Safety and regulation in health care are intertwined — after all, regulations are meant to promote safety. The Texas Board of Nursing (BON), the state agency created to regulate nursing, has a stated mission that is all about safety:

Our mission is to protect and promote the welfare of the people of Texas by ensuring that each person holding a license as a nurse in the State of Texas is competent to practice safely.

The BON protects the public through regulatory functions such as licensing of practitioners and enforcement of regulations. Enforcement includes investigation and resolution of complaints against nurses, such as nursing practice errors that are reported to the BON. Enforcement has historically and predominantly focused on individual nurses who made an error — but errors rarely emanate from a single cause. Instead, errors are multifactoral and occur when the right conditions are present, e.g., when the holes in the Swiss cheese line up, to use James Reason’s popular example.

The location of two look-alike medications in the same pyxis bin is an error waiting to happen (known as a latent error). A busy nurse rushing to get her meds passed on time and process a new admission before she goes to lunch may create the ideal situation for the latent error to become active — the wrong medication is pulled, not recognized as different from what is on the MAR, and is administered to the patient. Such an error is usually attributed to the nurse, e.g., if she would have used the five rights she wouldn’t have made the error. But such a conclusion ignores the external factors involved.

Recognizing the significant role of external factors in the occurrence of practice errors, the Texas Nurses Association in 2003 pressed for the introduction and adoption of Senate Bill 718 which required the BON to conduct a pilot study of alternate approaches for regulating nursing. The bill enabled the BON to suspend mandatory reporting and other requirements during the pilot.

Pilot study
The Hospital Alliance Safety Partnership (HASP) is one such pilot project, developed by leaders from The University of Texas M.D. Anderson Cancer Center, St. Luke’s Episcopal Hospital, and Texas Children’s Hospital, and funded by a grant from the Agency for Healthcare Research and Quality, an agency of the U.S. Department of Health & Human Services. This unique program involves a partnership between the participating hospital and the BON and allows an alternative reporting and review process so that the efficacy of no-
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Texas Nurses Association and the Arthur L. Davis Publishing Agency shall reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.
Texas law specifically defines a nurse’s duty to a patient as conduct required by standards of practice or professional conduct adopted by the Texas Board of Nursing (BON). Nurses tend to be conscientious about their practice, and have concerns about their risk of being reported to the BON for making an error.

In 2007, TNA successfully advocated for significant changes in Nursing Peer Review Law to protect nurses, as well as patients, through the passage of Senate Bill 993. SB 993 was the result of work by a special TNA task force that considered regulation implications of two reports of the Institutes of Medicine (IOM): To Err Is Human (1999) and Keeping Patients Safe: Transforming the Work Environment of Nurses (2003). These reports recommend promoting safer patient care by creating “cultures of safety” (see related article, page 8). An important aspect of a safe environment is one in which nurses can advocate for their patients without fear of retaliation. SB 993 clarified and strengthened the protections for nurses when advocating for patients.

The IOM reports also documented the relationship of errors in health care to organizational system and process issues rather than individual fault. Accordingly, SB 993 was designed to shift the perspective reflected in the regulation of nursing in Texas. Previously, errors were viewed as an individual’s fault, and therefore, when an error occurred, the job of the regulatory system (BON) was to identify, blame and punish the person at fault.

The perspective offered by the IOM is that errors are the result of system inadequacies that either made the error likely to occur or failed to provide the safeguards necessary to prevent the error from occurring. SB 993 shifted the focus of blame from the individual. It did it in two ways:

1. By modifying the mandatory reporting provisions of the Nursing Practice Act to emphasize that who should be reported to the BON are nurses whose continued practice poses a risk of harm to patients (rather than every error a nurse makes); and

2. By requiring nursing peer review committees to strengthen their focus on external factors — system and process issues — that may have contributed to the nurse’s error, and share this evaluation with a patient safety committee (so that the organization may act to prevent other nurses from making similar errors).

Texas Patient Safety Alliance: Saving Lives is Our Business

The Texas Patient Safety Alliance is comprised of several of Texas’ largest health care organizations: the Texas Nurses Association, Texas Medical Association, Texas Hospital Association, Texas Pharmacy Congress, and the Texas Federation of Drug Stores.

These organizations joined forces in 2002, forming a coalition to study and implement strategies to improve patient safety outcomes. The Alliance provides a forum for representatives of participating organizations to share and discuss opportunities and strategies to improve patient safety.

A current project is the standardization of color coding of patient wrist bands (see related article). http://www.tx-psa.org/index.html ★
Texas Nurses Association’s 8th Annual Nursing Leadership Conference

September 11 and 12, 2008
Omni Austin Hotel Southpark
Austin, TX

The Nursing Leadership Conference of TNA is an annual two-day event that promises to enlighten, inspire and engage attendees in discovery and information exchange that can better prepare them to meet their daily challenges of a health care environment in transformation. With a unique bedside view of patient care, nurses are more readily called upon when legislators, policy makers, educators and stakeholders need perspective and insight to address a workforce shortage, reform a health care system, and plan a future for health care where quality patient care remains paramount.

Over two days, attendees will hear a variety of thought-provoking speakers — all experts in their fields.

**Featured speakers**

**Eugene Litvak, PhD**, co-founder and director of the Program for the Management of Variability in Health Care Delivery, Boston University Health Policy Institute; and professor, Boston University School of Management.

Surely, there is no finer complimenter than to have renowned colleagues quote your research concepts. That’s what happens often to Eugene Litvak, PhD, one of TNA’s featured Leadership Conference speakers.

A man who ties patient safety and quality of care improvements in hospitals to better management practices that reduce unnecessary variabilities, Litvak has devoted a significant portion of his career to studying operational issues in health care delivery. Reduce the artificial (potentially controllable) variabilities in the demand and supply of health care services, he contends, and you improve the outcomes. There are ways for hospitals to better staff around the peaks and valleys of patient flow; better manage variability in patient flow and resource allocation on the front lines of care, he promotes, in order to improve patient outcomes, staff morale and quality, and decrease costs.

“Variability is the enemy to efficient, quality health care delivery,” attests Dr. Litvak.

**Marilyn Rudolph, MBA, BSN, RN, vice president, performance improvement, VHA Pennsylvania, Inc.**

In her current role, Rudolph supports VHA Pennsylvania member organizations in their efforts to improve clinical and operational performance, in a wide variety of health care initiatives. Rudolph’s health care background includes nursing leadership, performance improvement, and a clinical focus in ambulatory, emergency, critical care and perioperative nursing.

A popular speaker nationally, state-wide and locally, Rudolph has also co-authored a number of articles on clinical and operational improvement and improvement methodologies. She has also received faculty appointments at Carnegie Mellon University, Waynesburg University, and The Institute for Healthcare Improvement.

**Brenda Cleary, PhD, RN, FAAN**, executive director of the newly created Center to Champion Nursing in America, a joint initiative of AARP, AARP Foundation, and the Robert Wood Johnson Foundation.

The Center to Champion Nursing in America, made possible through a $10 million from the Robert Wood Johnson Foundation, will work to improve patient care for all Americans by pursuing an aggressive agenda to elevate the visibility of the nursing shortage while identifying actionable solutions to improve the quality of patient care. Dr. Cleary was named to lead the effort.

With a robust career in nursing accomplishments — most recently as executive director of the North Carolina Center for Nursing, a state funded agency committed to assuring nursing resources for meeting the health care needs of North Carolina citizens — Dr. Cleary will enlighten Leadership Conference attendees about how new types of partnerships, especially business ones, can advance nursing

(Continued on page 5)
As both patient and self advocate, nurses need to stay informed about the laws and regulations in the State of Texas that govern nursing practice and the rights of the practicing nurse. This annual update of regulations, legislation and policies that come to bear on nursing practice is delivered by a panel of experts on the topics.

**State of the profession**

Clair Jordan, MSN, RN, executive director, Texas Nurses Association.

In Texas, as well as in the rest of the nation, nursing is in transformation. From the unique perspective of TNA, Jordan will share with conference attendees the state of the profession in Texas.

**Texas focus on nursing**

Update Your Knowledge – New Texas Regulations, Legislation and Policies: always popular and according to many annual Nursing Leadership Conference attendees, a must have in the agenda.

