

Effective Nursing Communication

by Stephanie Smith, MS, BSN, RN, CPN

CE948 | 0.50 contact hrs

Course Objectives

The goal of this course is to educate nurses in acute care settings about effective nursing communication.

After taking this course, you should be able to:

- Describe the patient safety issues associated with verbal and telephone orders.
- List The Joint Commission's unacceptable medical abbreviations.
- Discuss the importance of accurate handoff communication.

Accreditation Information

The course is intended for nurses.

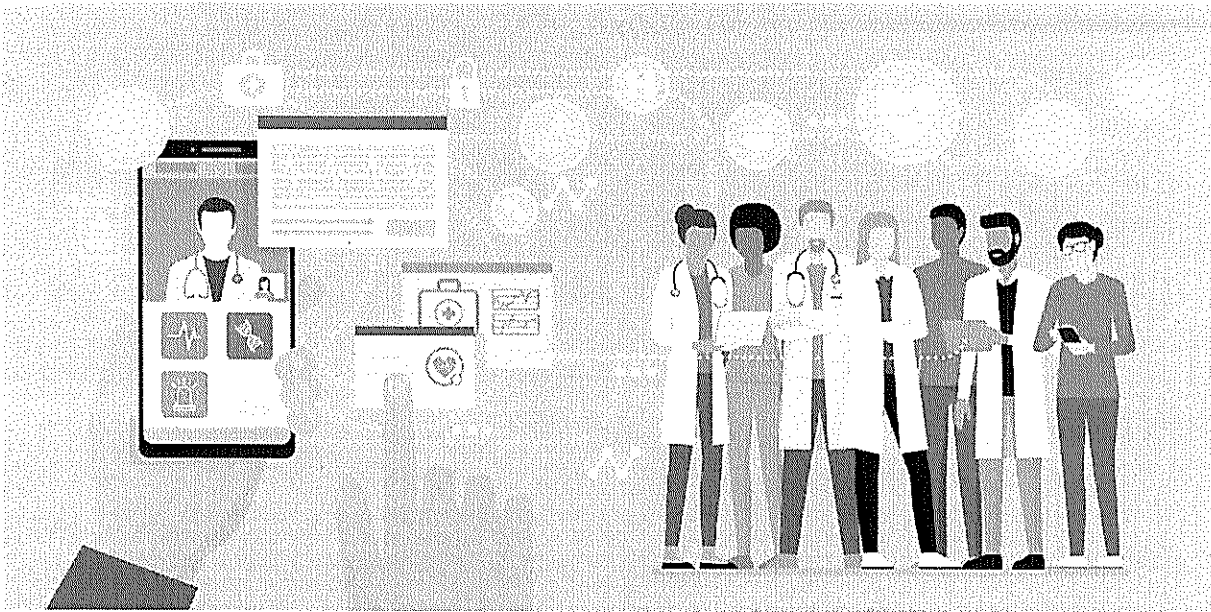


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Does this sound familiar? A physician calls with telephone orders for one of your patients. It is one of “those” days. The nurses’ station is frantic with activity and noise. Phones are ringing, visitors are at the desk asking questions, admissions are coming in, discharges are waiting to go home, and you are trying to get critical information from a physician over the phone. This is likely one of the scenarios that The Joint Commission had in mind when it addressed effective verbal/telephone communication between healthcare providers in its National Patient Safety Goals.

In 1999, the Institute of Medicine published “To Err Is Human: Building a Safer Health System,” finding that between 48,000 and 99,000 people in the U.S. die each year due to medical errors (Institute of Medicine, 2000). Ineffective communication, including over the telephone, contributes significantly to these errors. After this report, consumers and healthcare providers have changed the way they regard patient safety. The IOM report helped to bring the issue of patient safety to the forefront in the minds of both the public and healthcare providers.

A 2013 review of four studies using the Institute for Healthcare Improvement Global Trigger Tool for adverse events conservatively estimated the number of deaths to be 210,000 directly associated with preventable harm in hospitals. However, these researchers also proposed that the true number was likely to be closer to 400,000 annually (James, 2013).

