Malpractice Risks in
Communication Failures

2015 ANNUAL BENCHMARKING REPORT

CRICO | strategies

Are you concerned that information you convey through the EHR, or directly to other providers, is not received or reviewed?

Do you ever find that test results or reports you expected to have are missing or unavailable?

Have you ever been unclear why you are seeing a patient in consultation?

Have you ever failed to share information or escalate a patient concern for fear of bothering or upsetting someone?

Have you ever had a post-op patient angry with you due to misunderstood expectations?

MARK E. REYNOLDS
President
CRICO

For more than 10 years, we have relied on malpractice data from our Comparative Benchmarking System (CBS) partners to identify patient safety risks in the most vulnerable parts of health care delivery. As our 2015 Report demonstrates, errors in communication are common across all care encounters. All providers are susceptible to miscommunicating with other providers or with patients; they are routinely at risk of mismanaging crucial information and instructions; and in doing so can expose patients to preventable harm, and other caregivers to avoidable ramifications stemming from those harms.

Our CBS Reports represent an extraordinary partnership among those of you who contribute data, share experiences, inspire analyses, and implement solutions to the problems we uncover. This is your Report. As we explore how we can work together to enhance communication skills and systems for providers in all phases of health care delivery, our collaboration is once again proving to be a vital tool for improving patient safety.

When Communication Fails Us

HEATHER RIAH *Assistant Vice President, CRICO Strategies*

We may not typically think of communication as a clinical skill, but health care providers and patients are frequently exposed to the tragic consequences of inadequate communication of critical information. Our 2015 Comparative Benchmarking System (CBS) Report investigates how specific weaknesses in communication impact patient safety. When information falls through the cracks, diagnoses are confounded, procedures are complicated, and subsequent care is compromised.

CRICO has analyzed more than 23,000 medical malpractice claims and suits in which patients suffered some degree of harm; three out of every 10 cases include at least one specific breakdown in communication. Our 2015 CBS Report looks at 7,149 cases in which facts, figures, or findings got lost between the individuals who had that information and those who needed it—across the spectrum of health care services and settings. These cases shine light on the who, what, when, and where of miscommunication. Consequently, they identify specific opportunities to improve skills and systems in order to bridge those knowledge gaps and keep everyone involved in a patient's care promptly and fully informed.

Communication difficulties are not isolated to providers lacking "people skills" or patients with language or comprehension deficits. Nor is the problem exclusive to communication that is misspoken or misunderstood: errors often occur because information is unrecorded, misdirected, never received, never retrieved, or ignored. Every mode and system by which patients and caregivers share health-related information is vulnerable to failure.

Just as the malpractice data indicate that communication errors are everybody's problem, every health care organization has the ability and obligation to reduce those errors. Our 2015 Report highlights both high-profile and grass roots solutions. We encourage you to explore these initiatives, let us know what works in your practice or system, and any other ideas that can help all of us improve our communication skills.

"The single biggest problem in communication is the illusion that it has taken place."

George Bernard Shaw

CRICO Strategies' Comparative Benchmarking System (CBS) contains 350,000 medical malpractice cases representing more than $25 billion in reserves and losses. CBS reflects the medical professional liability experience of more than 400 hospitals and 165,000 physicians from commercial and captive insurers across the U.S.
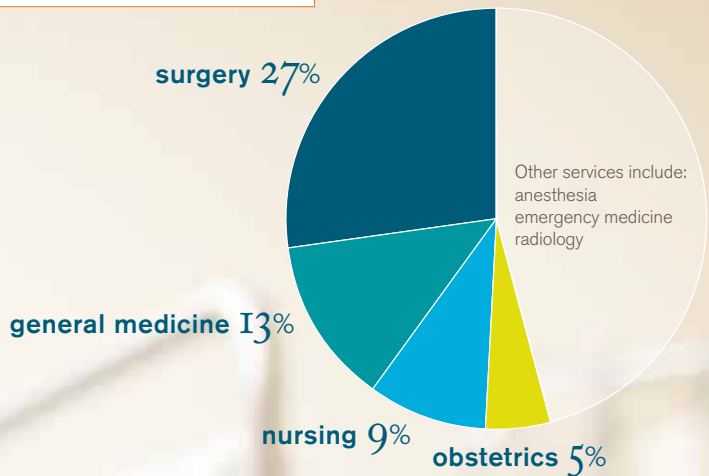
30% Communication was a factor in 30% of 23,658 cases filed from 2009–2013.
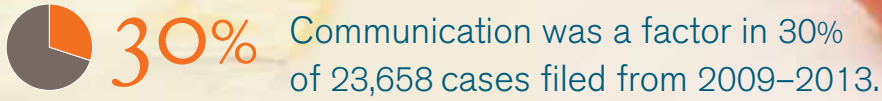
Failures in Communication

7,149 cases

$1.7B total incurred losses*

We identified 7,149 cases in which communication failures contributed to patient harm.
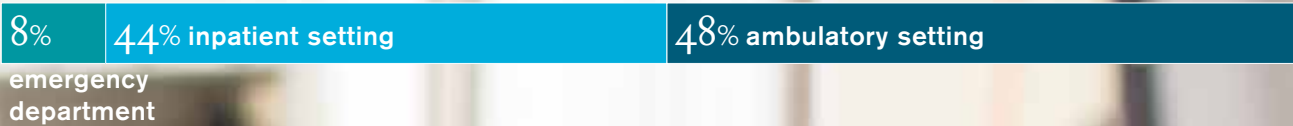
This report explores communication challenges in key **primary responsible services**.

surgery 27%

Other services include: anesthesia emergency medicine radiology

general medicine 13%

nursing 9%

obstetrics 5%

*includes reserves on open cases, and payments on closed cases

N=7,149

WHERE COMMUNICATION FAILS

8% emergency department

44% inpatient setting

48% ambulatory setting

N=7,149

SEVERITY OF PATIENT INJURIES

SEVERITY:

