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Commentary

Transforming Communication and Safety Culture in Intrapartum Care: A Multi-Organization Blueprint

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Effective, patient-centered communication facilitates interception and correction of potentially harmful conditions and errors. All team members, including women, their families, physicians, midwives, nurses, and support staff, have a role in identifying the potential for harm during labor and birth. However, the results of collaborative research studies conducted by organizations that represent professionals who care for women during labor and birth indicate that health care providers may frequently witness, but may not always report, problems with safety or clinical performance. Some of these health care providers felt resigned to the continuation of such problems and fearful of retribution if they tried to address them. Speaking up to address safety and quality concerns is a dynamic social process. Every team member must feel empowered to speak up about concerns without fear of put-downs, retribution, or receiving poor-quality care. Patient safety requires mutual accountability: individuals, teams, health care facilities, and professional associations have a shared responsibility for creating and sustaining environments of mutual respect and engaging in highly reliable perinatal care. Defects in human factors, communication, and leadership have been the leading contributors to sentinel events in perinatal care for more than a decade. Organizational commitment and executive leadership are essential to creating an environment that proactively supports safety and quality. The problem is well-known; the time for action is now.
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EDITOR'S NOTE:

This document was developed with the participation of the American College of Nurse-Midwives, the American College of Obstetricians and Gynecologists, the Association of Women's Health, Obstetric and Neonatal Nurses, and the Society for Maternal-Fetal Medicine. The information reflects emerging clinical and scientific advances as of the date issued, is subject to change, and should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Four organizations that represent professionals who care for women during labor and birth (the American College of Nurse-Midwives, the American College of Obstetricians and Gynecologists, the Association of Women's Health, Obstetric and Neonatal Nurses, and the Society for Maternal–Fetal Medicine) and industry behavior expert VitalSmarts recently came together to study safety issues in labor and delivery teams. The results of this collaborative research make clear that perinatal health care providers often have concerns about patient safety and clinical performance but are not always willing or able to speak up and resolve these concerns.[1,2]

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Effective communication among team members and with patients is a hallmark of safe and highly reliable patient care. Reluctance or inability to proactively identify and resolve problems in clinical care creates safety risks and undermines teamwork, resulting in poorer quality of care at best and patient harm at worst. Furthermore, significant interpersonal and intrateam conflicts are likely to interfere with the ability to provide truly patient-centered care.

In the first of 2 collaborative research studies, more than 90% of 3282 physician (906/985), midwife (385/414), and registered nurse (1846/1884) respondents indicated they had witnessed shortcuts, missing competencies, disrespect, or performance problems in the preceding year.[1] A majority of respondents indicated that the observed concerns undermined safety, harmed patients, or led health care providers to consider leaving their positions. Furthermore, few respondents reported fully discussing their concerns with the person(s) involved, thus many concerns likely were left unaddressed. The second study included 1932 respondents. Among these, 34% of physicians, 40% of midwives, and 56% of registered nurses reported experiencing situations within the prior 2 years in which patients were put at risk by other team members' lack of listening or responsiveness.[2] Thirty-seven percent of respondents (30% of physicians, 25% of midwives, and 43% of nurses) in this study also reported they had witnessed unresolved clinical performance problems during the same time period. Qualitative analysis of events described by study participants indicated profound disconnections among clinicians about patient-care needs and between clinicians and administrators about resources and support needed to provide safe care and a sense of resignation on the part of clinicians regarding their ability to change situations and protect patients from harm.

These collaborative research findings are consistent with the results of other studies in which researchers found that

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Box 1. Commonly Identified Root Cause Categories and Subcategories From The Joint Commission

Category	Subcategory
Human Factors	Staffing levels, staffing skill mix, staff orientation, in-service education, competency assessment, staff supervision, resident supervision, medical staff credentialing/privileging, medical staff peer review, other (eg, rushing, fatigue, distraction, complacency, bias).
Communication	Oral, written, electronic, among staff, with/among physicians, with administration, with patient or family.
Assessment	Adequacy, timing, or scope of; assessment; pediatric, psychiatric, alcohol/drug, and/or abuse/neglect assessments; patient observation; clinical laboratory testing; care decisions.
Leadership	Organizational planning, organizational culture, community relations, service availability, priority setting, resource allocation, complaint resolution, leadership collaboration, standardization (eg, clinical practice guidelines), directing department/services, integration of services, inadequate policies and procedures, non-compliance with policies and procedures, performance improvement, medical staff organization, nursing leadership.

