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Clarity PSO Learning Series

Topic: Human Factors & Perinatal Events

In healthcare, it is obvious that good communication is crucial. It is widely known that communication failures are among the top root causes of patient safety events and often times lead to devastating outcomes (Dingley, Daugherty, Derieg, & Persing, n.d.). Yet, is it just as obvious that the formatting and standardization of the communication is central to assuring that good communication?

What We Learned

In 2004, the Joint Commission released a Sentinel Event Alert regarding the prevention of infant death and injury during delivery. The following list (in order of most frequent to least frequent) includes the root causes identified within this retrospective study of *perinatal death or permanent disability* events that were submitted to the Joint Commission:

- **Communication**
- Culture (hierarchy and intimidation, failure to function as a team, failure to follow the chain-of-command)
- Staff competency
- Orientation and training process
- Inadequate fetal monitoring
- Unavailable monitoring equipment and/or drugs
- Credentialing/privileging/supervision issues for physicians and midwives
- Staffing issues
- Physician unavailable or delayed
- Unavailability of prenatal information

While this alert was released over ten years ago, unfortunately many of these root causes remain heavily present within current perinatal events as well as many other patient safety events. In fact, The Joint Commission released a report that evaluated root causes from 2004 to 2014. **This report found that communication failures were a root cause within 48% of US maternal sentinel events and 70% of US perinatal sentinel events.**

In our own data analysis, we also found:

- 22% of perinatal events were directly related to the certified nurse midwife (CNM) or OB/GYN physician not being present for part or all of an infant's delivery
- 90% of these events were "no harm" or "near miss"
    - Near miss and no harm events provide insight into underlying barriers that eventually lead to failures in teamwork, communication, and subsequently patient harm

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While patient outcomes vary, we need to ask the question "what if?" What if an unforeseen circumstance arises and those who are at the bedside are unable or untrained to handle the situation? These questions are applicable to any patient care area and high-reliability organizations (HROs) ask themselves the "what if" question constantly. The Joint Commission summarizes Weick and Sutcliffe's work about how HROs stay safe. "High-reliability organizations are preoccupied with failure, never satisfied that they have not had an accident for many months or many years, and they are always alert to the smallest signal that a new threat to safety may be developing" (Chassin & Loeb, 2013, p. 462). **Healthcare needs to think like HROs, constantly trying to improve patient safety.**

This brings us full circle, and interestingly enough, after a discussion with an OB/GYN physician and expert in human factors, **the format of the message is *central* to securing good communication.** Often times, frontline staff and providers are not aware of the multiple of communication tools and formats available to them (i.e., briefing, handoff, debriefing, closed-loop communication, SBAR). Nor is there often a sense of timing as to when you should implement each specific format or tool to ensure good communication.

What Now? Recommendations & Action

Once we admit that communication problems exist and are an issue, how do we tackle them?

1) The underlying foundation of tackling communication failures begins with creating a culture of safety
    a. Implement AHRQ's culture of safety survey throughout your organization
    b. Make the results clear and easily accessible to every employee throughout the organization
    c. Discuss and show your plans of action for improvements of the culture
2) Educate staff and providers on human factors and its integral role in understanding errors
    a. Identify champions or leaders (create teams on units that include at least one administrator, physician and nurse) within your organization and within each department. Considering training these individuals on AHRQ's TeamSTEPPS
        i. Use those individuals and create a dyad structure (a nurse and physician on each unit) to be accountable for action items
    b. Use your identified champions to create, initiate and sustain teamwork principles and a culture of safety throughout your organization
3) Perform an audit of your organization's policies and procedures (perinatal units: do we have a postpartum hemorrhage cart?, is it stocked in a reliable fashion?, massive transfusion protocols, etc.). Are these procedures streamlined, effective, efficient and easily performed? What are the implementation barriers of these procedures? How can the barriers be removed or overcome?

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4) Observe the units and pay attention to the culture of each unit. How do staff communicate with each other, etc.?
5) Interview lots of people! Talk to everyone about the culture and the organization. Leave no one out. This includes housekeeping, pathology, blood bank, physicians, nurses, patient care technicians, volunteers, administrators, managers, and more
6) Ask yourself, "*What behaviors am I looking for*?"

These are only the first steps toward improving communication issues and failures. This a constant improvement cycle that is never perfect and requires continuous vigilance and fostering. Only those who embark on this journey will benefit from the multitude of positive changes that are a part of the ripple effect of great communication.

Resources

- AHRQ's TeamSTEPPS Training Video on Inpatient Medical SBAR
  - A short video on how to perform SBAR (nurse to physician)
- IHI: SBAR Technique for Communication - A Situational Briefing Model
  - A short explanation on SBAR with SBAR guidelines and a worksheet
- AHRQ's CUSP Toolkit
  - A toolkit designed to help make each unit safer by improving the way all clinical team members on the unit work together

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