12% low

44% medium
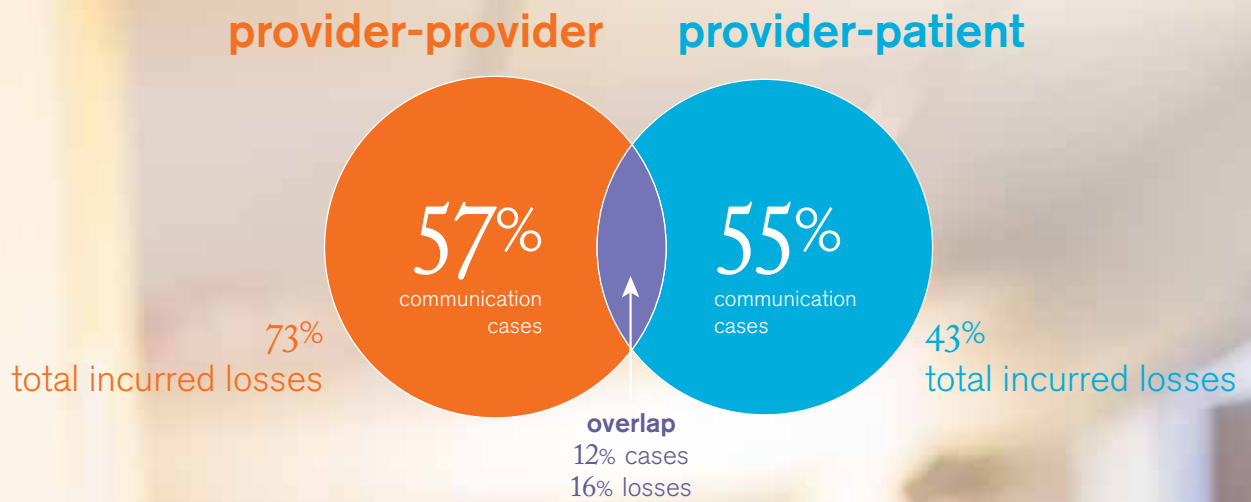
44% high *including* death

N=7,149

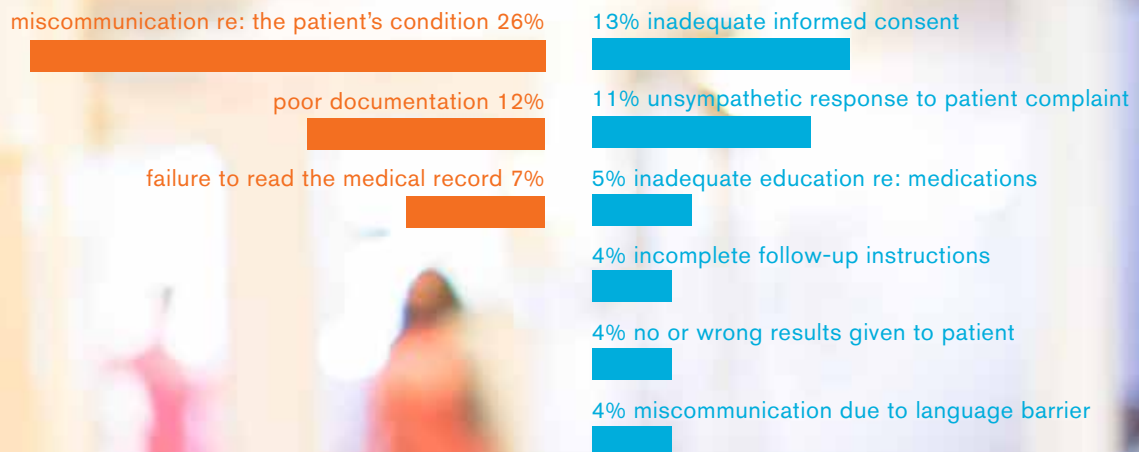**37%** of *all* **high-severity injury cases** involve a communication failure

N=8,445 cases involving a high-severity injury

WHAT GOES WRONG

Communication errors may involve face-to-face conversations, electronic exchanges, or clinical notation and interpretation via the patient's medical record. For this Report, breakdowns in documentation timing, accuracy, and legibility were also included, as were systems failures in sharing information (e.g., test results and referral findings) and instructions among providers, patients, and family members.

provider-provider   provider-patient

57% communication cases

55% communication cases

73% total incurred losses

43% total incurred losses

overlap
12% cases
16% losses

common breakdowns

miscommunication re: the patient's condition 26%

13% inadequate informed consent

poor documentation 12%

11% unsympathetic response to patient complaint

failure to read the medical record 7%

5% inadequate education re: medications

4% incomplete follow-up instructions

4% no or wrong results given to patient

4% miscommunication due to language barrier

N=7,149; a case may have multiple factors identified

COMMUNICATION FAILURES WITHIN SELECTED SERVICES

Vulnerability to communication lapses differs by clinical service.

38% of *all* **general medicine cases** involve a communication failure
N=2,488 cases

34% of *all* **obstetrics cases** involve a communication failure
N=1,102 cases

32% of *all* **nursing cases** involve a communication failure
N=2,019 cases

26% of *all* **surgery cases** involve a communication failure
N=7,536 cases

Information is the currency of safe care, and communication is the vehicle by which that currency moves. Every health care encounter involves communication between a patient and a provider, and in most cases, between multiple providers who are part of the care team.

MISCOMMUNICATION BEGETS MISINFORMATION

A third of medical malpractice cases can be directly linked to communication breakdowns. While such cases represent a minute portion of all health care encounters, they are significant indicators of systemic risk. At the tip of the patient safety iceberg, malpractice cases highlight a less visible, but even larger, set of errors and adverse outcomes that may not trigger litigation, but do contribute to patient harm. And because the communication of important clinical information drives every health care encounter, malpractice cases with a substantial communication issue deserve closer scrutiny.

Whether face-to-face, by phone, or via the medical record, information exchange guides the patient's diagnosis, treatment and, ultimately, his or her prognosis and outcome. Patients and providers rely on information being timely, accurate, and accessible. When communication is unreliable, then providers and patients dependent on being fully-informed are left vulnerable to medical errors that can lead to serious harm.

More than half (57%) of the cases in our analysis reflect miscommunication between two or more health care providers. Slightly less (55%) reflect miscommunication between providers and patients. A noteworthy 12% involve breakdowns in both categories.

Together, these cases illustrate the multiple factors that can impede safe care. Workload pressure, cumbersome EHRs, lack of role clarity, distractions, workplace culture (and hierarchies) all contribute to communication failures: a nurse or physician says or documents only what is critical before moving on to the next task; a colleague reads or listens with less than full attention amidst the chaos of a busy office or an inpatient unit; a physician sees a patient for a scheduled visit without the expected test results necessary to conduct a thorough evaluation.

Our analysis reveals that communication failures vary by service, setting, and the individuals involved. But across all specialties and care delivery settings, miscommunication begets misinformation. If the systems that providers rely on to alert them to information gaps or discrepancies are inadequate, then misinformation can lead to mismanaged care, unmet expectations, and patient harm.

Medical malpractice cases often reveal multiple points in the patient's course when the efficiency and accuracy of clinical information communication broke down, or expose missed opportunities for the health care team (or the patient) to have clarified information and prevent harm. Reoccurring errors with common underlying causes offer guidance for systems improvement, staff training, and culture change.

