at one minute, 4 at five minutes and 6 at ten minutes. The baby's global condition is that of hypoxic-ischemic encephalopathy, cerebral palsy with spastic quadriparesis, and profound brain damage. The child cannot sit up or crawl and is totally dependent for all activities of daily living. The child is nonverbal, but can respond to simple questions by using gestures.

Risk Management Comments

There were several co-defendants in the case. They included the insured L&D registered nurse, a second L&D nurse, the OB practitioner and the hospital. The allegations against the insured nurse were:

- Failure to immediately transfer plaintiff to L&D;
- Failure to identify the risk of placental abruption in light of the history and presentation;
- Failure to properly interpret non-reassuring fetal heart monitor tracings;
- Failure to attach a scalp electrode when the toco (cardiotocograph) was not picking up the fetal heart tones; and
- Failure to advocate for a timelier C-section and implement the chain of command.

In preparing the insured nurse's defense, there were several key issues to consider:

- Given the allegation that the insured RN failed to implement the chain of command, presenting an expert who was critical of the OB practitioner might serve to directly or indirectly support the claim that the RN should have recognized the MD was mishandling the delivery.
- The defense expert opined that the fetal heart monitor strips in this case were non-reassuring despite hydration. Thus, an emergent C-section was appropriate and should have been performed shortly after the patient arrived on the L&D floor.

Resolution

Given the deviations from the standard of care and the failure to implement the chain of command protocol, the decision was made to resolve the case on behalf of the defendant nurse. The total incurred costs to manage, defend, and resolve this case exceeded $770,000. Several other healthcare practitioners were also included in the lawsuit, but their settlement amounts were not available.

Case Study Footnotes:
[1]Obstetrician
[2]Patient is at over 37 weeks gestation with her first pregnancy.
[3]Fetal heart tones
[4]Non-reactive
[5]Long term variability
[6]Gastrointestinal virus
[7]Fetal heart rate
[8]Caesarean delivery
[9]Amniotic fluid index

Risk Management Recommendations: Communication

The following guidance is designed to assist nurses in evaluating professional risk exposures associated with their practice. For additional risk control tools, or to download the *Nurse Liability Claim Report: 4th Edition*, visit Nurses Service Organization or CNA Healthcare.

Communication basics

Interpersonal skills, those which promote a good relationship between individuals, do not come naturally to all healthcare professionals. Individual methods and styles of communication are primarily learned responses to how we have communicated in the past. Many individuals were taught to communicate poorly by well-intentioned individuals who also may have been taught inadequate ways of communicating. Fortunately, communication skills can be improved through education and practice. The following suggestions can help nurses enhance efforts to communicate effectively:

- Set aside any personal judgments about patients and build each patient relationship with empathy.
- When listening to what a patient is saying, concentrate on both the verbal and nonverbal messages.
- Maintain good eye contact, focusing on the patient's eyes whenever you are speaking or listening.
- Be aware of your own facial expressions and gestures. Practice giving difficult messages. Do your best to be relaxed and natural. Remember that nonverbal communication is automatic, but you can practice becoming more aware and comfortable. Be a patient listener. Avoid interrupting and limit your own talking until the person speaking has finished what they are saying.
- Suspend judgment. Don't dismiss the value or importance of what is said by a person speaking in a monotone voice, or with a foreign accent.
- Listen for the feelings behind the facts. Using the patient's behavioral cues, facial expressions, and word choices, infer what emotions they may be feeling.
- Respond in a way that indicates your awareness and validation of the patient's feelings and concerns.
- Clarify by asking questions and paraphrasing. Try to reflect the feelings and thoughts the patient is expressing by rephrasing questions and comments using their own words.
- Nurses can develop these and other communication skills by including coursework on refining communication skills as part of their regular nursing continuing education.

Communication techniques

Effective communication is complete, clear, concise and timely. Nurses may utilize several communication techniques and strategies to help ensure that they are communicating effectively and advocating for their patients to receive safe, quality care. The Institute for Healthcare Improvement (IHI) and the Agency for Healthcare Research and Quality's TeamSTEPPS® program present effective strategies to improve communication among members of the interprofessional team and promote situational awareness. The program presents several verbal strategies, including the following:

- **SBAR:** Stands for Situation, Background, Assessment, and Recommendation/Request. SBAR is a means to relay significant information regarding a patient's condition or may be used as the patient's care is handed off from one caregiver to another.
  - **Situation**—What is going on with the patient?
    - Identify yourself, your unit, the patient, and the room number.
    - Briefly state the problem, when it happened or started, and the level of severity.
  - **Background**—What is the clinical background or context?
    - The date of admission and admitting diagnosis.
    - Current medications.
    - Most recent vital signs.
    - Lab results, including the date and time the test was performed and results of previous tests for comparison.
    - Other clinical information.