The Joint Commission (2015) has described communication problems as one of the leading causes of sentinel events. Sentinel events are unexpected incidents that result in death or serious, permanent injury to a patient or the risk of such harm known as a “near miss”. Other leading causes include human factors and/or ineffective leadership. Human factor errors are errors that people make due to the nature of being human such as forgetting, being distracted, or from a lack of sleep.

Verbal and Telephone Orders

Verbal or telephone orders are a significant source of medical errors. Errors can occur not only in the scene described above at the nurses’ station, but also when the person giving an order is difficult to understand. Think about potential misinterpretations due to varying accents, dialects, and pronunciation patterns, leading to a medical error. Other dangers of telephone or verbal communication are (Institute for Safe Medication Practices, 2017):

- Interruptions

- Distractions
- Unfamiliar medication names or terminology
- Medications with sound-alike names
- Reliance on memory with delayed transcription



These scenarios each increase the risk for order errors. Verbal or telephone orders are typically made in haste. Actions resulting from verbal and telephone orders usually occur at once, providing no time for correction if the person taking the order noted it erroneously. With verbal or telephone orders, the prescriber has an expectation that the person transcribing the order will understand it and copy it accurately into the medical record. But even if the person taking the order understands it, they may make an error in transcription.



As part of its National Patient Safety Goals and the standards in which this goal is now addressed, The Joint Commission requires the person receiving a verbal or telephone order to transcribe the entire order or input it into the patient's electronic health record as it is being given. They must read it back to the prescriber and receive confirmation that the order is correct (Institute for Safe Medication Practices, 2017). This ensures the accurate transcription of all verbal or telephone orders. In emergencies, such as during a code event or surgery in the OR, this read-back process may not be possible. In this case, a "repeat back" is acceptable.

The best way to prevent errors resulting from verbal or telephone orders is to limit their use (Institute for Safe Medication Practice, 2017). But this is easier said than done. It is much easier for the provider to give a verbal or telephone order than to write it in the medical record. The Joint Commission suggests that organizations make the written process as easy as possible. Organizations have done this in several ways, including using preprinted order sheets with check boxes or having providers fax written orders if they are not onsite. Organizations with computerized physician order entry may use handheld computers or easy-access terminals to make it convenient for providers to enter their orders electronically.

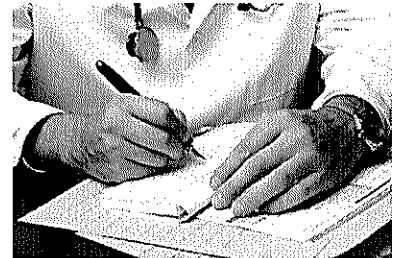
Additional suggestions to improve the verbal/telephone order process and ensure safety include:

- Ask the provider for the correct spelling of a medication if you are unsure.
- When repeating an order back to the provider, spell out numbers. For example, 17 would be one, seven.
- Eliminate abbreviations where possible. For example, "1 tab TID" should be written as "Give one tablet three times daily."
- Record a verbal order directly onto the physician order sheet. This eliminates delayed or transposed transcription as a source of error.
- Limit those allowed to receive verbal orders and be sure they are familiar with the verbal/telephone order policy.
- Restrict the use of verbal/telephone orders in certain areas such as oncology, where chemotherapeutic drugs are involved. Medication orders and/or medications which are high risk, complicated, or have sound-alike names should not be prescribed verbally.
- Write the purpose of the medication on the order. The order should also include the medication trade/generic name, dose, strength, route, and frequency.

Employees should take verbal/telephone orders only for those that are within their scope of practice. For example, a ward clerk should not take a provider's verbal order for patient-related issues. Read back does make a difference, but practitioners do not do it consistently (Moghaddasi et al., 2017). A review published in May 2017 about the challenges caused by verbal orders in medicine. It noted that =, a reported 2.3% of errors were related to verbal orders.