Culture, technology, and miscommunication delay treatment for fetal demise

Deborah Ling, two-months pregnant, is brought to the ED with back and abdominal pain following a car accident. She is extremely upset after a miscommunication with triage and, because she does not speak English, has to communicate through her husband.

The average 500-bed U.S. hospital loses **$4 million** a year specifically as a result of communication inefficiencies.
Journal of Healthcare Management

Ultrasound notes no fetal heart rate. The Emergency Medicine physician, Dr. Holgram, noting her emotional state, withholds that (FHR) information and advises her to follow up with her obstetrician, Dr. Morley, within three days. Dr. Holgram assumes Dr. Morley's hospital affiliation enables her access to the ED visit records. Although Mrs. Ling brings a note from Dr. Holgram indicating "need for f/u re: 7-wk pregnancy," Dr. Morley is unaware of the accident or Mrs. Ling's ED visit. No ultrasound is performed at this visit, or at a follow-up visit the next week.

An estimated **80%** of serious medical errors involve miscommunication between caregivers during the transfer of patients.
Joint Commission Center for Transforming Health Care

From 2010–2013, the Joint Commission identified inadequate IT support of team communication in **29 sentinel events.**

Two weeks after the accident, Mr. Ling calls Dr. Morley's office to report that his wife is extremely lethargic; he's told this is normal for her stage in pregnancy. Two weeks later, Dr. Morley orders an ultrasound, which notes fetal demise (which Mrs. Ling chooses to address with misoprostol). Later that day, Mrs. Ling presents to the ED with abdominal pain and vaginal bleeding. She subsequently undergoes a D&C, and treatment for endometritis and retained fetal products. Dr. Holgram later notes that he had treated two non-English speaking women from the same car accident, one two months pregnant, and one seven months, and apparently confused the two and, thus, included the wrong patient's information in the note Mrs. Ling brought to Dr. Morley.

Physicians interrupt patients between **8–16 seconds** after they begin speaking.
Family Medicine

73% of patients say they are concerned about the potential for medical errors.
Wolters Kluwer Health Survey 2012

Emergency physicians are interrupted more often **(10–12 times per hour)** than any other medical professional.
Annals of Internal Medicine

38%

of General Medicine cases involve one or more communication error.

GENERAL MEDICINE

- Because a positive pathology result (available in the EHR) is not flagged for PCP review, the patient is not notified and her cancer diagnosis is delayed by a year.

- Provider's failure to respond to calls from a diabetic patient (documented, but not relayed by office staff), is followed by the patient's collapse (and death) from diabetic ketoacidosis.

- A medication dosing error corrected, but not documented, by one physician, is later reintroduced by a second physician.

- Relevant information not forwarded by PCP to consulting MD narrows the consultant's focus and leads to a missed diagnosis.

Nearly four out of 10 malpractice cases naming a primary care provider (PCP) cite some form of miscommunication. Most commonly, the absence of the right information needed at a crucial point in the diagnostic or treatment process leads to patient harm. For example, a PCP seeing a patient in follow up misses an incidental finding, or refers a patient to a cardiologist without noting his cocaine use, or forgets to communicate an important consult finding to a patient.

Hindsight easily finds what was missed in these cases, but in real time, PCPs have to manage a Herculean volume and variety of information. Diverse and (increasingly) complex patients present a broad spectrum of engagement, comprehension, and articulation abilities to a team of caregivers who each hold different pieces of information often critical to the correct diagnosis and treatment. Safe care hinges on the successful gathering, processing, and transfer of that information among multiple clinicians across multiple settings. General Medicine practitioners are expected to be "in the loop" about all the care their patients have received (ED visits, admissions, post-discharge care); are receiving (testing and imaging); and will receive in the future (consultant referrals). In essence, patients, subsequent providers, and jurors in malpractice cases hold the patient's PCP responsible for managing all of the patient's health care information.

That is not easy. For every encounter, PCPs have to refresh their knowledge of the patient's history, status, and problem list. Then they have to determine who else needs that patient's updated

951 GENERAL MEDICINE CASES

provider-provider 60% | 14% overlap | 54% **provider-patient**
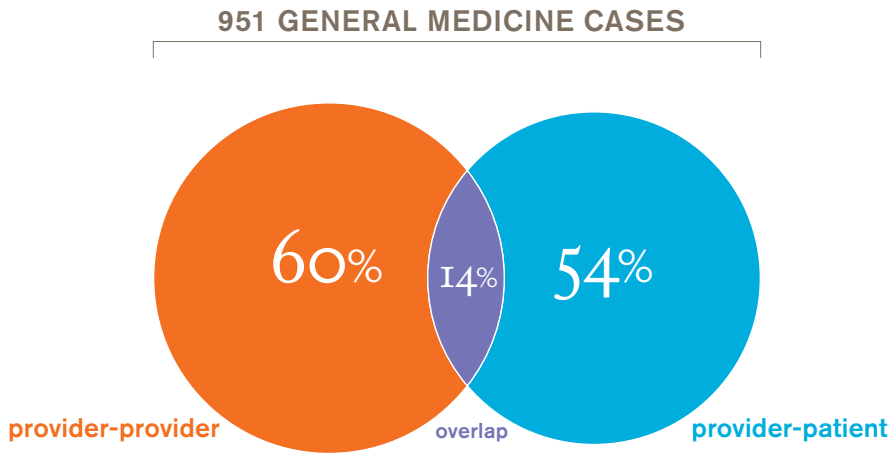
The preponderance of General Medicine communication breakdowns occur in outpatient settings during the diagnostic process.

information from them and ensure they have received back the clinical information (labs, consult note, etc.) to inform the next step in the diagnostic or treatment process. And all too often, the PCP is asked (or expected) to reconcile missing, lost, or misinterpreted information before it's too late.

The mechanics of those processes are subject to the range of care delivery models, organizational cultures, EHR limitations, and communication styles of the individuals and entities that collaborate for patient care. To help General Medicine practitioners keep pace with all of those demands, EHRs, test result and referral management systems, along with broader clinical communication policies, must be developed with an underlying patient safety commitment to having the right information in the right hands at the right time.

Report

Among 951 General Medicine cases...

45% reflect a diagnostic error
(most commonly, missed cancers)

68% occurred in an ambulatory setting

60% resulted in a high-severity injury

37% resulted in death

TOP COMMUNICATION FACTORS

26% miscommunication among providers
re: patient's condition

14% poor documentation
of clinical findings

10% inadequate education
re: risks of medications

General Medicine relies on the accurate exchange of information across extended time and distance.

Poor documentation is miscommunication.

39% of provider-provider communication cases reflect insufficient, inaccurate, delayed, or illegible documentation of clinical findings.

Medication without communication can lead to patient harm.