James H. Willmann, JD, director of government affairs for the Texas Nurses Association; Elizabeth Sjoberg, JD, RN, associate general counsel, Texas Hospital Association; and Kathy Thomas, MN, RN, executive director, Texas Board of Nursing.

**Special conference event**

Recognitions of accomplishment are always fruitful and inspiring. At this year’s Nursing Leadership Conference, Texas Nurses Association will recognize the recipients of some of nursing’s highest acclaim — hospitals who achieved Magnet® recognition, redesignated Magnet® hospitals, and recipients of the new Pathway to Excellence™ designation — at a special Celebrating With Your Colleagues luncheon.

**Registration details**

Registration fees:
- TNA members — $350 per registrant
- Non-members — $450 per registrant

**Group discounts** — groups of five or more registrants from the same facility are eligible for a 10% discount off registration fees. To receive the group discount, all of the group’s registrations must be received together at TNA using the printed registration form (one form per registrant); one payment per group (either check or credit card information) must accompany the registrations.

**Registration deadline:** September 1, 2008 (registration availability is limited; register early).

**Hotel accommodations**

- **Host hotel:** Omni Austin Hotel Southpark
  4140 Governor’s Row
  Austin, TX 78744
  Toll-free reservations: 1-800.THE-OMNI
  In Austin phone: 512.448-2222
- **Room rates:**
  - $125 per night for single/double room.
  - $145 per night for triple occupancy
  - $165 per night for quadruple occupancy
- **Reservation deadline:** August 20, 2008
- **Online Omni Hotel reservations:** [www.texasnurses.org](http://www.texasnurses.org) or [www.omnihotels.com](http://www.omnihotels.com)

**Supporters/sponsors**

Selected program events of the 8th Annual Nursing Leadership Conference are provided through the commercial support and generosity of Decision Critical, Bank of America, and Marsh Affinity Group Services — a service of Seabury & Smith.

Texas Nurses Association/Foundation is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission of Accreditation.
fault reporting mechanisms in identifying system errors can be tested.

Nurses in the partner hospitals may self-report errors to the HASP program (i.e., errors not meeting exclusion criteria such as those contributing to death or serious injury, demonstrating intentional disregard for safety, involving criminal activity, etc.). In the pilot program, the nurse is interviewed by HASP staff and a comprehensive assessment is conducted to identify external factors which may have contributed to the error. The data is then analyzed and classified further into system and human factors to more thoroughly evaluate and understand how the error occurred and what system, as well as individual, remedies are appropriate. An event review committee made up of experts from each participating hospital considers the report and determines an action plan. All levels and components of factors involved in the event will become part of the corrective action plan.

This pilot was expanded to five additional hospitals in 2007, and is planned to extend to 2009. Progress is reported regularly at BON quarterly meetings, and findings consistently reveal the significance of external factors in human errors: nurses do not make errors in a vacuum, rather, errors tend to result from the convergence of multiple factors and multiple causes. HASP’s in-depth analysis affords new learning about external and system factors that contribute to human error. These lessons offer the opportunity for new approaches to future regulation of nursing.

References

http://texashasp.org/


TNA’s 8th Annual Nursing Leadership Conference

(Continued from page 5)

REGISTRATION FORM NURSING LEADERSHIP CONFERENCE

FILL IN THIS FORM. Print and fax it to the Texas Nurses Association at 512-323-5379. Registration and payment may also be made electronically at texasnurses.org: Members Only, or send form by mail to Texas Nurses Association, 7600 Burnet Road, Suite 440, Austin, TX 78757-1292, ATTN: Nursing Leadership Conference.

Seating is limited. Prompt registration is advised and encouraged. Onsite registration is subject to space availability. Registration is NOT COMPLETE until payment is received by TNA. Registrations include both breakfast and lunch each day.

FILL IN THE INFORMATION BELOW—PRINT MORE FORMS FOR ADDITIONAL REGISTRANTS

- Member of TNA or TxA
- Non-Member of TNA or TxA
- I am employed by a Magnet™ designated hospital.
- I am employed by a Nurse-Friendly™/Pathway to Excellence™ designated hospital.

Last name* ________________________ First name* ________________________ Middle initial

Credentials ________________________

Home address* ________________________

City* ________________________ State* ________ Zip code* __________

Employer ________________________

Work phone * ________ Home phone____________ Fax

E-mail* ________________________ DOB* (MM/DD) ____________ [used for identification purposes only]

*required information

- I am interested in receiving information about TNA membership

- Send me information about future programs/offering via e-mail

CONFERENCE PRICING

- Full Conference Both Days
- Member of TNA $350.00
- Non-Member $450.00

There is NO student discount for the TNA Leadership Conference. GROUP DISCOUNT: Groups of 5 or more registrants from the same facility are eligible for a 10% discount. To receive the discount all of the group’s registrations must be received together using the printed registration form (one form for each registrant) and be paid with one payment — either check or credit card.

EITHER a check is enclosed made payable to Texas Nurses Association in the amount of: $__________

OR charge this amount: $__________ to my credit card. □ VISA □ MasterCard □ American Express □ Discover

Print Name on Card:

Card No. ________________________ Exp. Date: ____ / ____

Credit card billing address if different from participant’s mailing address:

Address ________________________ City ________________________ State ________________________ Zip ________________________

Signature ________________________ Date

REGISTRATION CONFIRMATION WILL BE SENT.

Additional information: cne@texasnurses.org or by phone to 512-452-0645 x125.

CANCELLATION POLICY

Cancellations will be honored if a written request is received at Texas Nurses Association at least one week prior to the activity. A $25 processing fee will be deducted from all refunds. Send written request to cne@texasnurses.org or fax to 512-323-5379.

The Texas Nurses Association/Foundation Provider Unit is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
Anatomy of an Error

Anatomy is “science dealing with structure... analysis, minute examination,” (www.dictionary.com). While all nurses completed a human anatomy course at some point in their training, most of us have not considered the structure — or anatomy — of human errors until we have been faced with one in our practice. At that point, we then ask “How could this have happened to me? I am always so careful!”

The obvious answer is: because you are human and humans will make mistakes. Less obvious, perhaps, is why one can perfectly perform a task, such as administer medications to patients, for long periods of time and then, out of the blue it seems, make a significant error harming a patient. Scientists have actually developed complex techniques known as human reliability analysis or probabilistic risk assessments, to calculate the likelihood of error in any human operation. Errors are expected and, for too long in health care, errors were accepted. Reports from the Institute of Medicine, beginning with To Err is Human in 1999, demanded action to eliminate preventable errors in health care, forever changing the way health care dealt with patient safety and errors.

An understanding of how and why errors occur provides an important framework for preventing errors. Duke University Medical Center has several online modules on patient safety and quality improvement that provide an excellent background on patient safety and errors in health care. These modules can be accessed FREE at http://patientsafetyed.duhs.duke.edu/index.html.

Root Cause Analysis Triage Questions to Identify Human Factors Related to Communication

From NCPS Triage Cards™
Developed by the VA Center for Patient Safety
Version Oct. 2001-A
http://www.patientsafety.gov
http://vaww.ncps.med.va.gov

When analyzing the root causes of an occurrence, these human factors questions help assess issues related to communication, flow of information, and availability of information. These questions also reveal the importance of communication when using equipment, and during application of policy and procedure, the unintended barriers to communication, and the organization’s culture with regard to sharing information.

If communication, misinterpretation, or a lack of information was a factor in an error or significant event, consider the following questions to assist you in identifying the root causes.