- **Assessment**— What is your nursing assessment of the situation?
- **Recommendation/Request**—What is your recommendation or request?
- Document any change in the patient's condition, conversations with treating providers, and their response.
- Examples of SBAR can be reviewed here and here.

- **Call-out:** Used to communicate important information to all team members simultaneously during a critical event.
  - Informs all team members simultaneously during emergency situations.
  - An example of how call-outs can be used can be seen here.
  - Call-outs are typically followed by a check-back.
- **Check-back:** Closed-loop communication to ensure that information conveyed by the sender is understood by the receiver as intended by repeating back information.
  - In a check-back, the sender initiates a message, the receiver accepts the message and provides feedback, and then the sender verifies that the message was received.
  - This tool is used to verify and validate information exchanged between team members.
  - An example of check-back works can be seen here.
- **Hand-offs:** Accurate and timely transfer of information from one caregiver to another.
  - The discussion includes the patient's current condition, treatment, and any recent or anticipated changes.
  - Hand-off discussions also include:
    - Transfer of responsibility and accountability, with acknowledgment by receiver.
    - Opportunity to review, ask questions, and clarify information.
    - For more information, see The Joint Commission's infographic on 8 tips for high-quality hand-offs, available here.
- **Two Challenge Rule**: When an initial assertion is ignored, it is your responsibility to assertively voice concerns at least twice to ensure it has been heard.
  - The team member being challenged must acknowledge the other team member's concern.
  - If a team member assertively voices their concern at least two times and the outcome is still not acceptable, the team member should:
    - Take a stronger course of action.
    - Invoke the chain of command.

Recognizing and addressing biases

In addition to taking steps to address language barriers and health literacy issues with their patients, nurses must also work to recognize how individual biases and structural oppression impact clinical care. Nurses should consider cultural, racial, and social differences when treating patients or working with colleagues. Some communication issues may arise due to implicit biases between culturally and racially diverse patients and healthcare staff. Creating an inclusive environment for patients and colleagues is critical to providing equitable, quality nursing care. Independent research and continuing education on implicit biases and cultural competency enhances healthcare professional skills. Nurses can take direct steps to address individual and systemic biases and racism, including correcting themselves and other team members when they make an error. There are many interesting resources for nurses to take surveys that let them know of their implicit bias, such as project implicit.

One way to foster an inclusive environment is to address microaggressions – defined as subtle, indirect and often unintentional statements or acts that are racist or otherwise prejudiced. Microaggressions are the manifestation of biases that erode the nurse-patient relationship as well as nurses' relationships with their colleagues. As nurses work to build a safer environment for African American, Indigenous, LGBTQ+, and other racial and cultural minorities, they first must be able to recognize microaggressions and act against them in the workplace. Some examples of common microaggressions include:

- **Assigning nicknames:** A healthcare provider may use a nickname if a patient of a different ethnicity has a name that is difficult to pronounce. Though this may seem harmless, it can be perceived as disrespectful if it is not a nickname the patient offers.
- **Assuming healthcare status:** A healthcare provider may make assumptions about a patient's health or healthcare payment status based on their race, sexual orientation, gender identity, or appearance, which can interfere with nursing assessments and administering proper treatment.
- **Embodying dismissive behavior:** A healthcare provider may exhibit dismissive body language or actions as they go about their daily routines, such as spending less time with certain patients, avoiding eye contact, or adopting a more closed posture towards certain colleagues.
- **Failing to use interpretation services:** A healthcare provider may not choose to use an interpreter for every interaction with a non-English speaking patient. But for a patient, every interaction matters – even the act of walking in the room – and may require a brief explanation such as, "I wanted to see if you'd eaten your lunch."

Nurse Spotlights

For risk control strategies related to:

- Defending Your License
- Documentation
- Liabillity for Nurse Managers
- Home Care
- Medication Administration
- Depositions

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Advocating for your patients

Nurses are their patient's advocate, ensuring the patient receives safe and appropriate care when needed. The connection that nurses foster with the patient and family members allows them to understand the patient's goals and values. Nurses' holistic perspective allows them to promote the patient's and patient's family members' roles in the healthcare team, and to identify changes in the patient's condition that may indicate potential complications. Advocacy includes the duty to invoke both the nursing and medical staff chains of command to ensure timely attention to the needs of every patient with a goal of achieving a satisfactory resolution. Nurses must be comfortable with utilizing the medical chain of command whenever they believe a practitioner is not responding to calls for assistance, fails to appreciate the seriousness of a situation or neglects to initiate an appropriate intervention. The following strategies can help nurses advocate for their patients:

