The Joint Commission Guide to Improving Staff Communication

Second Edition
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Communication—we take it for granted. We instinctively recognize that it is the “glue” that holds an organization together and that when it fails, things go awry—sometimes horribly so. We spend millions to enhance it with information technology, and we look for “the ability to communicate” in our leaders.

But do we really understand communication’s role in health care, and do we systematically study its characteristics, successes, and failures in order to improve it? That is what this book is about; it provides concrete advice on improving communication between the leaders of health care organizations, between these leaders and the organization’s clinicians and staff, and between these clinicians or other staff members and their patients or patients’ families. There is something of value here for leaders, clinicians, and other staff—and patients.

The first chapter particularly emphasizes the role of the organization’s leadership in improving communication throughout the organization. Because of the special mission and organizational structure of a health care organization, its “leadership” encompasses three groups: governing body members, the chief executive officer and other senior leaders (sometimes called the “C-suite”), and the clinical leaders (for example, the leaders of the medical staff in a hospital). Why this special focus on the organization’s leaders? Traditionally, one of the fiduciary responsibilities of the leaders of any organization has been to manage three types of organizational resources: people, money, and material. But we now recognize a fourth resource that the leaders must manage: information. And in health care, the management of information may well be more important than in many other endeavors. Why is this so?

We quickly recognize the importance of information management in an “information business” such as Google, banking, or consultancy. But we rarely think of health care as an information business—perhaps we should. In the simplest medical model of health care, information from the clinician’s education and training, experience, literature review, and online resources is combined with information solicited from the patient, the patient’s family, and diagnostic testing, to generate new information about the patient’s condition and possible therapeutic interventions. This information, along with information about the benefits, risks, and alternatives of potential interventions, is then communicated to the patient in order to agree on a patient-specific course of treatment. The course agreed on (still more information) generates additional information—instruction, counsel, education, prescription, care orders—that is communicated to the patient, the patient’s family, nurses, pharmacists, and other health care professionals. If this chain of information management breaks down at any point—whether in data collection, data storage, data integration, data analysis, transformation of data into information, data or information transmission, or information dissemination—the quality or safety of patient care is at risk. So, is health care itself “information management”? Certainly it is much more, but to ignore the critical role of information management in providing safe, high-quality health care is a mistake we, and our patients, cannot afford.

This book is about communication, so you may be asking about now, “Why the digression on information management?” A quick look back at the previous paragraph should provide the answer. Repeatedly, information management in health care involves communication from one participant to another. From the clinician’s first solicitation of information from the patient, to the sharing of information about the patient between the clinician and other staff, to the final education and instructions provided to the patient about his or her illness and treatment—and how to remain well—communication between and among leaders, clinicians, nurses, pharmacists, and other health care professionals is essential.
information has established that we all read or hear and contemporary understanding of how humans receive not, the fault must lie with the receiver. However, the first and second goals, the third will follow; and if it does complete; and third, is understood by the receiver. As such, content that the sender perceives as timely, clear, accurate, and complete may not be understood or may be misunderstood by the receiver. When the content is not understood, the receiver has the opportunity (if he or she overcomes the embarrassment of admitting a lack of understanding) to request further communication. The greater danger lies in misunderstanding, because both the sender and receiver believe they have a shared understanding when they do not.

Although barriers to shared understanding such as language, cultural, and health literacy differences have become the focus of attention in our increasingly multicultural and multilingual society, in the absence of these more evident differences, we often fail to appreciate how frequently there is a lack of shared understanding between sender and receiver. This lack of understanding may occur when the sender is speaking or writing to a group or to a single individual. In unidirectional communication, neither the sender nor the receiver can tell whether shared understanding has been achieved. The fact that each reader may understand and respond differently to the same piece of fiction is one of the hallmarks of great literature. However, differences in “reader response” are dangerous in health care; shared understanding between sender and receiver is necessary for safe, high-quality care, whether the communication is among staff or between clinicians and patients. Throughout this book are examples of tools and methods that help to improve and assess shared understanding, such as “teach back” by the receiver, and the use of protocols that provide a standardized and, therefore, mutually understood context for repetitive types of communications.

One powerful communication tool that is often overlooked, although the message is usually readily understood by the receiver, is called behavior. We all know what it means to “walk the talk.” Part of the meaning is to “practice what we preach”: if the advice we give is good, we should be following it ourselves. But “walking the talk” is also a communication medium; failure to behave in a manner that is consistent with what we say or write is communication that negates (for the receiver) the verbal message.
Organizational leaders are at special risk of having their communication misunderstood by the receivers. First, their communications are often unidirectional (for example, memos, policies, announcements) that do not automatically generate feedback from the recipients, and second, their behavior, if inconsistent with their verbal message, is a highly visible communication that contravenes their intended message. So what behaviors should leaders exhibit to “walk the talk” about the importance of communication? Again, this book provides a guide. One of the most effective behaviors is Executive WalkRounds™ described in Chapter 1. But many other routine leadership behaviors (for example, listening, having an open door policy) are also described.