Abbreviations

The Joint Commission's recommendations on abbreviations have been difficult to enforce, largely because of ingrained behavior. Changing the ordering practices of physicians who have been writing orders the same way for 10, 20, or 30 years is challenging. Similarly, clinicians and other professionals who accept physicians' orders verbally or telephonically may use nonstandard abbreviations on the order sheet, or when transcribing orders to the medication administration record. Suggestions for reducing the use of unapproved abbreviations include:



- Printing an authorized abbreviation list at the top or bottom of order sheets or in the margins
- Printing a "Do Not Use" abbreviation list and posting it in areas visible to medical providers
- Removing "Do Not Use" abbreviations from preprinted order forms
- Educating, monitoring, and providing feedback to physicians and staff who document in the medical record
- Making dangerous abbreviations and all National Patient Safety Goals an agenda item at all medical staff department/section meetings
- Running articles in physician and employee newsletters about "Do Not Use" abbreviations

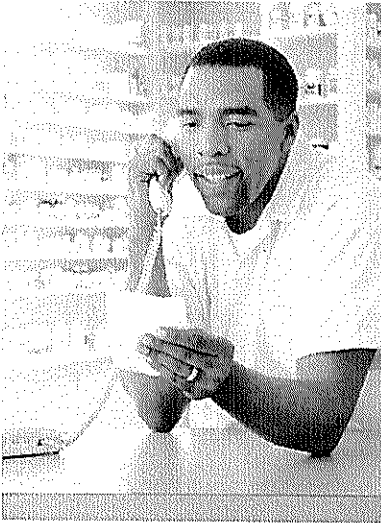
A major source of medication errors is dose designations that include decimal points. For example, a patient receives 10 times the normal dose of a medication because the nurse did not see the decimal point in the "1.0" written by the physician, or an order for ".1 mg" is interpreted as "1 mg," because the nurse does not see the decimal point. Overdoses can easily result from using a trailing zero. For example, 1.0 mg instead of 1 mg, or failure to use a leading zero when writing a fractionated dose such as .1 mg instead of 0.1 mg.

The Joint Commission's "Do Not Use" abbreviation goal is integrated into the Information Management standards (The Joint Commission, 2020). The requirement is for facilities to have a standardized list of "Do Not Use" abbreviations to include the following dose designations, abbreviations, acronyms, and symbols:

- The abbreviations "U" and "IU," which may appear as the number "0," especially when the "U" is too close to the number. For example, a patient could receive 60 units of insulin because the nurse interprets "6U" as "60." Or "IU" may appear as "IV" or the number "10." The safest way is to write out "unit" and "international unit."
- The abbreviation "QD" (daily), which may appear as "QID" (four times a day), especially if the period after the "q" or the tail of the "q" is misunderstood. Writing out "every day" will eliminate this error. Similarly, the abbreviation "QOD" (every other day) may appear as "QD" or "QID" if the "o" is poorly written. The correct form here is to write out "every other day."
- Trailing zeros and a lack of a leading zero. For example, ".2 mg" could be misread as "2 mg" due to the misplacement of the decimal point. A leading zero includes the text reading as "0.2 mg."
- The last of The Joint Commission mandates on abbreviations relates to magnesium sulfate and morphine sulfate. Quickly written $MgSO_4$ and MSO_4 orders may easily be confused. Write out "magnesium sulfate"

and "morphine sulfate" so they are clear.

Another approach is having the pharmacy refuse orders that contain prohibited abbreviations. The order would require the proper abbreviation before the pharmacy processes it. Nurses and other healthcare professionals can play a role by notifying the prescribing physician before the order is sent to the pharmacy.



The bottom line is to focus on the elimination of prohibited, error-prone abbreviations as a system-wide concern, not one just for healthcare professionals including nurses, pharmacy staff, or physicians. To create a culture of safety regarding abbreviations, hospital and medical staff leadership needs to promote educational efforts, physician "champions" must support the initiative, and clinicians must encourage their peers to adhere to the program. This must be a "physician-owned" process to enforce physician compliance.