- When advocating for a patient, assert your viewpoint in a firm and respectful manner directly to the individual who is involved in the patient's care and is responsible for addressing the concerns of the nurse and taking action. You should also be persistent and persuasive, providing evidence or data for your concerns.
- If attempts to voice the concern are still disregarded, but the nurse believes patient or staff safety is or may be severely compromised, then take a stronger course of action, by notifying a supervisor or invoking the chain of command policy/protocol.
- Proactively address communication issues between nursing and medical staffs, and identify instances of intimidation, bullying, retaliation or other deterrents to invoking the chain of command.
- Notify facility leadership of individuals or situations that prevent nursing staff from invoking the chain of command or impose punitive actions for doing so. If retaliation is a concern, many facilities offer an anonymous reporting system for employees to notify facility leadership of quality or patient care concerns. These goals may be achieved by using already established channels, e.g., corporate compliance hotline, occurrence reporting, or via your patient safety officer.
- If the organization's current culture does not support invoking the chain of command, explain the risks posed to patients, staff, practitioners and the organization, and initiate discussions regarding the need for a shift in organizational culture.

Documentation

Documentation is a tool for the planning and provision of healthcare services, communication among providers, and demonstration of compliance with federal, state, third-party payer and other laws and regulations. Patient care assessments, observations, communications and actions should be documented in an objective, timely, accurate, complete, appropriate and legible manner. At minimum, the record should include:

- Patient's chief complaint and review of current problems or symptoms.
- Review of clinical history, including relevant social and family history.
- Documentation of each visit or encounter, documenting the date and time, implementation of the plan of care, changes in patient status, and progressions of specific interventions used.
- Documentation of evaluations and communication of any problems to the primary provider. Document the method of communication. For example, phone call, in person discussion, electronic "sticky note" etc.
- Educational materials, resources, or references provided to the patient.
- Encounters with other healthcare providers, including those via telephone, facsimile, and email, with a summary of the discussion and any subsequent actions taken.
- Documentation of reexaminations, including data from repeated or new examination elements, in order to provide useful context for evaluating progress and help inform plans to modify or redirect interventions.

For more documentation-related risk control recommendations for nurses, see NSO and CNA's publication, *Nurse Spotlight: Documentation.*

Diffusing difficult situations

Conflict can become a barrier to communication when emotions detract from the task at hand or shared goals. Difficult or strained communications place patients at risk because nurses, patients, or other members of the patient care team may be less likely to ask questions or confirm information. Nurses can promote teamwork and prevent communication barriers by using strategies to de-escalate tense situations, including the following:

- Address conflict promptly before it becomes a more prolonged barrier to communication.
- Use cognitive rehearsal to practice what you want to say and how you want to say it so that you can respond to a situation in a professional manner.
- Maintain calm and state your primary concern. Refocusing conversations on the patient's needs diverts the focus from power struggles that may occur when people get angry.
- Frame communications using safety language. Safety language is a collection of words or phrases that is understood by everyone to articulate a potential hazard or desired behavior. It is used to describe the situation as you see it, expressing your concerns and potential consequences. An example of this would be "eyes on task" -meaning to stay focused on what you're doing to reduce your risk of injury.
- Focus on what is right, not who is right. Avoid making statements that assign blame, instead use "I" statements to minimize potential defensiveness.
- Nurses have an obligation to report behaviors that can compromise patient safety or the well-being of their coworkers to their supervisor or other authority.

Reflection and feedback

Providing feedback to team members allows the team to identify strengths and weaknesses, make changes to systems and processes, and adjust practices for individual growth and development. Nurses who communicate concerns and address problems in their workplace are essential to ensuring quality care for their patients and improving the systems in which they work. Remember that constructive feedback is most effective when it is focused on a task or process rather than an individual. This approach helps foster an environment of shared accountability and learning and prevents individuals from assigning blame or becoming defensive. At the same time, nurses should also be open to receiving feedback. Receiving feedback is often the catalyst for change and should be viewed as an opportunity for growth rather than a personal slight.

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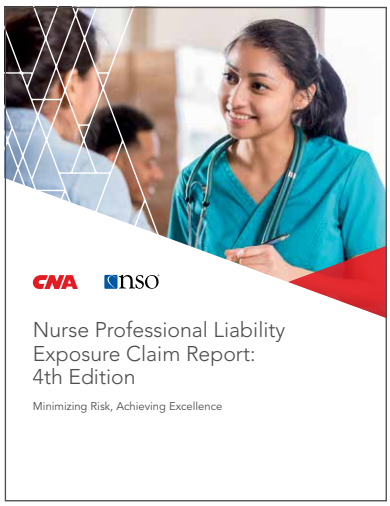
This information is designed to help nurses evaluate risk control exposures associated with their current practice. It is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.



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