Reprinted from The Joint Commission. Sentinel event data: root causes by event type (2004–2013). Available at: http://www.jointcommission.org/assets/1/18/Root_Causes_by_Event_Type_2004-2Q2013.pdf. Retrieved January 20, 2015.

registered nurses, medical residents, attending physicians, and others within and outside perinatal care are known to observe problems with safety more often than they report or address them.[3–6] These results are also consistent with Joint Commission findings that human factors, communication, assessment, and leadership (Box 1) gaps have been the most frequently identified root causes of reported maternal and perinatal sentinel events since 2004.[7] In perinatal care, identifying and acting on safety concerns frequently involves communicating with other team members to affect the course of patient care. Effective, patient-centered communication reduces injury risk by facilitating interception and correction of potentially harmful conditions and errors.[8–10] However, clinicians consistently report discrepant assessments of the quality of collaboration, communication, and teamwork in labor and delivery and other settings.[11–15]

The communication of safety concerns involves more than simply sending and receiving clinical data. Speaking up about safety concerns is a dynamic social process that is highly context-dependent and is influenced by multiple personal, group, and organizational factors, such as those described under human factors, assessment, and leadership.[3,5,6,16,17] Having structured formats for debriefing and handoffs are steps in the right direction, but solving the problem of communication breakdowns is more complicated than standardizing the flow and format of information transfer. Indeed, solving communication breakdowns is a matter of individual, group, organizational, and professional responsibility for creating and sustaining an environment of mutual respect, curiosity, and accountability for behavior and performance. Highly reliable organizations have a generative safety culture in which everyone is proactively responsible for safety, expertise is valued over positional authority, and there is a clear understanding of how people in diverse roles are dependent on each other to achieve safe, high-quality care.[18]

REDUCING MORBIDITY AND MORTALITY IS POSSIBLE

Absolute avoidance of adverse outcomes is unachievable—some morbidity and mortality may not be preventable, and some degree of human error in clinical operations is inevitable. Yet, improving organizational resilience and the capacity to intercept the progression of morbidity and mortality and recover from errors is within reach. Researchers suggest that at least 50% of maternal morbidity and mortality is preventable,[19,20] and several organizations and collaboratives have demonstrated that sustained implementation of multifaceted safety programs can be attained across varied settings and can improve safety attitudes, patient outcomes, or both.[21–26] Several prominent examples of successful programs are provided in Box 2.

The inability of clinical team members to speak up or effectively communicate has been shown to a have devastating effect not only on the people being cared for, but also on the members of the team involved.[27] The experiences affect the emotional and financial well-being of individuals and communities and can reverberate for decades. Improving teamwork and communications is imperative for reducing morbidity and mortality and health care costs in the perinatal unit.

TEAMWORK AND ACCOUNTABILITY

It takes an expert team and shared accountability to provide excellent care to women and their families. Differences of opinion about clinical assessments, goals of care, and the pathway to optimal outcomes are bound to occur with some regularity in the dynamic environment of labor and delivery. Every person has the responsibility to contribute to improving how we relate to and communicate with each other. Collectively we must create environments in which every team member (woman, family member, physician, midwife, nurse, unit clerk, patient care assistant, or scrub tech) is comfortable expressing and discussing concerns about safety or performance, is encouraged to do so, and has the support of the team to articulate the rationale for and urgency of the concern without fear of put-downs, retribution, or receiving poor-quality care.

Box 3 lists some approaches to improving communication at potential points of conflict or clinical disagreement.[17] It is unlikely that a single approach, such as standardizing handoffs or using a communication checklist, will effectively shift the underlying dynamics demonstrated in the collaborative research studies. However, multifaceted approaches have

Box 2. Selected Example Programs

The Department of Veterans Affairs demonstrated a significant decrease in surgical mortality with a program that included team training with ongoing coaching and the use of checklists for operating room briefings and debriefings.[21] In this cohort study, investigators also demonstrated a dose–response relationship between the length of the teamwork training program and the reduction in surgical mortality.

Yale University and Yale-New Haven Hospital implemented a perinatal comprehensive unit-based safety program in 2004 that included training in teamwork and fetal heart monitoring skills, external review of safety practices, standardization of key clinical practice protocols, and creation of a patient safety committee and a patient safety nurse role.[22] They demonstrated a significant reduction in a composite measure of adverse maternal and neonatal outcomes over a 2-year period[22] and substantial improvements in safety and teamwork climate scores 5 years after implementation.[23]

Cornell Hospital's perinatal service hired a perinatal safety nurse who led the efforts to implement a comprehensive safety program that included team training. This program resulted in improved outcomes and reduction in malpractice claims that led to significant cost savings.[24]