19% of provider-patient communication cases reflect inadequate education/ instructions regarding medications. Analgesics and anticoagulants were the most common drugs involved.

CASE EXAMPLE

An unspecified referral

A 63-year–old, mildly overweight, male with a history of smoking and hypertension saw his PCP with chest congestion and shortness of breath. A chest X-ray confirmed bilateral pneumonia, but labs raised concern for possible early congestive heart failure. The significance of these findings was not conveyed to the patient, who was treated with antibiotics and referred for further evaluation by a pulmonologist. The PCP's referral request did not contain a detailed indication for the consult, notably absent were details regarding the concerning labs. Neither did the PCP contact the pulmonologist directly with this information, incorrectly assuming he would access key details of the patient's history via the EHR. At his pulmonology consult one week later, the patient's pneumonia symptoms were much improved. The pulmonologist—assuming his role was to assess respiratory function—determined the patient to be well-appearing, in no apparent distress, and requiring no further follow up. Two days later, the patient developed severe chest pain and difficulty breathing, and was rushed to the ED. His condition rapidly deteriorated into pulmonary edema and ventricular dysfunction, requiring admission to the ICU where he ultimately died.

SAFER COMMUNICATION IN THE REFERRAL PROCESS

To address the risks of mismanaged referrals, Atrius Health, a multi-specialty medical group serving the greater Boston area, sought to help hundreds of physicians improve their referrals-related communication. The goal was to ensure that all parties were aware of, and responsive to: appointments not made/kept, findings not sent/received, and patient follow ups not completed. Achieving those goals was considered the foundation for ensuring that referrals essential for timely and accurate diagnoses were successfully completed.

Although an IT solution for referral management was already in place, more than software was needed to address the communication breakdowns that frequently hindered the referrals process. In essence, the software *users* needed some help. From optimizing how the providers ordered the referrals to ensuring timely follow up, everyone responsible for closing the loop had to be shepherded away from workflows that relied on undocumented phone calls, sticky notes, and memory. Once Atrius decided to track a distinct set of referrals—and report to leadership on the rates of successful closure— the next step was to resolve several impediments to broad adoption.

- Ownership of the referral
- Policies to be adjusted
- EHR fields to standardize
- Workflow and staffing implications
- Which referrals to track
- Defining "closed"

Atrius chose metrics that gauge the success of these close-the-loop efforts and enable reporting across a range of perspectives, including referral type, practice groups, and individual providers. Those reports help to fine tune the referral management system and guide adjustments to staffing and resources.

34%
of Obstetrics cases involve one or more communication error.

OBSTETRICS

- A prenatal positive Strep B status is not transferred to the hospital record, thus not conveyed to the L&D team; baby is infected via vaginal delivery.

- Mother's request for tubal ligation following caesarian delivery is not shared with covering OB. Subsequent pregnancy leads to claim.

- OB attending, unfamiliar with patient and team, doesn't receive report on concerning EFM pattern until patient is in active labor and in need of a c-section, which is complicated by an extended uterine incision and ureter damage.

- RN fails to communicate sense of urgency to OB regarding possible decelerations noted on EFM strips, leading to delivery of a severely compromised baby.

One-third of obstetrics-related malpractice cases involve communication errors. While a woman and her obstetrician or midwife may exchange considerable information leading up to labor, the preponderance of communication errors take place once labor has begun, often engaging caregivers new to the patient or unfamiliar with one another. Indeed, miscommunication among obstetrical team members is what most commonly leads to adverse outcomes and allegations of malpractice.

Review of obstetrical cases indicates that communication often breaks down when complexity is introduced to the routine that defines most pregnancies and deliveries. From the first signs of labor until mother and baby(s) have transitioned out of obstetrical care, everyone involved is vulnerable to mistakes if information is not appropriately sought, shared, or acknowledged. And, if the communication of that information is not clear, then providers may not be able to safely attend to the mothers' and babies' most pressing needs.

Before labor and delivery, information about pre-existing conditions, changes in patient status, or the birthing plan can get lost in the urgency to deliver the baby. Before and during labor, mothers need to be informed (and reminded) of the risks they may encounter—especially when plans might suddenly need to be adjusted. Providers who were not involved throughout the patient's pregnancy need to be made aware of any issues (e.g., Strep B positive status, recent development of gestational diabetes, previous drug use) that might prompt a change of course. Potential communication pitfalls during the transition to labor and delivery (e.g., interrupted charting, language barriers) require attention before it's too late.

380 OB CASES

70%   14%   44%

provider-patient

overlap

provider-provider
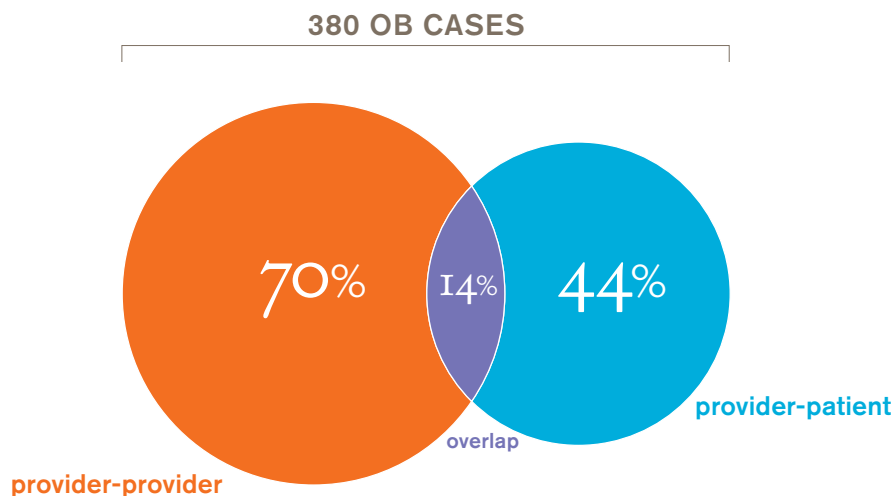
Obstetrics-related communication failures are most common during the second stage of labor as the urgency for a safe delivery builds.

Report

Among **380** Obstetrics cases...