1. Was the patient correctly identified?
2. Was information from various patient assessments shared and used by members of the treatment team on a timely basis?
3. Did existing documentation provide a clear picture of the work-up, the treatment plan, and the patient’s response to treatment (e.g., assessments, consultations, orders, progress notes, medication administration record, x-ray, labs, etc.)?
4. Was communication between management/supervisors and front line staff adequate (e.g., accurate, complete, using standard vocabulary and no jargon, and unambiguous)?
5. Was communication between front-line team members adequate?
6. Were policies and procedures communicated adequately?
7. Was the correct technical information adequately communicated 24-hours-a-day to the people who needed it?
8. Were there methods for monitoring the adequacy of staff communication (e.g., read-back, confirmation messages, debriefs, etc.)?
9. Was the communication of potential risk factors free from obstacles?
10. Was there a manufacturer’s recall/alert/bulletin on file equipment, medication, or transfusion related elements at the time of the event or close call? Were relevant staff members aware of the recall/alert/bulletin?
11. If relevant, were the patient and their family/significant others actively included in the assessment and treatment planning?
12. Did management establish adequate methods to provide information to employees, who needed it, in a manner that was easy to access/use and timely?
13. Did the overall culture of the facility encourage or welcome observations, suggestions, or “early warnings” from staff about risky situations and risk reduction? (Also, has this happened before and was anything done to prevent it from happening again?)
14. Did adequate communication across organizational boundaries occur? ★
The 1999 IOM report *To Err is Human* marked a new era of accountability for health care providers around patient safety. Since that landmark publication, the focus on patient safety and outcomes of care has intensified. Pay for performance financial models have further motivated providers to take intentional action to improve safety for hospitalized patients. As attention becomes directed toward the environment of care and tenets of a culture of safety, the critical role of nurses as a prime regulator for the patient in the hospital environment and often the final safety net for patients becomes paramount. Ensuing IOM reports maintained a focus on the need to address the environment of care, cultures of safety and individual characteristics of the nurse to accomplish improvements in patient safety.

**Background and Significance**

The 1999 IOM report *To Err is Human: Building a Safer Health System* rocked the nation by exposing the prevalence of medical errors in health care and their unfortunate results. Subsequent reports looked deeper into the issue of safety in health care: *Crossing the Quality Chasm: A New Health System for Improving Quality and Safety* (2001) and *Keeping Patients Safe: Transforming the Environment for Nurses* (2004). These reports demand nothing less than an overhaul of internal hospital operations. Business as usual will not ensure patient safety.

The recommendations (IOM, 2004) challenge leaders at all levels of the organization to create work environments and cultures of safety through leadership structures and processes (Recommendation 1). Leaders must establish safety as a priority as reflected in allocated resources (Recommendation 4-2). Safety must be assimilated into every aspect and activity of the organization. Education and involvement of all staff is a necessary but insufficient component to establishment of a safe environment — safety must become woven in the cultural fabric of the organization.

A safe culture demands a change from established practices which target human error — the individual who makes a mistake (Recommendations 7-1 & 7-2). Blaming the individual limits reporting of errors and near misses. Moving from a culture of blame to a “just culture” pays greater attention to how the error occurred than who made the mistake (Marx, 2001). The focus shifts from the individual to the organizational systems, processes and environments which may have contributed to errors. It is the environment and the resulting accountability of both the individual and the organization in promoting patient safety.

A safe environment also involves an assessment of work embedded in systems and processes. The IOM (2004) reports recommendations “designing out” errors that is, revising processes and systems to reduce the possibility of error (Recommendation 6-2). The involvement of frontline staff closest to the process being redesigned is critical to success of such endeavors (Recommendation 4-1 & 4-3). Programs such as “Transforming Care at the Bedside” which utilize direct care staff in fast tracked problem solving activities have been effective in achieving significant safety improvements (Rutherford et al, 2004; Marin et al. 2007). Strategies to reduce errors include use of technology to eliminate some human factors of errors, work space design to support safe work processes, and reduction of process variation.

Numerous studies consistently support the direct relationship between nurse staffing and patient outcomes in acute care and the important association between staffing and quality (Kane et al, 2007). Workforce issues therefore play a critical role in patient safety. Staffing practices must plan for adequate nurses to accommodate work flow, patient turnover and unpredicted changes in patient volume and acuity (Recommendation 5-2). Internal oversight and evaluation of staffing practices must occur (Recommendation 5-3). Additionally, IOM recommends (5-4) publication of staffing and turnover data. To ensure that staff have the necessary knowledge and skills to perform their role effectively in an ever changing environment, IOM recommends (5-5) that facilities budget for initial and ongoing education and training. Further, facilities should introduce process improvement efforts, such as “Transforming Care at the Bedside,” to assist staff in redesigning their work.

Staff nurses are not only critical to but determinative of patient safety and outcomes. Nurses must appreciate their role and share in the organization’s accountability for identifying processes that may contribute to errors, reporting near misses, and participating in workplace improvement efforts. Nurses are accountable for responsible practice including monitoring their own hours of work.

The Texas Nurses Association (TNA) actively leads and supports workplace improvement efforts. TNA supported legislation requiring the development of organizational staffing plans in the state’s interfacility transport regulations (Liberi, Konzier, 2007). The FedEx model (Kane, 2007) recommends that facilities budget for initial and ongoing education and training. Further, facilities should act to support collaborative practice within the institution (Recommendation 5-6).

Because of the direct relationship between errors and fatigue, Recommendation 6-1 challenges regulatory bodies to limit hours of work for nurses to 12 hours in any 24 hour period and 60 hours in a 7 day period. Additional recommendations address reducing fatigue related to work design and identify hand washing and medication administration as the first processes to receive attention (Recommendations 6-2, 6-3). Finally, the IOM recommends (8-1) ongoing research to support patient safety for every patient every time.

**Conclusions**

Hospitals are predisposed to errors due to their human nature and complexity; yet, hospitals have not kept up with other high risk industries in managing this risk. With the new millennium came a loud wake up call to health care organizations — definite, immediate and significant change must occur. The 2004 IOM report provides specific recommendations to assist hospitals in creating environments and cultures of safety. These recommendations impact the role of nursing in several ways.

Nurse leaders are called to create and sustain work environments of trust and open communication. Cultures known for relentless pursuit of root causes rather than individual fault will support open reporting and sharing information and processes. Nurses and leadership are responsible for involving staff in the development of a staffing plan which considers numbers of nurses and patients as well as individual characteristics of nurses and patients and contextual factors such as patient turnover, unit geography; this is consistent with the Nurse Practice Act of Texas. Nurse leaders can introduce process improvement efforts, such as “Transforming Care at the Bedside,” to assist staff in redesigning their work.

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Staff nurses are not only critical to but determinant of patient safety and outcomes. Nurses must appreciate their role and share in the organization’s accountability for identifying processes that may contribute to errors, reporting near misses, and participating in workplace improvement efforts. Nurses are accountable for responsible practice including monitoring their own hours of work.
“I’m busy trying to keep people alive and you want me to attend a meeting?”

I DON’T HAVE THE TIME.

WHILE YOU TAKE CARE OF PATIENTS, WE TAKE CARE OF YOU. TNA has been working hard for Texas nurses for more than 100 years, helping to pass legislation on personal protection rights, workplace safety and safe patient handling, negotiating rules affecting mandatory overtime and floating, and assisting in securing $35 million for nursing schools to address the shortage. And you don’t have to attend meetings to be a part of TNA. Convenient tools such as email alerts, online forums and surveys make it easy to stay informed and give feedback. TNA membership is not only easy it’s essential.
Communicating Safely: Color-Coded Patient Wrist Bands

In many industries, color is used to simplify communication. A red light means stop; green, go. A red faucet is hot; blue is cold. Yellow means caution. And white or gray electrical wires are neutral. But what happens when the meaning of the color is not shared?

To alert staff of specific patient needs or risks, many hospitals have implemented color-coded wristbands to quickly communicate allergies, fall risk, resuscitation status, etc. This well-intended, color-coded safety strategy has instead become a safety risk because the use of colors is not standardized across the industry. That is, one hospital may use the color yellow to indicate DNR (do not resuscitate) and another may use yellow to indicate restricted limb (no blood draws or BP).

The consequences of misunderstanding the intent of a color can be severe. That’s exactly what happened in a Pennsylvania hospital in 2005. A nurse worked in two different hospitals. In one hospital, a yellow wristband meant “restricted limb.” In the second facility, yellow meant DNR. The nurse placed a yellow wristband on a patient in the second facility and the patient later coded. Fortunately, the nurse’s error was discovered and the patient was successfully resuscitated.

Following the near miss, the Pennsylvania Patient Safety Reporting System issued an advisory including survey data which indicated that 76% of Pennsylvania hospitals used color coded wristbands, color is significant to communication of information (98%), and there is little consistency in the meaning of the colors. Recommendations included limiting the colors used, and standardizing their meanings among health care facilities. In response to this advisory, health care organizations in several states have worked together to standardize the meaning of wristband colors. Texas is soon to join this group.