The Michigan Health and Hospital Association conducted a statewide collaborative to implement comprehensive unit-based safety programs in 15 Michigan hospitals in 2009 that included assessment of safety culture; team building; establishment of safety infrastructure; individual, team, and peer coaching; and ongoing evaluation of defects, care processes, and patient outcomes.[25] The collaborative demonstrated improvement in safety culture, structure, and process measures and a trend toward improvement in outcomes in just 11 months. The lead investigators also demonstrated reduction in birth trauma, obstetric injury, and liability claims after implementation of a similar program in 16 perinatal units in the Catholic Health Care Partners system.[26]

Additional organizations such as Ascension Health Care, Kaiser Permanente, Intermountain Health, Hospital Corporation of America, and Dignity Health also have been leaders in sustained application of system-wide perinatal safety and quality programs, with demonstrated improvements in outcomes and often reports of cost savings.

been successful in improving safety and quality. Comprehensive safety programs are likely to improve communication and teamwork by providing teamwork training, creating shared expectations for performance, and providing a structure for ongoing feedback on unit performance.[28,29] We expect that such programs, bolstered by enhanced training in communication and conflict resolution, are the most likely to produce sustained improvement in individual and collective behavior. Programs that have demonstrated significant safety improvement provide evidence that, with organizational commitment and ongoing support, improved reliability is achievable.

WHAT CAN WOMEN AND THEIR FAMILIES DO?

Sometimes women and their families hesitate to raise concerns for fear of upsetting their health care providers,[30,31] or they may feel that their concerns are not heard when they are expressed.[32] Health care providers need to know about women's goals for care as well as any concerns that may arise to maintain safety and satisfaction. Women should share their care goals with health care providers and ask questions about anything that does not seem right or is unexpected or confusing. Women have the right to expect their health care providers to be receptive, listen openly, and respond to their concerns. Women and their family members also can consider serving on facility-based or community-based advisory councils for health care facilities to promote the development and implementation of family-centered practices.[33–35]

WHAT CAN INDIVIDUAL CLINICIANS DO?

Many clinicians agree that communication breakdowns and performance problems are serious and frequent and that communication with patients could be improved. However, most clinicians see these issues as problems with other people: the other party doesn't listen, the new people can't speak up, and so on. Few health care providers recognize themselves as contributors to the problem, most people prefer to avoid conflict, but almost everyone can benefit from additional skill development in effective communication and conflict resolution.[17]

Key steps toward improving communication include assuming the best motives of others, recognizing that we all make assumptions that reflect our own world views, seeking first to understand others' views and then to be understood, and avoiding stereotyping. Differences of opinion and judgment occur naturally in complex situations such as labor and birth. Ensuring that patients' interests are the focus of action at all times serves as a powerful resource for proactive problem solving.

Key steps toward actively engaging women in dialogue include explicitly inviting their concerns and questions before delivering information, inviting their input on the plan of care, determining how they like to make decisions, providing adequate information and time for decision making, and soliciting their feedback.[29] Women and their families also may feel more empowered to engage health care providers in potentially sensitive discussions if health care providers include statements about their commitment to safety and openness to women's concerns in their patient information materials.

WHAT CAN TEAM LEADERS DO?

Team leaders—physicians, charge nurses, managers, and others—often expect to accomplish their goals by telling

Box 3. Approaches for Improving Communication

Sources of Potential Miscommunication or Conflict	Approach
Differing expectations for information needs, communication content, and style	Team training
	Structured communication tools (eg, SBAR, structured handoffs)
	Board rounds
	Huddles
	Explicit elicitation of patient concerns and preferences
	Attentive listening
Failure to communicate rationale	Routinely ask for plan and reasoning
Inattention to concern	Persistently restate concerns until resolved
	Consider instituting continuous in-house physician or midwifery coverage if health care provider fatigue is a frequent concern or if service is large with many primary care providers
Concerns remain unresolved	Ensure adequate staffing and break relief
	Ratify plan before concluding conversation
Differing opinions and perspectives on treatment (eg, differing views on use and dosing of oxytocin)	Standardize oxytocin protocol to include shared decision making with patients and clear delineation of interprofessional autonomy and responsibilities
Fetal monitoring methods, interpretation, and management of complex tracings	Standardize fetal monitoring language and application
	Provide regular interprofessional case reviews to discuss management; role model expression of concern and positive resolution of differences
	Standardize expectations for notification of complications
	Articulate and plan for potential problems early in care
	Individuals take responsibility for collaboratively discussing differing views
	Avoid professional stereotyping as an explanation for behavior
	Consider instituting continuous in-house physician or midwifery coverage (especially at night)
Disruptive behavior	Establish and consistently enforce a code of conduct
	Individuals and peers stand up to unprofessional behaviors
	Administrative commitment to addressing and resolving issues such that individuals are held accountable for their actions and repeat offences are not tolerated
	Availability of anonymous incident reporting system
	Implementation of tiered disruptive behavior response program
Lack of shared understanding of how communication affects team performance during an emergency	Develop agreed-on emergency management plans and establish regular drills that include time to practice how to communicate concerns and insights
	Establish regular debriefings immediately following emergencies to learn from successes and identify areas for improvement
	Elicit insights and concerns from all team members
	Record issues identified during drills and debriefings; communicate these issues effectively to encourage replication of what went well and work on fixing what needs improvement