72% occurred in an inpatient setting

56% resulted in a high-severity injury

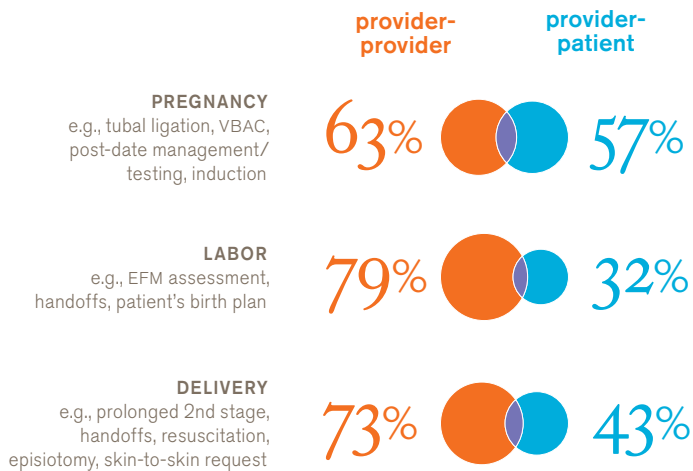**23%** resulted in death (maternal or fetal)

TOP COMMUNICATION FACTORS

37% miscommunication among providers re: patient's condition

16% poor documentation of clinical findings

8% miscommunication due to language barrier

8% inadequate informed consent

As pregnancy transitions to labor, and then delivery, the cast of providers may vary based on clinical needs, labor characteristics, and coverage models. A reliance on notes and informal exchanges that are effective for typical deliveries may become a risk if the situation shifts to atypical. A 36-year-old first-time mother delivering premature twins via cesarean; an obese, asthmatic 28-year-old delivering her third child vaginally; and a drug-abusing teenager have varying needs. Those specifics may need to be communicated to a diverse team of providers, across multiple shifts, and sometimes across different care settings (midwife en route, OB in office, laborist in house).

Good communication—including conflict management and systematic escalation of urgent concerns—keeps obstetrical care providers apprised of rapidly changing events. Well-defined roles (who needs to know what, when), clarity in leadership, and a shared protocol and language for assessment, decision making, and communicating clinical urgency (e.g., interpretation of the EFM) are critical to the consistent exchange among this labyrinth of providers.

The source of communication failures varies across each stage of obstetrical care.

	provider-provider	provider-patient
PREGNANCY e.g., tubal ligation, VBAC, post-date management/ testing, induction	63%	57%
LABOR e.g., EFM assessment, handoffs, patient's birth plan	79%	32%
DELIVERY e.g., prolonged 2nd stage, handoffs, resuscitation, episiotomy, skin-to-skin request	73%	43%

CASE EXAMPLE

Key info lost during shift change

A second-time mother at 36 weeks gestation presented in the early morning to Labor and Delivery and was seen immediately by an obstetrician. She was noted to be 2cm dilated and FHR was noted as "flat" but "without other acute findings present." Her membranes ruptured at 11:00 a.m.; thick meconium was present. As the OB shift was due to change at noon, the outgoing obstetrician sent a text to the incoming obstetrician to call her for a "head's up" on a "potentially troubling strip" (without mention of meconium). Having to return to her clinic, the outgoing OB ordered an epidural and left the hospital, not having spoken directly to the incoming OB for a more detailed handoff. Just before noon, the patient's EFM strips showed decelerations, with the FHR in the 70s. The patient's nurse paged the incoming OB—who had arrived and, unbeknownst to the nurse, was already attending to another urgent delivery. The nurse noted the concerning decelerations but, since they appeared to have resolved when the OB returned her call, did not convey a strong sense of urgency that the OB come to immediately assess her patient. When the OB did arrive 20 minutes later, the patient was 3-4cm dilated, at 0 station, and strips showed recurring late decelerations. The patient was delivered 20 minutes later; Apgars were 1, 4, and 6. The infant was diagnosed with hypoxic ischemic encephalopathy, with need for a g-tube and "low-end" life expectancy.

TURNING LESSONS INTO HABITS

High-risk events (e.g., shoulder dystocia, maternal hemorrhage) are relatively infrequent in a Labor and Delivery Unit averaging less than 1,500 deliveries per year. That means obstetrical care providers rarely get to practice the communication skills that can help to avert an adverse outcome during such events. For example, San Francisco General Hospital (SFGH) noticed that safety drills designed to improve provider-provider communication skills were not gaining traction after the training sessions.

SFGH's broad effort to improve communication in the Obstetrics service included technical and systems changes, as well as skills training for physicians, midwives, and nurses. The former led to clearer terminology for emergencies and potential adverse events, but the providers who honed skills for speaking up, check-ins, closing-the-loop, etc. during simulation-based training need to exercise those communication muscles more frequently. They want those skills to evolve from lessons to habits before the next real-life crisis.

To capitalize on occasional downtime in the Unit, the SFGH staff developed a handful of 10-minute role-playing scenarios that highlight communication techniques needed to manage a crisis. The activity will be run by a nurse, but everyone available participates, playing the roles they serve in real care situations (an observer offers feedback). SFGH's current plan is to run its OB care team (midwives, obstetricians, nurses, anesthesiologists) through 4–6 scenarios during a typical six week Labor and Delivery rotation.

32%
of Nursing cases
involve one or more communication error.

NURSING

- An incomplete effort to confirm that a text message about vital sign changes reaches the patient's MD (who has switched phone numbers) leads to an inpatient's decline.

- A patient at risk for falling, arrives in Radiology without any fall risk indicator (note, bracelet, slippers) and falls during the procedure.

- Nurse fails to communicate notable change in discharge vital signs (temperature and pulse) to ED physician; patient returns several hours later in acute sepsis.

- A diabetic patient's small wound that went unattended due to poor documentation of his skin assessment, eventually worsened and led to amputation.

One-third of malpractice cases involving nursing cite a breakdown in communication. The majority of these cases expose gaps in verbal and documented communication with other providers about the patient's condition. They occur in both extended interactions with colleagues and patients (e.g., inpatient care units), or more transient encounters in surgery, Labor and Delivery, or emergency care. Seventy-five percent of the communication-related malpractice cases naming nurses occur in inpatient settings. Almost half of the 647 cases analyzed involved a high-severity injury; in one-third, the patient died.

At the front line of care, nurses must accurately assess and communicate risks, clinical changes, and concerns on their patients' behalf. Up to date and accurately documented risk assessments (e.g., falls, ulcerations) assure that all providers are aware of and attentive to their patient's clinical status and ongoing needs.

Nurses are seen as the principle conduit for important information. The safety of mothers in labor, observation patients with evolving MIs, patients declining from post-op complications, etc. is dependent on mutual respect for that communication process. Unfortunately, time constraints and distractions often interrupt this. A failure to close the loop, to debrief on a patient, or to read the nurses' notes can mean that critical information is not communicated where it's needed. All too frequently, those gaps trigger—or fail to prevent—patient harm.