In 2001, the Joint Commission published Sentinel Event Alert 23: Medication errors related to potentially dangerous abbreviations. In 2002, a National Patient Safety Goal was established to require hospitals to identify and implement dangerous abbreviations. This goal was integrated into the Information Management Standards in 2010. During this time, The Joint Commission has stated that the "Do Not Use" abbreviations do not apply to preprogrammed computer systems. If the abbreviation is in the software of the computer program and not entered by the practitioner, then it is not considered a danger or a "Do Not Use" abbreviation. The Joint Commission will reconsider this decision over time.

In the 2017 SAFER Matrix scoring system, The Joint Commission has changed the way in which the survey results are scored (The Joint Commission, 2017b). In the interest of patient safety, the scoring system weights the score as a high, moderate, or low risk of harm and then it is evaluated by a time frame of occurrence as limited, pattern, or widespread. A facility that has widespread use of "Do Not Use" abbreviations could be assigned an "immediate threat to life" risk score, which could result in an immediate preliminary denial of accreditation.

Handoff Communication



Many communication breakdowns in healthcare occur when one caregiver hands off patient care responsibilities to another (AHRQ, 2019). Consider the following scenario:

- A patient is hospitalized with a thoracic spine injury and is ordered to have a routine chest X-ray.
- The nurse tells the transporting attendant about the patient's injury but does not tell them that the patient must remain flat and not logrolled when transferred between beds.
- The patient is transported to the radiology department and the attendant leaves the patient.
- During the X-ray, the patient is placed in an upright position to maximize the quality of the study.
- After the X-ray is completed, the patient is returned to her room still in a sitting position.
- The nurse lowers the head of the bed and notifies the physician.
- A neurological exam reveals that the patient cannot move her legs.

Although most licensed healthcare professionals would understand that a thoracic spine injury indicates the need for the patient to remain flat and not rolled during bed transfers, a transporter may not have this knowledge and should be instructed likewise.

Given the tremendous number of times handoff communication takes place and the opportunities for miscommunication, it is easy to see why The Joint Commission created the National Patient Safety Goals to improve handoff communication and has now integrated this goal into the standards. The standards require that healthcare organizations implement a standardized approach to handoff communication, including the ability of the healthcare professionals to ask and respond to questions. When handing off a patient, caregivers must provide information to staff members receiving the patient that reflects the patient's current condition, treatment, recent changes in condition, and possible changes or complications for which to observe. This must be done in a consistent manner throughout the organization. But the process may be modified based upon the type of handoff such as nursing shift-to-shift report, a patient transferring from the ED, or a patient going to a radiology exam.

Handoffs can be one of the most dangerous points in any patient's hospital treatment. The Joint Commission very specifically defines that the opportunity to ask questions of the person providing the handoff should be included in



the handoff. Experience with new and different technical tools has given healthcare providers many time-saving tools, one of which is recording a handoff for the other person to listen to. This helps by reducing the time that the person who is providing the handoff report has to wait on the phone while the next provider arrives at the phone to listen to the information and ask questions.

The key to using new technology and tools safely is to assess them for potential failures or new problems that they may cause. The Joint Commission has required hospitals to complete a proactive risk assessment, previously known as failure mode effects analysis, at least every 18 months (The Joint Commission, n.d.). A proactive risk assessment is one of the tools that promotes patient safety by having leaders and staff assess potential risks, errors, and negative consequences of errors, then rate the priority of the risks and address the process to reduce the risks before the use of a technology or tool is initiated. While not all negative outcomes may be prevented, the proactive risk assessment greatly reduces the number of errors or variances when using the technology or tool.

SBAR Communication

A way to provide standardized information during handoff is the SBAR technique, which stands for situation, background, assessment, and recommendation (Institute for Healthcare Improvement, n.d.). SBAR helps the communicator organize their thoughts and increases the chances the person listening will understand. Brief definitions for SBAR are:



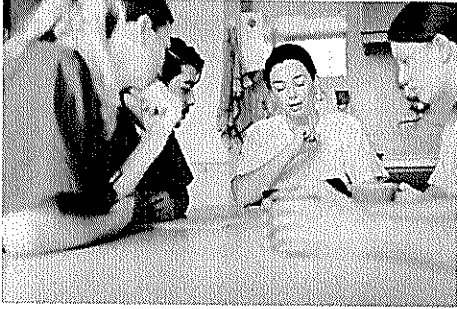
- **Situation:** Communicate what is occurring and why the patient is being handed off to another department or unit
- **Background:** Explain what led up to the current situation and put it into context if necessary
- **Assessment:** Give your impression of the problem or situation
- **Recommendation:** Explain what you would do to correct the problem

