Quality Qorner

"Lack of Communication"

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I came across an interesting statistic the other day. As it often happens, I was searching for something else in my newly relocated-and-still-not-altogether-organized office when I found this scrap of paper. The problem with my notes on scraps of paper is that there are so many little pieces of paper tucked here and there that choose to hide on me and force me to search for them. I can hear their nasty snickers as I mutter in frustration, "Now, where did I put that?" or, as in this case, I was looking for something completely different when this one revealed its presence.

In 2002, the JCAHO reported that 63% of reported sentinel events were attributed to "lack of communication." I was stunned by that figure! Almost two-thirds of major bad things happening to patients are due to not communicating! How very interesting, indeed. Considering that just about everyone in the mall, grocery store, airline terminal, and hotel lobby is walking around with a cell phone held to their ear—or the head thingy stuck in their ear—or their thumb twitching over a text keypad—I find it hard to believe that people aren't communicating.

Oh—I get it! We're not communicating at work in the health care environment! Is that true? When I walk around my clients' facilities I see health care professionals talking to each other all the time—in the halls, in the cafeteria, in the laboratories, in the other ancillary services, at the nursing stations, in the lounges. Now, I understand that health care professionals are not talking about patients while in public places like elevators and the cafeteria. We have federal laws protecting confidential patient information.

There appears to be a lot of communication going on. So, how is it that so many events that have harmed patients are occurring due to lack of something that is so ubiquitous? I know the answer to this question. It isn't "lack of communication." It's lack of *effective* communication—that is, lack of a documented understanding of who is responsible for a certain action at a certain time to get to the correct end result—an understanding of *process*.

Communication doesn't have to be verbal; in fact, verbal communication in the laboratory can be detrimental. For example, take training new staff by simply telling them how things happen and expecting them to memorize it. Multiply the telling by the number of staff members explaining to the new person how they each do it and you have the formula for "lack of communication." There is no one correct process here; rather, there's likely to be a different process for each person doing the telling.

Adverse outcomes attributed to "lack of communication" have been published at the national level. At one facility, a young girl tragically died due to the wrong blood type of the heart and lung transplant that was supposed to save her life. In another, no one listened to the entreaties of a young laboratory professional that there were quality problems in her laboratory. Elsewhere, there was no way to tell whether surgical instruments were contaminated or sterile, so they were used anyway.

To correct such problems, the JCAHO has had as one of its ongoing national patient safety goals to "improve communication among caregivers." I don't think they mean the idle chatter at breaks and lunch. The JCAHO has talked about improving the "handoffs" of patient information between health care professionals themselves and with other clinical services and departments. Also, one of the CAP's patient safety goals is to improve communication of life-threatening or life-altering results and diagnoses to the appropriate clinical caregivers. Another CAP patient safety goal is to improve the "identification, communication, and correction of laboratory errors."

As a quality management professional, all these stories of "lack of communication" and their proposed solutions scream to me, "We need a process!!" In every one of the 3 stories above and in every one of the patient safety goals, the means to accomplish the objective of improving communication between health care professionals is to establish a common understanding of "who does what and when"—my favorite and easiest-to-remember definition of process. Once a common understanding of the correct sequence of activities is agreed to by the persons who work in that process, the process should be documented. Visual tools such as flowcharts and tables can clearly designate what happens, who's responsible, and in what order activities need to be sequenced to get to the correct end result.

But we can't stop there. Once processes are documented, we need instructions for the activities done in that process.

We should train all the people who work in that process to follow the process with no shortcuts or other personal deviations. We should also regularly measure, monitor, and improve the processes. As I see it, process management is the only thorough solution to the entire problem of lack of communication among health care professionals, with the process document used as the tool for communicating the activity, the sequence, and the responsibility.

Some days, some things are so clear to me—this is one of them. What's not clear, however, is exactly where my notes on the upcoming ASCP Leadership Exchange meeting in Chicago in March are hiding today!

This Month's Quality Quote:

"Medical error is a failure of process."

—IOM, 1999

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