647 NURSING CASES

72% 7% 35%

provider-provider overlap provider-patient
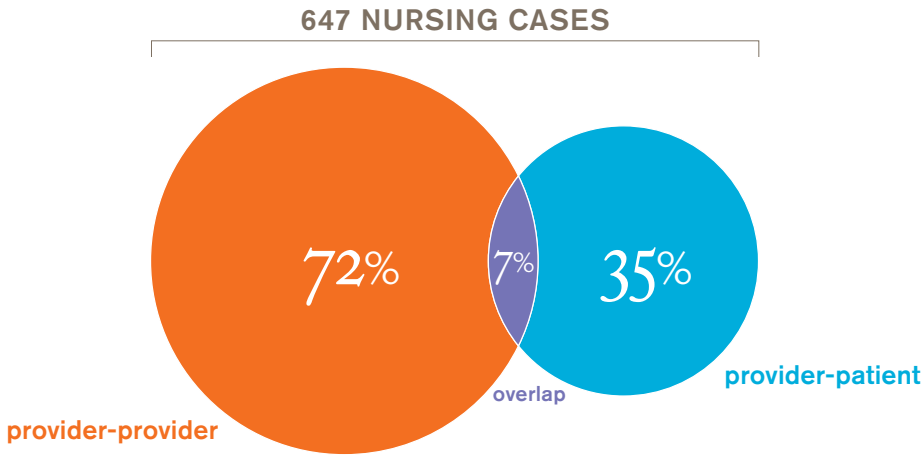
Their pivotal role in the continuity of clinical communication
increases nurses' risk of provider-to-provider communication failures.

Across the rapid succession of interactions with patients and clinical colleagues, nurses have to manage those exchanges carefully so that critical information is not lost amidst peripheral details. But knowing what to communicate is only part of the equation. Many of the tragic events found in the malpractice cases reflect instances when communication *almost* happened: an effort to transfer information was intended, or even initiated, but not completed. If only the nurse had been able to talk directly to the physician instead of a staff member; if only the note in the record had been more prominent; if only the patient's wife hadn't left the room; if only the nurse had not been afraid to "bother" the physician in the middle of the night. Systems, processes, and a culture that encourages nurses to communicate (and, if necessary, escalate) concerns helps ensure that all communication is completed in an accurate and timely manner. Otherwise, the lack of important patient information, or information discovered too late, leaves patients, nurses, and other providers vulnerable to harm and allegations of malpractice.

Report

Among **647** Nursing cases...

24% reflect a patient monitoring error

75% occurred in an inpatient setting

45% resulted in a high-severity injury

33% resulted in death

TOP COMMUNICATION FACTORS

38% miscommunication among providers re: patient's condition

21% poor documentation of clinical findings

8% unsympathetic response to patient complaints

Effective communication by nurses is critical in preventing high-severity injuries.

16%

OF NURSING COMMUNICATION CASES INVOLVED **DECUBITUS ULCERATIONS** (N=105).

Of those, 55% resulted in a high-severity injury, including 42 deaths.

Top communication failures in decubitus ulceration cases

62% poor documentation of clinical findings

33% miscommunication among providers re: patient's condition

11%

OF NURSING COMMUNICATION CASES INVOLVED **FRACTURES** (N=68).

Of those, 25% resulted in a high-severity injury, including 11 deaths.

Top communication failures in fracture cases

28% miscommunication among providers re: patient's condition

16% unsympathetic response to patient complaints

9% inadequate patient/family education

9% miscommunication due to language barrier

CASE EXAMPLE

Unconfirmed orders

A 71-year-old female diabetic with advanced Parkinson's, hypertension, and cardiac issues presented to the ED with altered speech "for a few days," lethargic, and disoriented. Testing showed a left middle cerebral artery stroke probably 4/5 days prior. Neurology admitted the patient at 11:00 p.m., contacted the unit's night nurse, and ordered the patient to be NPO with continuation of IV fluids started in ED. The nurse was also asked to contact a hospitalist to see the patient.

When the neurologist next saw the patient at noon, the following day, she was obtunded and unresponsive, with right hemiparesis. The neurologist determined that the hospitalist had not been contacted, the NPO and IV fluid orders had not been documented nor administered. A brain CT revealed left parietal hypodensity. The patient failed a swallow test and her blood sugar was out of control.

The day nurse informed the neurologist that the patient had been fed small amounts at breakfast. Intubation, and a transfer to ICU on an insulin drip and anticoagulants stabilized the patient's blood sugar within a couple of hours, but a chest X-ray confirmed aspiration pneumonia. The patient never regained consciousness and died 10 days later.

IMPROVING COMMUNICATION AT TRANSITIONS OF CARE

I-PASS is the mnemonic for the communication of essential clinical information and patient plans during shift changes and other care transitions. Inspired by AHRQ's TeamSTEPPs teamwork training system, I-PASS was originally developed for and implemented by residents at Boston Children's Hospital. A 40 percent reduction in medical errors among those using I-PASS led to its subsequent adaptation for nursing handoffs—with similar results.

Illness severity
Patient summary
Action list
Situation awareness and contingency planning
Synthesis by receiver

Those pilot efforts (and data) supported formal development of I-PASS, a multi-center implementation study funded by the federal government. Across nine U.S. hospitals, that study demonstrated a 30 percent reduction in preventable injuries due to medical errors. That degree of impact is rapidly increasing interest in adopting I-PASS in multiple delivery settings for all clinicians involved in the communication of patient information during transitions in care.

A major side benefit of adopting I-PASS is that individuals receive training in communication principles that go beyond the handoff itself (situational awareness; optimization of teamwork; the importance of leadership; huddles; briefs; debriefs; assertion and advocacy, etc.). Implementation also shines a light on broader key teamwork principles that are the foundation of overall patient safety.

26%

of Surgery cases
involve one or more communication error.

SURGERY

- Surgeon fails to communicate abnormal finding in pre-op EKG to anesthesiologist and patient experiences cardiac event in surgery.

- Neurosurgeon's failure to document intra-operative drop in impulse level to covering post-op surgeon results in delayed diagnosis of nerve damage.

- Abdominal pain/hematocrit drop in post-op patient are not communicated by nurse to surgeon before discharge from surgi-center. Patient subsequently dies due to post-op hemorrhage.

- Patient with multiple post-op visits for continued pain following hip surgery files a suit alleging the neurosurgeon "promised to get him right."

Even surgeons with exemplary technical skills are vulnerable to allegations of malpractice if they mismanage the communication of critical information. Analysis of more than 7,500 surgery-related malpractice cases finds that 26 percent involved significant communication errors. In more than half of these cases, the surgical technique was not questioned, but the patient's care was impacted by miscommunication within the surgical team—or more commonly, by inadequate communication with the patient.

While adverse outcomes are likely to trigger patient dissatisfaction, appropriate communication throughout the surgical process better positions both patient and provider to manage expectations and complications, and to navigate the short- and long-term journey of recovery.