What, then, should leaders themselves communicate verbally and in their behavior about communication in their health care organization? The following behavior-focused points should be considered:

- Effective communication is highly valued.
- Good communication is integral to high-quality patient care.
- Failure in communication can be the cause of harm to patients, to staff, and to the institution.
- Communication is integral to the teamwork and collaboration on which health care organization performance depends.
- Good communication skills can be learned, practiced, and continuously improved.
- Communication—both vertically and horizontally—in the organization is not only welcome, it is encouraged and enabled.
- Messengers bearing news—whether good or bad—are never shot; instead, they are rewarded.

The last point above is particularly important in health care organizations. Health care is a high-risk endeavor. For many reasons—for example, complexity, time pressure, tight complying, dependence on error-prone humans—it is easy for things to go wrong in health care. And when things go wrong, patient harm often results. Having studied other high-risk industries that have, nevertheless, become highly reliable, there is a pressing need to adapt their methods to transform health care into a high-reliability activity.

One of the keys to creating high reliability is to understand the properties of complex systems. Certainly, health care organizations are complex systems. In complex systems, causes and effects are not linear; that is, a small change at one point in the system can lead to a large change elsewhere. Further, the resulting changes cannot be fully predicted; there are invariably unintended, unexpected consequences somewhere in a complex system when changes occur or are made in the system. Therefore, the only way to effectively manage a complex system—to make it highly reliable—is to be vigilant for even the smallest changes and to monitor their progression and results—a culture of “mindfulness” in all the participants. This vigilance must be accompanied by an expectation that observations of variation will be communicated. We know that failure to communicate variations in a patient can result in a “failure to rescue” the patient. Likewise, failure to communicate variations in an organization’s processes or outcomes can result in changes or breakdowns in systems and processes that endanger patients, staff, or the organization. The observer must be encouraged to be the messenger; to communicate about variation, even when it seems inconsequential.

Effective communication is a characteristic of organizational culture; what the organization’s leaders say and how they behave may be the most important influence on this culture. This book can help organization leaders create a culture in which the organization’s clinicians and staff and their patients and families effectively communicate—communication that is integral to providing safe, high-quality patient care, a goal shared by all.
Introduction

Communication involves interaction between people, groups, and organizations. It occurs in every area of health care, every day of the year. When communication is effective, it can help improve the quality of care an organization provides. When it is poor, it can lead to inconvenience, frustration, error, and sometimes tragedy. Organizations reporting sentinel events* such as medication errors, patient abduction, and wrong-site surgery have all cited poor communication as a root cause. Because poor communication is linked to many types of errors in health care, it is clear that organizations must collaborate on initiatives to improve leadership and staff communication to help prevent errors and preserve patient safety.

Communication is an art form. And like good artists, good communicators are well trained and highly skilled, and they often practice their craft. The Joint Commission Guide to Improving Staff Communication, Second Edition, discusses the art of communication and provides some suggestions on how organizations can improve their communication efforts. The following areas are covered:

- How to establish a culture based on open communication
- How to foster an environment that promotes a team approach
- How to use structured communication techniques to enhance staff communication
- How to support effective communication with the patient and family
- How to train individuals to be better communicators
- How to implement specific initiatives that can improve communication at the staff and organization level

Overview of the Book

The chapters of this book aim to break down the topic of communication into easy-to-understand components. The following is a brief overview.

Chapter 1, “Setting the Stage for Effective Communication,” discusses the importance of communication and identifies what can happen if communication breaks down in a health care organization. In addition, the chapter discusses the role of leadership in improving organizationwide communication and provides information on how to assess an organization’s current communication and teamwork efforts.

Chapter 2, “The Joint Commission’s Requirements Regarding Communication,” covers the many ways in which The Joint Commission addresses the topic of communication. This chapter offers information on specific standards and National Patient Safety Goals that relate to communication and offers suggestions for compliance.

Chapter 3, “Improving Communication Between Staff Members,” discusses the importance of positive, proactive, and comprehensive communication between health care providers, such as between physicians and nurses, and how to improve these interactions. Creating teams that effectively communicate, fostering a teamwork approach, and improving staff communication skills are covered in this chapter.

Chapter 4, “Staff Communication with Patients,” discusses the importance of effective provider-patient communication. Suggestions on how to improve these interactions are included in this chapter.

* Sentinel event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
Chapter 5, “Planning for Communication Improvement Initiatives,” provides organizations with a step-by-step approach to implementing communication programs. Topics such as creating a multidisciplinary team, setting goals, determining outcome measures, and celebrating success are all addressed in this chapter.

Frequently Used Terms
The Joint Commission defines the word patient as an individual who receives care or services, or one who may be represented by an appropriately authorized person. Within different types of health care organizations, there are different synonyms for patient, including client, resident, and customer. To prevent confusion and ensure consistency, the term patient is used universally in this publication to represent any individual served within a health care organization.

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