Abbreviation: SBAR, situation, background, assessment, recommendation.
Modified from Lyndon A, Zlatnik MG, Wachter RM. Effective physician-nurse communication: a patient safety essential for labor and delivery. *Am J Obstet Gynecol*. 2011;205:91–6.

others what should be accomplished rather than inquiring what is needed to achieve desired outcomes. Team leaders need to develop outstanding skills for listening and eliciting feedback and cross-monitoring (ie, being aware of each other's actions and performance) from other team members.[36,37] An effective dialogue often can be initiated by asking team members about their goals early in planning and ensuring that the team has a shared understanding of what is to be done and why. Reviewing plans, concerns, and potential contingencies early in care can improve cohesion and potentially improve team performance when emergencies arise.[38,39] Team leaders also can guide and model for the team effective communication methods in their daily interactions. In addition, team leaders can encourage the team to practice more effective communication styles when running drills, holding team briefings and huddles, and holding multidisciplinary, interprofessional mortality and morbidity reviews.

WHAT CAN ADMINISTRATORS DO?

Key responsibilities of administrators include providing safe environments for expression of concern and supporting staff and patients who speak up, regardless of outcomes.[40] Administrators must model for others the principles of effective communication, help team members work out disagreements in a manner that is respectful and open, and provide the resources necessary to support safe care.[41] Administrators can ensure frequent and ongoing assessment of unit safety culture, select interventions to address identified improvement opportunities, and provide team members with feedback about improvement needs and progress toward safety and quality goals.[42,43] One such goal would be to identify communication training as an organizational priority and advocate for funding for this type of training. Administrators should work to provide opportunities for interdisciplinary conferences where nurses, physicians, midwives, anesthesiologists, and pediatric health care providers can interact on a professional level, on a regular basis, on communication and systemic issues (eg, multidisciplinary morbidity and mortality meetings).

WHAT CAN HEALTH CARE ORGANIZATIONS DO?

Organizations that prioritize decisions based on patient-centered care and patient safety generally will have visible executive safety leaders.[28,44] Such organizations include patient advisors on key committees, value input from all team members, foster just culture, and develop forums for communication and tracking issues of concern. They provide resources for training in safety, teamwork, communication, and conflict resolution; systematically track, evaluate, and provide feedback on care processes and outcomes; facilitate resource sharing; and provide resources for data collection and analysis.[41,45] Furthermore, such organizations hold individuals accountable for performance problems and disruptive behavior. Organizations that dedicate personnel specifically for team training, patient-safety programs, and tracking outcomes in real time are much more successful in implementing and sustaining team-focused patient-safety initiatives (see example programs in Box 2).

HOW CAN PROFESSIONAL ASSOCIATIONS HELP?

The professional associations representing health care providers who care for women during labor and birth have worked together to make significant strides over the past few years to advance safety and quality. The 2012 document "Quality Patient Care in Labor and Delivery: A Call to Action,"[46] the collaborative study summarized here, other joint statements, and the multi-stakeholder National Partnership for Maternal Safety[47] are good examples of these important efforts. The National Partnership is promoting nationwide adoption of maternal safety bundles, and the hemorrhage safety bundle includes mechanisms for promoting effective communication and teamwork skills, including drills, emergency management plans, and postevent debriefings.[48] Future opportunities for building on this collaborative approach include developing standards for healthy work environments that are applicable across professions and disciplines and developing and supporting dissemination of evidence-based obstetric communication-skills training that emphasizes small-group, case-based learning for skills practice, feedback, reflection, and discussion.[49] In addition, organizations could develop community advisory councils to more fully engage women and families in developing innovative and effective perinatal safety solutions.[35,50] Finally, safety concepts and best practices must be communicated to the public so that women and their families are empowered to speak up when concerns about care arise.

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CONFLICTS OF INTEREST

Mr. Maxfield is employed by VitalSmarts, LC. Although VitalSmarts products are not mentioned in this article, VitalSmarts, LC does create training products that are designed to address the kinds of problems identified in this commentary. The views expressed in this presentation are those of the authors and do not reflect the official policy of the Department of the Army, the Department of Defense, or the US Government.

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