Before surgery, engaging patients in frank and thorough consent discussions to ensure their understanding of risks, benefits, alternatives, and expected outcomes is key to thwarting post-op surprises—especially if the eventual outcome is unfavorable.

In the operating room, safety protocols like surgical checklists, briefings, and time outs protect patients from known liabilities (e.g., wrong patient, wrong site). When done earnestly, these processes empower team members to speak up with questions and concerns about any aspect of the procedure that may jeopardize the care of the patient before them. When things do go wrong, it is often because these planned steps are vulnerable to distraction, tedium, and crises. Without vigilant attention and commitment to routine communication patterns or protocols, clinicians and patients are at increased risk.

1,959 SURGERY CASES

48% | 11% | 63%

provider-provider | overlap | **provider-patient**
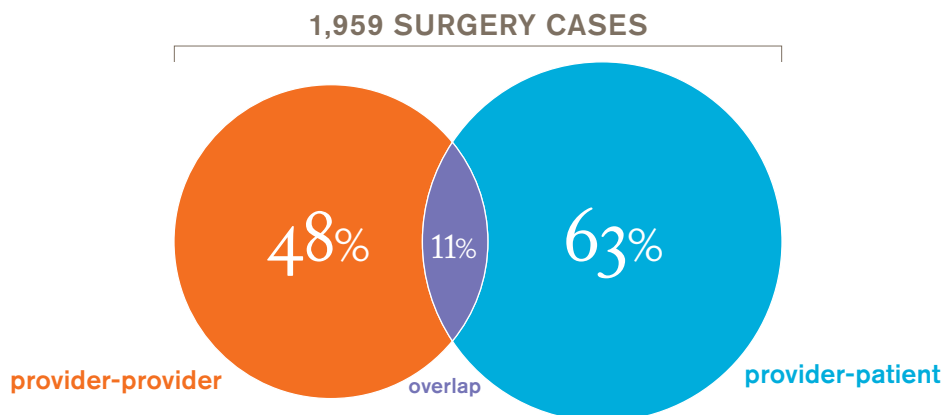
Surgical patients are vulnerable to communication failures from the pre-operative consent process through post-op recovery and discharge.

Report

Among **1,959** Surgery cases...

50% involved outpatients

34% resulted in a high-severity injury

14% resulted in death

TOP COMMUNICATION FACTORS

23% inadequate informed consent

19% miscommunication among providers re: patient's condition

13% unsympathetic response to patient complaints

After surgery, during the immediate post-op phase, effective communication and escalation of clinical changes and concerns to the rest of the care team (some who may have turned to their next case) are critical to safe care. Have vital signs changed? Are there indications of bleeding or infection? As the patient recovers and prepares for discharge, safe transition requires that therapy plans and incidental findings be communicated to the outpatient care team, and instructions for safety at home (call for this, go to the ED for that) be communicated to the patient and family members.

A culture that tolerates impatience, dogmatism, and a reluctance to express a safety concern leaves patients more susceptible to preventable injuries, and exposes all providers on the care team to allegations of malpractice. Surgical teams that master the ability to respectfully convey and receive information with patients before surgery, team members during surgery, and subsequent providers after surgery establish a model for colleagues from all disciplines. Nurturing communication skills demonstrates a commitment to ensuring that the patient and his or her providers know what they need to know when they need to know it.

The source of communication failures varies among surgical specialties.

SURGICAL SPECIALTIES WITH THE HIGHEST PROPORTION OF...

...PROVIDER-PROVIDER COMMUNICATION FAILURES REFLECT SCENARIOS WITH MORE URGENT/CRITICAL EVENTS EVOLVING OVER A SHORTER TIMELINE

64% Cardiac Surgery

61% General Surgery

53% Vascular Surgery
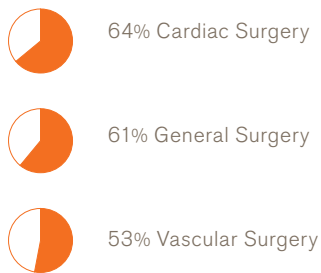
...PROVIDER-PATIENT COMMUNICATION FAILURES REFLECT SERVICES WITH PLANNED SURGERIES AND THE NEED FOR GREATER ATTENTION TO SETTING EXPECTATIONS

74% Plastic Surgery

74% Urology

65% Orthopedics

65% Neurosurgery
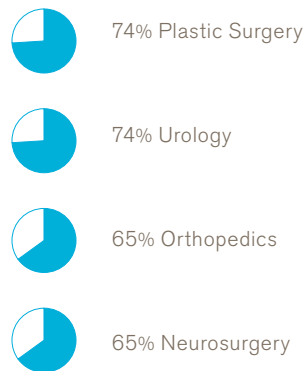
CASE EXAMPLE

Frustration follows an "unexpected" complication

A 67-year-old male underwent an uncomplicated total hip replacement with post-op studies that suggested normal alignment, stable implants, and no signs of fracture. He was discharged the day after surgery.

During post-op appointments over the following months, the patient repeatedly complained of intermittent pain and received reassurance that some discomfort was normal. Diagnostic imaging five months after surgery revealed a partially healed fracture of the acetabulum that had most likely occurred during surgery, and would require revision. The patient did not recall this as a possible complication covered in the consent process, in fact only recalling during the surgical consult the surgeon promising to "get him right."

In deposition documents, the patient noted feeling increasingly upset that his complaints of ongoing pain were not adequately appreciated by the surgeon.

OBSERVING AND ANALYZING COMMUNICATION IN THE OR

Recognizing that gaps in operating room (OR) team communication were often a root cause of adverse events and malpractice suits at their hospitals, a patient safety collaborative, supported by the Hospitals Insurance Company (HIC), decided it needed to go beyond teamwork training. Each participating hospital identified and trained observers to assess the use of teamwork skills during pre-op time outs and post-op debriefs (or sign outs).

According to HIC's Chief Nursing Officer, Patricia Kischak, surgery time outs and sign outs are a reasonable proxy for observing a teamwork event that potentially every member of the OR team participates in at one point or another. Thus, the strengths or weaknesses in communication and other teamwork skills during those times are likely to be representative of the team's overall interactions with each other, and potentially even with patients.

To capture and analyze the timeouts and debriefs, an HIC-supported focus group consisting of OR nurses, anesthesiologists, and surgeons selected nine skills to measure, and then developed a survey tool that can be easily completed during direct observation in the OR or via recorded video. Observers include nurses, surgeons, and even department chairs. Dr. David Feldman, HIC's Chief Medical Officer, points out that seeing your department chair as an observer sends a message to the entire team about the importance of the timeout process, and the overall value placed on teamwork and, especially, communication. The HIC surgical safety collaborative has already begun expanding the use of direct teamwork observation to other high risk areas, including Obstetrics.

