

Hospital Healthcare Team Communication: Strategies for Risk Reduction

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Communication deficits resulting in patient harm frequently arise from a combination of factors, including misassumptions, deficient listening, inadequate explanations and, sometimes, power struggles. Communication breakdown scenarios that are common in malpractice lawsuits include:

- Failing to communicate worrisome changes in patient status, recognize the significance of information reported, or elicit sufficient information during exchanges with other team members.
- Refusing requests to examine/evaluate patients.
- Not exchanging adequate patient information during hand-off.
- Assuming patient well-being because no one raised concerns.

The following case study illustrates the need for healthcare team members to develop and utilize communication strategies, particularly when conflicts arise. (Although the setting of the case study is labor and delivery, the communication issues highlighted can occur in any healthcare setting.)

Case Study

Issue: *The OB and nurse were unable to resolve their disagreement over the labor and delivery plan, which contributed to fetal brain injuries.*

A 30-year-old patient at 34 weeks gestation presented to the labor and delivery (L&D) department reporting decreased fetal movement.

10:14	The L&D nurse noted the fetal heart monitor (FHM) tracing showed minimal variability. Vibroacoustic stimulation (VAS) produced no response.
10:34	In response to the nurse's report, the OB ordered an ultrasound for amniotic fluid index and a Lactated Ringer's bolus. The nurse suggested a biophysical profile (BPP), but the OB told her they were unreliable. (The OB had a poor relationship with the L&D staff. Because of her past experiences, she doubted the competency of the L&D nurse and the sonographers.) The nurse obtained a BPP anyway.
11:31	The nurse called the OB to report 4/10 BPP results and continuing minimal and absent variability. The OB admonished the nurse for not executing her original order, then ordered an obstetrical ultrasound for size and dates. The L&D nurse reported to the charge nurse her concern for fetal well-being and disagreement with the OB's care plan.
12:00	The L&D nurse called the OB to report the ultrasound results: 2,300 grams estimated fetal weight, 34 weeks gestational age. The OB ordered continued observation. The nurse reminded the OB of the troubling BPP score and FHM tracing. She asked the OB to come to the patient's bedside immediately. The OB told her she would be there shortly.
12:37	The FHM tracing showed late decelerations which continued until the infant was born.

12:44	The L&D nurse called the OB again to express her concerns about fetal well-being and request the OB's presence at bedside. The OB told the nurse she was on her way.
12:53	The OB was at the bedside. She ordered betamethasone to promote pulmonary maturity, continued observation, and consideration of a C-section if the tracings worsened.
13:37	The L&D nurse documented minimal variability, a late deceleration, and contractions at 5-15 minutes apart lasting 60 seconds.
14:55	The OB ordered a C-section (not emergency) due to a nonreassuring FHM tracing.
15:51	The infant was delivered. Apgars were 0/2/5 at one, five, and 10 minutes.

The parents sued all members of the L&D team and the hospital, alleging the delivery delay caused the infant's brain injuries. The child was diagnosed with cerebral palsy and profound intellectual disability. He would require lifelong attendant and/or nursing care.

Discussion

At the outset of litigation, plaintiffs targeted the OB. Defense standard of care experts reviewed the OB's management of the patient and were not supportive due to several issues, including those regarding communication. In response to the L&D nurse's initial report of minimal to absent variability with no response to VAS, experts believed the OB should have presented at the patient's bedside more quickly. Furthermore, the OB's disregard for the 4/10 BPP results reported by the nurse could not be supported. Risk of fetal neurological injury or death associated with delivery delay outweighed the likely respiratory distress the infant would have due to prematurity and underdeveloped lungs. On the other hand the experts believed the L&D nurse's interpretation of the FHM tracing was accurate, and her advocacy for the patient was commendable.

In addition to standard of care issues, defense of the OB was complicated because she and the nurse blamed each other for the poor outcome. If the case went to trial there would likely be finger-pointing. This generally drives up the verdict amount and can cast defendants in a poor light in front of the jury. The patient and her husband witnessed the L&D nurse's heated telephone conversations urging the OB to come into the hospital to examine the patient. This too was expected to reflect poorly on the OB at trial. Sparse records further complicated the OB's defense. Her memories of the labor and delivery were limited, and they differed from the testimony of the L&D nurse, the charge nurse, and plaintiffs. The case against the OB was ultimately settled due to lack of standard of care support and these other issues, which would have made prevailing at trial unlikely. The hospital settled based on its failure to have adequate chain of command policies in place.

Risk Reduction Strategies

Consider the following strategies:^{1,2}

- Thoughtfully consider a team member's challenge to your treatment plan.
- If you believe a team member's failure to follow your orders puts patient well-being at risk, and initial attempts to resolve conflict fail, take steps to address the situation within the organizational framework of the hospital.
- If you are on-call, have not recently examined the patient, and are asked to examine the patient, consider the person requesting your presence bedside has been observing and evaluating the patient and has based the request on relevant information.

- Proactively monitor the patient's progress. Set expectations for ongoing updates, read progress and nursing notes, and ask team members at the hospital to describe the patient's status when you need more information.
- Evaluate the way you interact with other team members. If your attitude could be interpreted as dismissive, angry, or arrogant, it is probably frustrating communication efforts.
- Address conflicts with other members of the healthcare team in an area where the patient and family members cannot hear the conversation.
- Participate in team communication and collaboration training.

Although organizational factors can frustrate communication, in many malpractice claims communication failures can be traced to individuals on the plaintiff's healthcare team. A common theme in these claims is passive attitudes toward obtaining patient information. Passivity manifests as failure to: evaluate patients with adequate frequency, ask questions, provide information, and voice safety concerns, among other things. Why these failures occur is not always apparent, but they can often be attributed to causes such as distraction, fatigue, over-commitment, fear, and over-confidence. Communication is a team endeavor, which often requires team training to achieve proficiency. It requires the individual and collective commitment of every team member and the institution in which the healthcare takes place.

References

1. Agency for Healthcare Research and Quality, *Pocket Guide: TeamSTEPPS 3.0*, Revised May 2023, <https://www.ahrq.gov/sites/default/files/wysiwyg/teamstepps-program/teamstepps-pocket-guide.pdf>.
2. Gary L. Sculli et al, "Effective Followership: A Standardized Algorithm to Resolve Clinical Conflicts and Improve Teamwork," *Journal of Healthcare Risk Management* 35, no. 1 (July 30, 2015):21-30. <https://doi.org/10.1002/jhrm.21174>.

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