The Texas Patient Safety Alliance (see page 3) is supporting an effort spearheaded by the Texas Hospital Association (THA), Texas Organization of Nurse Executives (TONE), and TMF Health Quality Institute (TMFHQI) to standardize wristband colors of hospital patients in Texas. The Texas Center for Workforce Studies 2006 Texas Hospital Nurse Staffing Survey reported an average of 10.2 vacant hospital nursing positions, turnover rate of 18.2%, and use of temporary staffing agencies to meet staffing needs in 90% of hospitals. This means many nurses will work at more than one facility.

A survey implemented in January 2008 by the Alliance confirmed the potential for a harmful error in Texas: nine different colors are currently used to indicate DNR; seven different colors for fall risk. The Patient Safety Alliance group recommends Texas adopt wristband colors already used in 18 states for the following conditions:

- Purple — Do not resuscitate
- Yellow — Fall Risk
- Red — Allergy

Tool kits will be offered by the Alliance to health care organizations to facilitate the change process. While the transition to standardized colors may require significant effort for some organizations, the patient safety benefits are well documented.
Risky Business: Communication in Health Care

Earn FREE CNE Credit!
Requirements for Successful Completion
1. Read the article.
2. Take the test on page 22, and complete the Registration/Evaluation Form. To receive CNE Certificate of Successful Completion, mail the completed form WITH A SELF-ADDRESSED STAMPED ENVELOPE to Texas Nurses Association, 7600 Burnet Road, Suite 440, Austin, TX 78757
OR
3. To take the test ONLINE, go to http://tnacne.texasnurses.org and follow the prompts to submit your test answers, complete registration/evaluation form, and print your CNE certificate for 1.0 Contact Hours.
4. In order to receive the 1.0 Contact Hours, you must pass the test with 80% or greater.
5. DEADLINE for submitting is January 1, 2009.

Accreditation
The Texas Nurses Association/Foundation Provider Unit is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Disclosure to participants
• Successful completion: Once successful completion is verified, a "Certificate of Successful Completion" will be awarded for 1.0 Contact Hour.

• Conflict of interest: A conflict of interest occurs when an individual has an opportunity to affect or impact educational content with which he or she may have a commercial interest or financial relationship. All planning committee members and presenters are required to disclose any potential or actual conflicts of interest with any commercial entity that may have an interest in the activity's educational content. The planners and presenter of this CNE activity disclose that they are employed by the Texas Nurses Association.
  • Commercial support: This activity does not receive any commercial support.
  • Non-endorsement of products: TNA/F's ANCC accreditation status refers to the continuing education activity only and does not imply either TNA/F's or ANCC's real or implied endorsement of any product, service, or company referred to in this educational activity.
  • Off-label product use: This educational activity does not include any information about off-label use of a product.

Questions???
E-mail cne@texasnurses.org or phone 512-452-0645.

Educational goal/purpose
The purpose of this educational activity is to highlight the important role of communication in patient safety and provide nurses with tools to enhance the effectiveness of their communication and safety practices within their work environment.

Objectives
Upon completion of this educational activity, the nurse should be able to:
1. Relate the importance of effective communication in exchanging information and supporting team performance.
2. Identify safety risks and actual/potential errors associated with inadequate or ineffective communication.
3. Recognize physical, cognitive and organizational factors that affect human performance in a clinical setting and contribute to human vulnerability for error.
4. Describe three tools for organizing and standardizing information exchange to reduce potential error.
5. Define team behaviors that contribute to effective team functioning and patient safety.

Introduction
Humans are fallible; we will make mistakes. Even when we know how to do something perfectly, we will make mistakes a certain percentage of the time (Simpson & Knox, 2003). Often these errors occur as a result of interpersonal communications problems. One needs only to reflect on the childhood game of “telephone” to appreciate the spoken word’s vulnerability to distortion: one person begins passing a spoken message that is (Continued on page 12)
repeated to a series of individuals. The game’s amusement occurs when the last person hearing the message restates it out loud and it bares little resemblance to the original message.

Many nurses who practiced prior to computerized, physician order entry and standard abbreviations, can relate stories about trying to decipher physician handwriting by turning charts upside down and using other tricks of the trade. And, what nurse has not paused to rethink, “Was that Celebrex® or Celexa® or Cerebyx®?”

Nurses communicate with many individuals on many fronts within an environment which demands quick thinking and action. Yet, nurses must weigh what, when, where and who to question when communication is not clear — the person originating the message (order, chart entry) may not be readily available, power gradients between a novice nurse and medical director may inhibit clarifying questions, and a noisy environment, information overload, and numerous interruptions may interfere with the process of accurately relaying information.

Effective communication within the health care environment is a critical factor in patient safety. Communication has continually been identified as a National Patient Safety Goal of The Joint Commission since the goals were first implemented in 2003. In a review of over 3000 sentinel events from 1995 to 2004, The Joint Commission, a health care organization and program accreditation agency, found that more than 65% of sentinel events were caused by communication problems (Joint Commission, 2006). In 2005, the rate had grown to 70%. This comes as no surprise to nurses who provide and receive communication in diverse health care settings, with multiple individuals, through a myriad of channels, and with varying levels of urgency and importance. Nurses have firsthand knowledge of the difficulties and challenges in accomplishing effective communication in complex and dynamic environments (see Table I), and often witness the unfortunate outcomes when things go wrong.

This CNE activity establishes the significance of effective communication for patient safety and offers tools for nurses to use to improve communication and patient safety within their environment.

Human factors and patient safety

Historically, most health care organizations have viewed mistakes and errors as individual failures — a person makes a mistake because they were incompetent, careless or lazy. We now know that, except for rare, intentionally reckless conduct, mistakes occur because of human nature. Admonishing clinicians to be more careful or try harder or just follow the policy and procedure will not eradicate errors from health care. Such efforts target the wrong problem. Once we accept that competent

Table I: Barriers to Communication

- Inconsistency in team membership
- Lack of time
- Lack of information sharing
- Hierarchy
- Defensiveness
- Conventional thinking
- Complacency
- Varying communication styles
- Conflict
- Lack of coordination and follow-up
- Distractions
- Fatigue
- Workload
- Misinterpretation of cues
- Lack of role clarity

(Continued on page 13)
clinicians will err, the focus can shift to the challenge of designing errors out of the work context — a process known as human factors engineering.

Human factors engineering studies human capabilities and limitations, and then devises systems and processes to counteract these limitations (Boston-Fleischhauer, 2008; Helmreich, 2000). Factors affecting human performance inherent in any situation may include:

- Physical factors: noise, climate, lighting, distractions, interruptions
- Cognitive factors: memory, fatigue, stress, information processing
- Organizational factors: job and task design (multi-tasking requirements, workload, similarity/diversity of functions), time requirements, relationships

In a health care setting, such factors are pervasive and affect multiple processes including communication. Picture the following scenarios and consider how physical, cognitive, and/or organizational factors may impact the effectiveness of communicating important patient information:

- The nurses station of a busy med-surg unit: phones are ringing, patient call lights are beeping, several individuals are having conversations, walls are covered with signs or information boards or equipment.
- An ICU patient room: multiple IVs are infusing via different pumps, multiple monitors display data and beep or alarm, the TV may be on, lights may be dimmed, family may be present, the intensivist is dictating outside the room.
- A new grad nurse four hours into his third 12-hour shift without a break, with a full bladder, hungry, awaiting a call re: estimate from a car mechanic, just paged a physician known to be “difficult” to report a change in patient status.

Fortunately, through human factors engineering, tools have been developed to “hardwire” processes and systems, and lessen the opportunity for human error. These mitigating tools require individuals to adopt an attitude that: acknowledges human fallibility and vulnerability for error; embraces a collaborative, team approach toward patient care; intends patient safety and quality outcomes; and seeks opportunities for improvement, not merely solutions to problems. The proposed mitigators are used most effectively when adopted by an entire organization and made part of its cultural fabric. Organizations can best assist individual nurses in their implementation by providing education and ongoing support and backing. However, nurses may find tools useful even if not fully espoused by their organization.