Time spent developing the techniques and habits that improve communication during encounters with patients and exchanges with colleagues is considerably less stressful than time spent defending care complicated by communication failures.

LESSONS FROM CLOSED MALPRACTICE CASES

In many instances (e.g., a missed diagnosis), a clinician named in an allegation of medical malpractice might not be aware of the adverse outcome—or the assertion that a breakdown in communication contributed to the patient's harm—until years after the patient encounter(s) that triggered that allegation. Even after care providers are notified that they are defendants in a malpractice claim or suit, it may be many more months—or years—before they are asked via the legal investigation (e.g., interrogatories, depositions) to recall what happened. While the patient's medical record will offer specifics about the technical aspects of the patient's care, it probably will not retain what was communicated orally, non-verbally, or what wasn't communicated at all.

For cases in which inadequate communication brings the standard of care the patient received into question—and into court—recreating undocumented exchanges of information from long ago adds another layer of complexity and doubt. The defense of well-intentioned caregivers is hampered if exactly who said what is not crystal clear in everyone's recollection—especially if that exchange was crucial to the patient's outcome.

A patient who experiences an unfortunate medical result—whether due to negligence or not—needs to know that the clinicians still care. That's when you need to communicate more, not less. And, keep in touch—even if it takes a year of checking in with an injured patient, he or she will appreciate that.

Elizabeth Cushing, Vice President, Claims, CRICO

Timely and accurate documentation helps providers care for their patients, protect their reputations, and minimize their risks. Assessing and enhancing communication skills, as individuals and as teammates, helps everyone involved provide the best and safest care possible. One of the most important of those communication skills is recognizing when critical information has not been conveyed to everyone who needs to know, or has not been confirmed by those to whom it was directed. Ensuring that the act of communication has been successful is everyone's responsibility.

Malpractice cases with a communication breakdown closed with an indemnity payment more frequently than other cases, and those payments are above the overall average.

	# CASES CLOSED	CLOSED WITH PAYMENT	CLOSED WITH A PAYMENT >$1M	AVERAGE INDEMNITY
ALL CASES	25,607	31%	3%	$361K
COMMUNICATION CASES				
GENERAL MEDICINE	1,113	42%	3%	$386K
OBSTETRICS	476	52%	11%	$944K
NURSING	719	44%	2%	$328K
SURGERY	2,152	41%	3%	$372K

Cases triggered by provider-provider communication failures are significantly more likely to result in a payment than cases centered on provider-patient communication issues.

	CLOSED WITH PAYMENT	AVERAGE INDEMNITY
ALL COMMUNICATION	41%	$433K
PROVIDER-PROVIDER	49%	$484K
PROVIDER-PATIENT	35%	$381K

cases closed 2009–2013

Empathy

Analysis of its communication-related malpractice cases led the Minnesota-based medical professional liability insurance provider, MMIC, to address one of the most fundamental components of health care communication: ensuring that important information is not just conveyed, but is received and well understood. That's no simple task, especially when delivering difficult diagnoses, complex treatment plans, or explanations of unexpected outcomes. Balancing the technical and scientific aspects of medicine with the emotional aspects of the health care experience is an enduring challenge for clinicians, even more so in the face of increasing levels of provider burnout.

"Compassion plays a key role in effective communication," says Dr. Laurie Drill-Mellum, Chief Medical Officer for MMIC, who adds that empathy training also serves to combat physician burnout. At the front of MMIC's effort to support providers and improve patient safety, is a partnership with Dr. Helen Riess, Director of the Empathy and Relational Science Program at Massachusetts General Hospital. Dr. Riess' training modules provide clinicians with evidence of the neurobiological and emotional impact that expressions of empathy have on patient and provider experience, and helps those clinicians more accurately interpret their interactions with patients. Whether motivated by the measurable or the emotional aspects of compassionate communication, Dr. Riess's program teaches physicians how to empathetically engage with patients. And as Drill-Mellum says, "Not only are patients more engaged with their providers in the healing process, but in doing so, our doctors 'get the love back'."

Everyone Benefits from an Effective Consent Process

In 2014, surgeons at Montefiore Medical Center (MMC) sought to improve their informed consent processes. While the existing, standard, forms offered surgeons and administrators some liability protection, patients increasingly presented with comorbidities or unique needs that should be clearly documented.

MMC wanted a patient-centric document that fit into their surgeons' workflow. Key additions are sections to guide surgeons on informing patients of the outcome expectations for modifiable comorbidities, such as obesity and smoking, as well as preferences for blood products, sales representatives in the OR, delivery of anesthesia, or photography. Surgeons are now better able to inform patients during the consent conversation about specific indications, risks, complications, and benefits. Concurrently, MMC modified the standard text from dense legalese to patient (and provider) friendly language that removed a known barrier to meaningful consent discussions.

In addition, surgeons and administrators aimed to improve documentation of the surgical consent conversation, during which expectations are set, potential complications are explained, and plans for pre-operative modifications (e.g., weight loss, smoking cessation) are agreed upon and documented. To this end, MMC created a "smart phrase" in the EHR that can be added to any type of note (progress, consult, history and physical) and is searchable in the EHR for pre-op confirmation.

Says Dr. Peter Shamamian, Vice President and Chief Quality Officer and Vice Chairman of Quality Improvement and Performance, who led the effort, "We needed to create an opportunity for a conversation between surgeon and patient to be memorialized in the record and linked with the consent document. That's the best way to protect them, and ourselves."

MyICU

Patients in an Intensive Care Unit have a lot of questions. They (and their families) want to know what's happening now, what will happen later today, and what to expect after that. Individuals under the duress of poor health often have a hard time keeping track of what and who they've asked, especially questions that arise during a bedside vigil or a sleepless night of worry.

Boston's Beth Israel Deaconess Medical Center (BIDMC) recognized that unanswered questions and unnecessary confusion compound family members' stress and worry, so BIDMC set out to reduce the emotional trauma that can arise in the ICU. A pilot program, MyICU, offers patients and their families a better way to stay informed and empowered. MyICU is a mini-patient portal accessible by a dedicated tablet in the patient's room (and remotely). The goal is to bridge information gaps that accrue between face-to-face caregiver-patient interactions. Accessible information about the patient's plan of care may include explanations of upcoming procedures, monitoring devices in use, and a roster (names and roles) of the providers involved in the patient's care. Patients (and family members) can use MyICU to post questions; physicians and nurses can be sure that their answers are being captured.

Deployment of MyICU is in the early stages, so measurement of its value (to patients and providers) is immature. But indications are positive: both family members and providers alike report a greater sense of partnership in their team efforts to nurse their loved one/patient to health and comfort.

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