Communicating Better to Prevent Errors and Improve Patient Safety

Teamwork is widely recognised today as essential for high-quality cancer care, but does the communication within and between professional groups affect patient safety? Researchers have focussed on the cost of medical errors and how they can be prevented by communicating better.

Lena Sharp

Just over a decade ago an American book, To Err is Human: Building a Safer Health System, opened a new and interesting debate about medical errors and adverse events. According to the author, more than 50% of the errors can be prevented with effective teamwork and better communication within and between professional groups in health care.

More recently the Swedish National Board of Health and Welfare have estimated the costs of medical errors and adverse events to be as high as 20% of the entire national health care budget.

Several interventions to minimise the risk of errors have been tested with positive results, but the vast majority of the studies undertaken involved multi-professional emergency/trauma teams or operating theatres. Despite many similarities between emergency/trauma care and modern advanced radiotherapy (RT) and oncology (seriously ill patients, multi-professional teams, highly technical tasks, errors that may cause devastating damage, stress etc.) not much has been done to systematically improve patient safety in oncology and RT settings, using these interventions.

Two years ago, in an effort to address this pressing issue, researchers led by Professor Carol Tishelman and clinical cancer nurses at Karolinska University Hospital, Department of Oncology and Karolinska Institute conducted a series of focus group discussions to explore how patients, nurses and other professions view professional communication at the department. They found that problems with communication had the potential to seriously affect patient safety. While the focus group discussions with patient representatives provided useful advice on how to improve patient care, most of the problems raised clearly concerned communication among the staff. More problems than expected were found with hierarchical issues. For
instance, there were examples of RT nurses not following the treatment protocols, to avoid disturbing physicians on lunch breaks. There were also physicians who felt things had been better in ‘the old days’ when the nurses had shorter education and were less qualified, which made them less likely to change jobs or advance in their careers.

Subsequently the research team applied and received funding for a project from the Swedish Cancer Society, as well as the hospital and the Institute, to develop and implement a course in communication and patient safety for all groups of staff – nurses in particular. The project, entitled “Communicate Better”, aims to improve communication within and between different professional groups at Karolinska University Hospital, and consequently develop a safer patient care environment. A train-the-trainer course was held for the project group, incorporating material from the focus group discussions based on transcripts and later developed for use in the course for the oncology staff.

Crew Resource Management (CRM) is a management concept used in aviation to improve teamwork. It has been developed to be used in other complex, high-risk contexts, such as advanced health care and involves a wide range of knowledge, skills and attitudes including communication, situation awareness, problem solving, decision making and team work. CRM was implemented at the two RT units and the project is being extended to the rest of the department comprising four oncology wards, three outpatient clinics and three chemotherapy units. So far, 120 nurses, 10 oncologists, 20 physicists, eight nurse assistants and seven medical engineers have taken part.

What went well? What could have been done better? What needs to be reported to the next shift? The experience of briefing/debriefing sessions has become a crucial feature of every workplace team. Everyone has the same information and the same concept of the job to be done, saving time and improving communications.

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**CLINICAL CONSEQUENCES**

**Nurses’ professional identity and role**

It was clear from these discussions that the attitude of RT nurses to their profession changed as a result of the course. They stood up for themselves and took a more active role in the multi-professional teams. Some of the participants also initiated and developed a new job description for RT nurses with a more active and professional role than before.

**Briefing/debriefing**

In daily briefing/debriefing sessions at the RT units and some of the oncology wards, nurses who work together during a shift met for a few minutes to plan their daily work. Issues related to patient safety are written down to discuss at these sessions. At the end of each shift, the debriefing session takes place to evaluate the work.

**Checklist**

Another result of the project is the implementation of an RT-specific checklist. Before each daily RT session, the team spent less than one minute to examine together the items on the checklist, such as ID, correct target area, set up and positioning, couch settings and imaging in order to reduce the risk of errors. All of these areas have been involved in earlier reported errors. This evaluation is ongoing, but it became clear, after the first two-month follow-up, that the checklist helped avoid medical errors for 40 patients (5%) at two of the RT linac machines.

**SBAR**

The SBAR (situation-background-assessment-recommendation) technique provides a non-hierarchical framework for communication about a patient’s condition. The aim is to prevent miscommunication and promote patient safety. SBAR is used when making treatment decisions in critical patient situations, and everyone needs to be tuned into the plan and telephone consultations between professional groups. During the course, staff were trained in this technique and how to implement SBAR within their teams.

**Scientific evaluation**

At baseline questionnaires were collected anonymously from all groups of staff (Teamwork and Safety Climate Survey from The University of Texas at Austin). This will be repeated later in the year, to compare results. In addition, data from the diaries of nurses in the courses were collected to help better understand their experiences. The qualitative data from the initial focus group discussions have been analysed and will be published later.

Details of the references cited in this article can be accessed at www.cancernurse.eu/communication/eons_newsletter.html