Communication and patient safety

Care for any one patient involves groups of individuals, e.g., nurse, physician, pharmacist, dietician, physical therapist, medical transcriptionist, clerical assistants, etc. For care to be coordinated, information must be exchanged between and among these individuals. Effective communication should be complete, clear, brief and timely. Communication serves to relay information critical for patient care and to build team process (AHRQ, 2006); both functions are vital for safe and effective patient care.
Closed Loop Communication. Errors in the exchange of information related to patient care can be reduced with standardized approaches that define essential information and ensure closed loop communication. Closed loop communication validates that the intended information was received and understood correctly. “Read-back” or “check-back” processes are examples of closed loop communication (See Table II: Closed Loop Communication). The Joint Commission Patient Safety Goal #2 requires accredited organizations to utilize a “read-back” process for verbal and telephone orders and critical test results (i.e., diagnostic tests such as laboratory tests, imaging studies, and electrocardiograms) (JCAHO, 2004). The read-back process involves writing down what was heard (the verbal/telephone order or critical lab value) and then reading it back to the person who gave the order or result. This process ensures that not only was the information heard correctly, but it was also recorded correctly so it can be communicated to others.

Case study:

A physician ordered a routine EKG on an elderly gentleman who was scheduled to be discharged from a med-surg unit the following day. The technician completed the EKG at 1820 — just prior to shift change. Because the EKG tech could not find the primary nurse, she handed the report to the charge nurse at the nurses station, stated that the computer-generated reading indicated the patient was having acute cardiac ischemia, and left the area. As usual during shift change, the nurses station area was hectic. The charge nurse did not hear the EKG tech clearly. She placed the report on her clip board thinking that it needed to be filed on the chart. The patient later coded and died.

What was the “fatal error” in this situation? Had the hospital had a “check-back,” closed loop communication process in place for test results such as EKGs, the error may have been caught and corrected. Whether it would have changed the patient outcome is unknown, but it would have removed the error from the list of possible contributors. Consider the physical, cognitive and organizational factors which may have impacted communication in the case study.

Table II

<table>
<thead>
<tr>
<th>Process to ensure confirmed information is understood.</th>
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<tbody>
<tr>
<td>1. Sender initiates the message</td>
</tr>
<tr>
<td>2. Receiver accepts the message and provides feedback</td>
</tr>
<tr>
<td>3. Sender double-checks to ensure that the message was received</td>
</tr>
</tbody>
</table>

EXAMPLE:

Doctor: Give Laxis 40 mg IV now [message]
Nurse: 40 mg Laxis IV push? now. [request for clarification]
Doctor: Yes, 40 mg Laxis IV push now [understanding verified]

Handoff Communication. There are several popular tools, as well as homegrown versions, that attempt to reduce errors by standardizing communication. According to The Joint Commission (2006), a standardized approach should be used consistently throughout an organization and identify:

- To which situation it applies
- Who needs to be involved in the exchange
- What information is to be included (e.g., current patient condition, changes in condition/treatment, what to watch for in the next interval of care)
- Opportunities to ask and respond to questions
- When to use supplementary techniques (e.g., “read-back” or “check-back”)
- What print or electronic information should be available

Circumstances in which patients are “handed off” represent one situation in which standardized communication should be used to reduce reliance on human memory and ensure all pertinent information is relayed. Handoffs occur when a patient is passed from one care giver to another. Handoffs occur at change of shift, between nurses and transport staff, between primary care and specialty care providers, and between

(Continued on page 16)
units, departments, and levels of care. Of all communication errors, at least 50% occur during handoff situations according to The Joint Commission. Tools to facilitate effective handoff communication often include forms and checklists. At least one study (Arora, Johnson, Lovinger, Humphrey, & Meltzer, 2005) recommends that handoff communication include tools such as standardized templates and read-backs, as well as information regarding the rationale for decisions and anticipated problems. The acronym “I PASS the BATON” (AHRQ, 2006) (see Table III) offers one strategy to enhance information exchange during transitions in care. The goal of information exchange is to relay an understanding of essential information to ensure appropriate continuity of care.

**Case Study:**
Mr. Preston is seen in the ED for severe flank pain and suspected kidney stone. He is given Dilaudid® IVP for severe pain and a radiology study (KUB) is ordered. Mr. Preston is opiate naïve and within 15 minutes of receiving the Dilaudid, becomes very lethargic with reduced respirations and a slowed pulse. Narcan® is administered, to which he responds. The radiology transporter arrives to take Mr. Preston to radiology. The nurse tells the transporter: “Mr. Preston is to have a KUB to rule out a kidney stone. He had something for pain recently, but needed some Narcan. Let me know when you bring him back.” Mr. Preston is taken to radiology on a gurney and left in the hallway and told that the tech will be with him in a few minutes.

### Table III: “I Pass The Baton”

<table>
<thead>
<tr>
<th></th>
<th>Introduction</th>
<th>P Patient</th>
<th>A Assessment</th>
<th>S Situation</th>
<th>S Safety Concerns</th>
<th>The</th>
<th>B Background</th>
<th>A Actions</th>
<th>T Timing</th>
<th>O Ownership</th>
<th>N Next</th>
</tr>
</thead>
</table>
| I | Introduce self and role: Hi, I'm Sue, Charge RN in the ED. | Name, identifiers, location: Sam Johnson is a 39 year old white male who arrived by ambulance. | Chief complaint, VS, symptoms, dx: He fell from a ladder and suffers a skull and left clavicular fracture. VS stable; BP 154-92, P 84, R 22, T 99.8, Pain 6-2/10. | Current status/circumstances, code status, level of certainty, recent changes, response to treatment: Lost consciousness for an hour after a fall, now A&O x3. Pain managed with MS per PCA, full code. | Critical lab values/reports, socioeconomic factors, allergies/alerts (fall, isolation, etc.). Neuro checks have been OK. CT ruled out subdural, lab values within normal limits, allergic to penicillin. Wife is out-of-town, but he called and spoke with her. Concerned about dog at home. | Co-morbidities, previous episodes, current medications, family hx. He has a history of hypertension managed with Aldactazide 50mg daily. Also takes Lipitor 10mg daily; no other meds. History of smoking for 15 years, quit 2 years ago. No other health problems. | What actions taken/required and rationale. He needs continued neuro checks q 4 hours. Left arm is immobilized with sling. Outpatient PT to be ordered. Have social work assist him in contacting neighbor to care for dog until discharge. | Level of urgency and explicit timing and prioritization of actions. Next neuro check due at 2045. | Who is responsible (person/team and patient/family)? Dr. King is the admitting physician. | What will happen next? Anticipated changes? What is the plan? Are there contingency plans? Dr. King will see him before 2200. The plan is to watch him over night and no neuro changes, discharge by 1200. | (Continued on page 18)
Risky Business
(Continued from page 16)

When the tech approaches Mr. Preston several minutes later, he notes diminished respirations and is unable to arouse him. The radiology tech calls a code.

How many handoffs occurred in this case study? What was missing in the handoff communication? It is questionable whether the radiology transporter would have understood the implications of Narcan administration. Even if he did, this information was not acted upon or passed on within the radiology department so that the patient could be appropriately monitored. I PASS the BATON specifically directs communication of safety information about the patient so care givers are prepared to respond.

Situation Briefing. SBAR is a popular communication technique for communicating a patient’s condition to a physician. Because SBAR’s structure is consistent with a physician’s cognitive style of information processing, it assists nurses in presenting information in a way physicians are able to hear and respond. SBAR stands for:

- **S**ituation: What is happening with the patient?
- **B**ackground: What is the clinical background or context?
- **A**ssessment: What do you think the problem is?
- **R**ecommendation: What would you do to correct the problem?

SBAR provides a standardized way to organize and communicate information concisely and clearly. It also prompts the nurse to put the situation in context and provide complete information — important for a physician to make an accurate evaluation and provide appropriate direction as demonstrated in the case study below.