Here is an example of SBAR communication when transferring a patient to an ICU from an acute care unit:

- **Situation:** This is Mr. B. He is being transferred because he has been having trouble breathing, and his oxygen saturation continues to decrease.
- **Background:** He was admitted 2 days ago with COPD and has a history of congestive heart failure and pneumonia.
- **Assessment:** His treatment regimen includes bronchodilators and oxygen. His most recent vital signs were blood pressure 160/100, pulse 110, respirations 30, temperature 99, oxygen saturation 89%. He is experiencing significant dyspnea.
- **Recommendation:** Dr. Smith ordered a transfer to the ICU for closer observation and evaluation by an intensivist for possible intubation and ventilatory support. He may require arterial blood gases and respiratory therapy staff should be alerted. His family must be notified of his transfer.

The receiving nurse now may ask questions to clarify anything he or she did not understand. This example of SBAR can be modified to fit the situation such as change-of-shift report or the transfer of a patient to another facility. The

most important thing to remember is that any time a handoff occurs, the opportunity for error exists. Effective handoff communication significantly reduces the chance of errors.



The Joint Commission (2017a) published Sentinel Event Alert 58: Inadequate hand-off communication. The alert addresses the fact that inadequate or failed handoffs have led to significant safety issues in healthcare. Some suggestions in Sentinel Event Alert 58 refer back to the prior alerts in which leaders of healthcare organizations are responsible for developing a culture of safety. The alert states that leadership must be committed to adequate and successful handoff as part of patient safety and a safety culture. Sentinel Event Alert 58 also addresses the use of standardized content in all handoffs, completing

handoffs without interruptions, and providing standardized training to healthcare workers both in the sending and receiving of handoff communication. As an additional recommendation, the alert suggests reviewing the capabilities of technology to assist in accurate handoffs. Finally, the facility is challenged to monitor the results of interventions to improve the effectiveness of handoff.

The hospital can be a safe environment only through staff diligence and awareness of the safety pitfalls that pervade each patient encounter. By understanding the patient safety issues related to verbal and telephone orders, abbreviations and symbols, and handoff communication, healthcare professionals as a team can reduce the likelihood of medical errors and patient injuries. Patients trust that you will protect them in this potentially dangerous environment. Knowing the dangers is your first step!

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Conclusion

Course Summary

Now that you have finished viewing the course content, you should have learned the following:

- The patient safety issues associated with verbal and telephone orders
- The Joint Commission's unacceptable medical abbreviations
- The importance of accurate handoff communication

Course Contributor

The content for this course was revised by Relias staff writer **Stephanie Smith, MS, BSN, RN, CPN**. She has been a clinical nurse for 25 years. Stephanie was educated and trained in New York as a Licensed Practical Nurse where she practiced pediatric hematology/oncology nursing at the Children's Hospital of Buffalo. She earned a Master of Science in Nursing with an emphasis on Nursing Leadership and Administration from Excelsior College in New York and is a Certified Pediatric Nurse (CPN). She is Pediatric Advanced Life Support (PALS) certified and is a former PALS instructor. Her clinical expertise is in acute pediatric medical surgical nursing and case management for children with medical complexity. She most recently worked at Duke Children's Hospital as a Nurse Clinician before coming to Relias.

Acknowledgment: Joyce Lahue, MS, BSN, RN, CPHRM, FASHRM was the previous author of this educational activity but did not participate in the revision of the current version of this course.

Resources

Institute for Safe Medication Practices (ISMP)

<https://www.ismp.org/>



ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations

<https://www.ismp.org/sites/default/files/attachments/2017-11/Error%20Prone%20Abbreviations%202015.pdf>

The Joint Commission

<https://www.jointcommission.org/>

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