**Case study:**

Mrs. Summers is a 78-year-old widow on her third post-op day following a left total hip replacement. She has complained of pain in her left leg and foot all morning despite pain medication and repositioning. Mary RN assessed her left leg as cool and pale, diminished pulses, full ROM of knee and ankle, negative Homan’s, dry and intact hip dressing. Mrs. Summers becomes increasingly frustrated with her unrelieved pain and requests to see her podiatrist. Mary calls the physician stating, “Mrs. Summers is having pain in her left leg and wants to see Dr. Jansen, her podiatrist.” The physician orders additional pain medication and a consult for Dr. Jansen.

Later, when the charge nurse rounds and hears Mrs. Summers complaining of pain, she enters the room and assesses Mrs. Summers. She notices her left leg is cold, pale, no pedal pulses, no nail bed blanching. She pages the physician stat and reports:

- **S:** Mrs. Summers has a cold, pale left leg with no pedal pulses.
- **B:** She is three days post-op total hip and has experienced unrelieved pain in her left leg and foot since (930).
- **A:** I believe she may have an arterial occlusion
- **R:** and think we need an immediate Doppler study.

The physician concurs and orders a Doppler study and vascular surgery consult stat. The patient had an arterial occlusion requiring an above the knee amputation. She sued Mary, the hospital, and the physician. The hospital settled out of court and the suit against the physician was dropped as he was not provided adequate information to make a clinical decision until the charge nurse became involved at which time he responded appropriately.

Additional information and tools for implementing SBAR are available at no cost from: http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunication/SituationalBriefingModel.htm

These three techniques for information exchange — read-back, I PASS the BATON, and SBAR — provide a predictable format for communication applicable in any clinical setting or situation. They facilitate mutual understanding and promote effective communication.

**Team Communication**

In addition to the exchange of information, communication serves as a supporting structure for team work (AHRQ, 2006). Effective team work enhances patient safety, reduces medical errors, and depends upon effective communication. Team training supports the development of competencies — such as team-related knowledge, skills and attitudes — necessary for effective team performance (Baker, Gustafson, Beaubien, Salas, Barach, 2005). Knowledge includes an understanding of
human performance factors and propensity for errors. Skills include specific communication techniques, as well as situation awareness. And attitudes include a sense of team accountability, or shared responsibility, for achieving goals (patient safety, outcomes): “we’re all in this together.”

Shared mental models. As the team understands that everyone is at risk by virtue of being human, the team can be open to assisting each other in avoiding mistakes. This requires a shared mental model, or a common understanding of the situation. Everyone is singing from the same page of the hymnal. Situation awareness and monitoring facilitate this common understanding. Specific components (AHRQ, 2006) include:

- **Situation monitoring:** an individual skill involving the process of actively scanning to assess elements of the situation or environment.
- **Cross or peer monitoring:** “process of monitoring the actions of other team members for the purpose of sharing the workload and reducing or avoiding errors;” “watching each other’s backs”
- **Situation awareness:** “the state of knowing the current conditions affecting the team’s work” — STEP.

✔ **Status of patient:** history, vital signs, plan of care, psychosocial issues
✔ **Status of Team:** fatigue, workload, task performance, skill, stress
✔ **Status of Environment:** facility and administrative information, human resources, triage acuity, equipment
✔ **Status of Progress toward goal:** established goals of team, tasks/actions of team, plan still appropriate?

A familiar example of situation monitoring is the role of the circulating nurse in the OR — she maintains environmental scanning so she can respond to support the team with appropriate resources to provide for patient safety. She may note and intervene if a team member inadvertently and unknowingly contaminates the sterile field. An experienced nurse related the following story:

“I was circulating in a case and the patient had lost a lot of blood. The surgeon was getting into trouble. I asked him if I could call in his colleague to assist, and he said, no, that he could handle it. I looked at the anesthesiologist and could tell he was concerned as well. I asked a second time to call in help and the surgeon again refused. I decided, for the safety of the patient, I needed to call in help. It was a good thing. In the moment it took to get another surgeon in the room, the patient took a turn for the worse. She did OK in the end, but may not have if I had not acted on my assessment.”

Situational awareness is an ongoing process for the entire team to ensure everyone knows what is happening in the moment, what should happen next, and what to do if it doesn’t (Simpson & Knox, 2003). All members of the team must be empowered to communicate when they have a safety concern and to act if necessary.

The circulating nurse above acted appropriately to ensure patient safety. She twice stated her concern to the surgeon and then acted, based on her assessment and concern for patient safety. Her behavior is an example of the “two challenge rule” in which a team member’s critical safety concern is stated two times to verify that it was heard. The team member being challenged must acknowledge and respond. If the response is still not acceptable, the concerned team member has the authority to “stop the line” for resolution of the safety issue (see Table IV).

**Feedback.** In a review of errors and near misses in perinatal care, Simpson & Knox (2003) found that in most cases, communication was involved: “concern was expressed, but
not directly; the problem was stated, often not clearly; a proposed action didn’t happen; a decision was not reached or acted upon” (p.234). When potential or actual errors/risks are not called out, the consequences can be dire, as so aptly captured in the phrase “silence kills.”

The Association of Critical Care Nurses partnered with VitalSmarts® to conduct a study of the relationship of communication and medical errors (Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005). The study identified seven Crucial Conversations® that too often do not occur, thereby contributing to errors in health care. While essential for safe patient care, these conversations were identified as particularly challenging to master. Why? Because they involved confronting another person about their behavior, and talking to someone about their behavior is experienced as uncomfortable and difficult.

Crucial Conversations involve addressing the following observed behaviors when they are observed:
1. Broken rules: shortcuts that could be dangerous to patients.
2. Mistakes: failure to follow directions or demonstration of poor clinical judgment.
3. Lack of support: reluctance of coworkers to help.
4. Incompetence: questionable competence of provider.
5. Poor teamwork: gossip or clique behavior that divides the team.
6. Disrespect: condescending, insulting, rude or bullying behavior.
7. Micromanagement: abuse of authority by those who pull rank, bully, or threaten.

The vast majority of nurses and other clinical care providers participating in the survey had witnessed or worked with someone who demonstrated these behaviors, however, few had addressed the conduct. The top three reasons for not addressing problem behavior were: lack of ability, belief that it is “not my job,” and lack of confidence about the effectiveness of the confrontation — “it won’t do any good.” Additional reasons include time and opportunity for the conversation and fear of retaliation. Yet, up to half of survey participants indicated that they do talk about the problems with others — not to solve the problem, but to work around the person, warn others, or vent. Most did not find going to their manager to be a useful option as managers were only slightly more likely to confront the person with the problematic behavior. Often, individuals and teams require training to acquire skills and overcome the reluctance to address problem behaviors. Find more information about Crucial Conversations at: www.silencekills.com.

Most communication experts advocate an assertive model of communication to address concerning behaviors. Assertiveness involves direct, respectful communication in which a person owns their feelings and states their concern or want in an attempt to achieve a win-win resolution. The standard format of an assertive statement includes:

✔ An objective Description of the behavior: When you don’t offer to help others during your downtime...

✔ The Effects: I see others struggle to accomplish their assignments and I feel resentful.

✔ Suggest preferred behavior: I want to see you offer to help the rest of the team before you take your break...

✔ Consequences related to team goals: so the entire team can be more effective.
Risk Business (Continued from page 20)

(See Table V for another example of the DESC script.)

Rules for Giving/Receiving Feedback are outlined in Table VI. Highly functioning teams welcome the observation and feedback of a team member. The support of a team member to “watch your back” and facilitate error free performance is central to teamwork.

Crew Resource Management. Crew Resource Management (CRM) is a team training strategy developed and used in aviation, and now applied to clinical environments. Analyses of aviation accidents revealed that over 90% were due to human error; frequently, these errors occurred because the crew failed to utilize the resources available to them (e.g., verifying information, planning contingencies) (Pizzi, Goldfarb, & Nash, 2001). CRM stresses the role of human performance factors in the occurrence of errors and promotes the responsibility of the entire team for outcomes. Concepts of shared mental models, personal and situational awareness, peer monitoring, the two challenge rule, and feedback are incorporated within this team model.

Team Training. There are many models for enhancing team communication and effectiveness. Central to all these models is team training. Several healthcare facilities have implemented team training to enhance patient safety — some have contracted with established programs, others have implemented concepts and tools within their organization without a formal program. Some examples include:

• Through a grant from Kimberly-Clark Health Care, the Association of Perioperative Registered Nurses (AORN) Foundation developed and implemented a program in five diverse, surgical settings across the country (Marshall & Manus, 2007). AORN worked with Safer Healthcare LLC to implement a CRM training and skill development at these various sites.

• Kaiser Permanente utilized its own resources to develop and implement human factors training targeting teamwork and communication (Leonard, Graham, Bonacum, 2008). Surgical briefings, critical event training and simulation, and standardized communication processes are examples of strategies implemented to improve team functioning and patient safety.

• Moore and Putman (2008) describe the cultural shift experienced in a hospital which implemented SBAR, DESC, I PASS the BATON, STEP.

Conclusion
Nurses make errors, not because we are incompetent and careless, but because we are humans working in complex and dynamic environments. Human factors engineering has demonstrated that we can help ourselves by modifying systems and processes and by using mitigating tools to prevent ourselves from making errors. Some of these efforts require the support of the organization within which we work (e.g., team training); others are available to all of us to begin implementing now: read-back, SBAR, DESC, I PASS the BATON, STEP.

The first and perhaps biggest step is to acknowledge our own vulnerability for error, and the super-nurse mistake. As patient advocates, we must take responsibility for minimizing our own risk by monitoring our own behavior and utilizing available tools.

Table V

<table>
<thead>
<tr>
<th>Rules for Giving/Receiving Feedback</th>
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<tbody>
<tr>
<td>Feedback should be:</td>
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<tr>
<td>✓ Timely: given close to the time of the target behavior</td>
</tr>
<tr>
<td>✓ Respectful: focus on objective behavior (stay away from subjective, insulting words i.e. lazy, careless, inconsiderate, etc.)</td>
</tr>
<tr>
<td>✓ Specific: address a particular behavior/Event data/What exactly happened</td>
</tr>
<tr>
<td>✓ Directed toward improvement: provide example of preferred option or alternative behavior</td>
</tr>
<tr>
<td>✓ Considerate: be sensitive to feelings, be fair and respectful, use privacy</td>
</tr>
</tbody>
</table>

About the author: Cindy Zolnierek has a broad base of varied nursing experience in hospital practice environments and is currently the director of practice for the Texas Nurses Association.

Acknowledgment
This Risky Business: Communication in Health Care continuing nursing education resulted from a commitment of the Texas Nurses Association 2008 Practice Committee to educate nurses in Texas about patient safety, particularly the influence of human factors. Gratitude is extended to the members of the TNA Practice Committee for their contributions: Debora Simmons, MSN, RN, CCRN, CCNS (Committee co-chair) Mary Viney, MSN, RN, NEA-BC (Committee co-chair) Tamara Joan Cowley, MSN, RN, NEA-BC, FACHE Robert Dent, MBA, BSN, RN, FACHE Robin Gail Fleschler, PhD, RNC, CNS, NP Tamara Luedtke, MSN, RN, NEA-BC Sandi McDermott, MSN, RN, NEA-BC, FACHE Judy Turner, RN Julie Withhaeger, MSN, RNC Cindy Diamond Zolnierek, MSN, RN ★

Table VI

<table>
<thead>
<tr>
<th>DESC Script for Assertive Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>D—Describe the specific situation or behavior; provide concrete data</td>
</tr>
<tr>
<td>E—Express how the situation makes you feel/what your concerns are</td>
</tr>
<tr>
<td>S—Suggest other alternative and seek agreement</td>
</tr>
<tr>
<td>C—Consequences should be stated terms of impact on established team goals, strive for consensus</td>
</tr>
</tbody>
</table>

The team member may contribute information that facilitates meaningful problem solving...
I would if the forms were on the record before I leave the OR.
Risky Business: Communication in Health Care

1. Communication is critically important in health care because:
   a. it provides for information exchange among caregivers.
   b. errors in healthcare are frequently related to communication problems.
   c. performance of the team depends on effective communication.
   d. all of the above

2. Nurses make errors primarily because:
   a. they are rushed and not careful.
   b. they have not been well educated and trained.
   c. they are human and vulnerable to error.
   d. they don’t follow policies and procedures.

3. Human performance is affected by:
   a. noise, clutter, crowding.
   b. hierarchy of roles (e.g., nurse-physician, staff-manager).
   c. attention, anxiety, alertness.
   d. all of the above

4. Communication tools can reduce the potential for errors in health care by all of the following, EXCEPT:
   a. eliminating communication errors.
   b. mitigating human limitations and vulnerability.
   c. standardizing and organizing information exchange.
   d. establishing communication processes among the team.

5. All of the following exemplify closed loop communication, EXCEPT:
   a. a nurse transcribes a medication order and reads it back to the physician who verifies it.
   b. a nurse reports a critical lab value to the physician and requests she repeat it back to verify understanding.
   c. a physician gives a nurse a medication order by phone, the nurse repeats it to verify understanding, and then transcribes the order.
   d. a switchboard operator records a call announcing Code Red in exam room 2, and then repeats it back to the caller to confirm the location.

6. Handoff communication should include:
   a. opportunity to have questions answered.
   b. current situation and actions taken/required.
   c. who is responsible for the patient.
   d. all of the above.

7. A situation briefing model of exchanging information includes:
   a. Situation, Behavior, Assessment, Report
   b. Situation, Background, Assessment, Recommendation
   c. Standards, Behaviors, Attitudes, Results
   d. Situation, Background, Attitudes, Report

8. Effective team functioning is important in health care for all of the following reasons, EXCEPT:
   a. the entire team is accountable for patient safety and outcomes.
   b. effective team work reduces medical errors.
   c. human performance factors don’t apply to teams.
   d. team members can assist each other to avoid mistakes.

9. In situation awareness (STEP), each team member is aware of current conditions including:
   a. status of the patient, team, environment, and progress toward goal.
   b. status of the problem, team, environment, and policies.
   c. status of the situation, team, empowerment, and patient.
   d. status of the patient, time, environment, and progress.

10. Why is it important to provide feedback to health care team members?
    a. When problems are not addressed, the patient can be put at risk.
    b. To break down the hospital hierarchy.
    c. To design errors out of the system.
    d. To ensure a shared mental model.
Risky Business: Communication in Health Care

TEST QUESTION ANSWER/REGISTRATION/EVALUATION FORM

Send by mail with a self-addressed stamped envelope OR complete online and print certificate of successful completion at http://tnacne.texasnurses.org.

TEST QUESTION ANSWERS

1. A B C D
2. A B C D
3. A B C D
4. A B C D
5. A B C D

ACTIVITY EVALUATION

Purpose of this activity: The purpose of this educational activity is to highlight the important role of communication in patient safety and provide nurses with tools to enhance the effectiveness of their communication and safety practices within their work environment.

Please complete this evaluation questionnaire. Your responses will be used to revise this activity and to plan future educational activities. Circle the number/response that best fits your evaluation of the activity.

1 = Not at all  2 = Somewhat  3 = Almost completely  4 = Completely

1. Rate your achievement of these objectives:
   a. Relate the importance of effective communication in exchanging information and supporting team performance.
   1 2 3 4
   b. Identify safety risks and actual/potential errors associated with inadequate or ineffective communication.
   1 2 3 4
   c. Recognize physical, cognitive and organizational factors that affect human performance in a clinical setting and contribute to human vulnerability for error.
   1 2 3 4
   d. Describe three tools for organizing and standardizing information exchange to reduce potential error.
   1 2 3 4
   e. Define team behaviors that contribute to effective team functioning and patient safety.
   1 2 3 4

2. Rate the effectiveness of the teaching/learning materials.
   1 2 3 4

3. Were the objectives relevant to the overall purpose?
   1 2 3 4

4. How long, in minutes, did it take you to complete this activity?
   (Circle one) 0–30 minutes
   31–60 minutes
   61–90 minutes
   More than 90 minutes

5. List two (2) ways you will integrate what you learned in this activity into your practice and/or employment environment.

6. Were the following disclosed prior to the beginning of this activity?
   a. Requirements for Successful Completion  Yes No
   b. Conflicts of Interest  Yes No
   c. Commercial Support  Yes No
   d. Non-Endorsement of Products  Yes No
   e. Off-Label Use of Products  Yes No
   f. Did you notice any bias that was not disclosed in this activity?  Yes No
   If “Yes,” Please describe:

   ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________

   Additional comments:

REGISTRATION INFORMATION

Name:________________________________________________________________________
Address: ______________________________________________________________________
City: ____________________ State: ___________ ZIP: _____________________________
Phone: ____________________
Date of Birth (MM/DD): ___ ___/ ___ ___
E-mail: ______________________________________________________________________

Check one:  __ RN  ___ LVN  __ Student  __ Other: ________________________________

Check one:  __ Hospital  ___ LTC  ___ Non-clinical setting  Other: ________________
   Practice role:  __ Staff Nurse  ___ Manager/Supervisor  ___ Faculty  Other: __________
   __ Member of TNA/TxNN (TNA District # ______)
   __ Non-member of TNA/TxNN

Mail this completed form to: Texas Nurses Association, 7600 Burnet Road, Suite 440, Austin, Texas 78757
Please include a self-addressed, stamped envelope. If all fields are completed on the form and a passing grade of 80% is achieved on the Test for CNE Credit, certificates of successful completion will be sent in 4 to 6 weeks.
Each year during National Nurses Week, May 6-12, the Texas Nurses Association-District 5 announces its "Fabulous Five" award recipients. The awards — presented during the TNA-5 annual banquet — are bestowed upon only five nurses from more than 9,000 RNs who practice within nine Central Texas counties.

The nurses are selected by their peers for having made a difference through their leadership, compassion, role-modeling, community service, and contributions to the profession. This year's "Fabulous Five" are:

1. **Francisca Alvarado**, BSN, RN, OCN, oncology nurse information specialist, American Cancer Society;
2. **Toni Fuller**, RN, CEN, Director of Critical Care, South Austin Medical Center, St. David’s HealthCare Partnership;
3. **LeeAnn Christie**, BSN, RN, CCRN, Pediatric Intensive Care Research Coordinator, Dell Children’s Medical Center of Central Texas, Seton Family of Hospitals;
4. **Sylvia Moore**, BSN, RN, Med-Surg staff nurse, Seton Northwest Hospital, Seton Family of Hospitals;
5. **LaRita Spence**, MSN, RN, retired nursing educator, The University of Texas at Austin School of Nursing.

**TNA-District 5’s “Fabulous Five” Award Winners**

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**Contributed by**
Kim Belcik, BSN, RN
President of TNA District 5

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**Newest Resource For Nurses!**
FROM TEXAS NURSES ASSOCIATION

Order Your Copy Today!

**Safe Staffing: A Nurse's Guide to Advocacy**

TNA’s new 16-page pocket guide, Safe Staffing: A Nurse’s Guide to Advocacy, contains useful, straightforward tips on how best to question a patient assignment and advocate for patient safety.

It offers simple, step-by-step guidance on the correct way to request Safe Harbor — Texas’ formal mechanism for resolving patient safety concerns — when a nurse fears duty to patient is at risk.

*It’s a reference no direct care nurse should be without!*

**Safe Staffing: A Nurse’s Guide to Advocacy** is available in the Store at TNA: www.texasnurses.org/storeindex.cfm. Single copies are $5.00 each (includes tax, postage and handling).

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**TNA members can receive a pocket guide AT NO CHARGE!**
Order your copy today!

Volume pricing is available. Details at TNA’s online store or phone TNA at 512.452-0645.
“There aren’t enough caffeinated energy drinks in the world to get me through the overtime I have to work. Instead of limiting hours, they want to lecture us on fatigue.”

ANOTHER OVERTIME SHIFT, ANOTHER THREE ENERGY DRINKS.

TNA’S CONNECTED, SO YOU DON’T HAVE TO BE WIRED.

TOO MUCH OVERTIME ISN’T SAFE for nurses or their patients. That’s why in 2001, TNA negotiated hospital staffing rules to improve the practice environment, including policies to limit or eliminate mandatory overtime and floating. Built by Texas nurses for Texas nurses, no other organization knows how to lobby for change in the Texas Legislature like TNA. After all, we’ve been doing it for more than 100 years.
STEMS FOR JOINING TEXAS NURSES ASSOCIATION

To be eligible for membership in Texas Nurses Association, you must have been granted a license to practice as a registered nurse in a state, territory, possession or District of Columbia of the United States, and not have your license under suspension or revocation in any state.

1. FIND YOUR DISTRICT

Locate your county of residence OR county of employment. The large black circled number within the indicated boundaries, is your district.

2. SELECT YOUR TYPE OF MEMBERSHIP

from the options that follow. Then, using the chart below, match your TNA District, type of membership and preferred method of payment to determine correct dues.

Full Membership - Full rights and privileges of membership (all nurses employed more than an average of 20 hours a week).

Reduced Dues Membership - Pay 50% of annual dues (all nurses who are unemployed or working less than 20 hours a week, licensed RNs who are full-time students, new graduates from basic nursing education programs joining within 6 months of graduation, and RNs 62 years-of-age or older who are working and receiving Social Security).

Special Membership - Pay 25% of annual dues (nurses over 62 years-of-age and not employed, or 100% disabled).

3. COMPLETE APPLICATION

Complete this Application for Membership, and mail with check or fax ($125,042.0645) with credit card information. Secure, online membership payment with credit card is also available at www.texasnurses.org.

TEXAS NURSES NETWORK

A grand alternative to tri-level TNA-ANA-District membership, this state-only membership is a great first step in supporting the nursing profession and connecting with peers. While it doesn’t carry voting privileges, it will keep you abreast of important nursing issues, and includes professional involvement opportunities and product/event savings. With dues a flat $99 per year or $9.25 per month – TNN is a simple, affordable connection to professional involvement in Texas.

MEMBERSHIP DUES RATES 2008

<table>
<thead>
<tr>
<th>District</th>
<th>M-Full Membership Dues</th>
<th>R-Reduced Membership Dues</th>
<th>Reduced Dues Membership Dues</th>
<th>Special Membership Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>13, 14, 15, 16, 17, 18, 19, 20</td>
<td>$289.00</td>
<td>$254.25</td>
<td>$144.50</td>
<td>$12.54</td>
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<tr>
<td>21, 22, 23, 24, 25, 26, 27</td>
<td>$294.00</td>
<td>$254.50</td>
<td>$145.00</td>
<td>$12.54</td>
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<tr>
<td>31, 32, 33, 34, 35</td>
<td>$285.00</td>
<td>$250.50</td>
<td>$140.00</td>
<td>$11.54</td>
</tr>
<tr>
<td>51-53, 54-56, 57-59, 60-66</td>
<td>$286.00</td>
<td>$251.00</td>
<td>$143.00</td>
<td>$11.54</td>
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<tr>
<td>67-70</td>
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<tr>
<td>1-4</td>
<td>$334.00</td>
<td>$284.50</td>
<td>$167.00</td>
<td>$14.41</td>
</tr>
</tbody>
</table>

To be completed by TNA:

Date | State | District | Expiration Date | Amount Enclosed |
--- | --- | --- | --- | --- |

EDDP AUTHORIZATIONS

EDDP Authorization for TNA

To provide monthly electronic payments to Texas Nurses Network (TNN): (1) This is to authorize ANA to withdraw $117 of my annual dues and any additional service fee from my checking account each month or after the 15th of each month until the last day of each month. (2) Which is designated by the enclosed check for the first month’s payment. (3) ANA is authorized to charge the amount by giving the undersigned thirty (30) days written notice; (4) The undersigned may cancel this authorization upon receipt by ANA of written notice of termination twenty (20) days prior to deduction date as designated above. ANA will charge a $3.00 fee for any returned checks.

Signature: __________________________ Date: __________

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Signature: __________________________ Date: __________

Note: If you are applying for either TNA/ANA or TNN membership, $6.50 of your membership dues is for a subscription to THE AMERICAN NURSE. If you are applying for TNA/ANA membership, an additional $2.42 is for a subscription to American Journal of Nursing. If you are applying for TNN membership, an additional $3.00 is for a subscription to ANA’s newsletter, THE AMERICAN NURSE. Please allow 5-6 weeks for processing. If you would like to report a change in your address, phone number, or email address, please contact us at 1-800-583-7701. West Region | North Region | Central Region | South Region | East Region | District 40-A Large

www.texasnurses.org