Pre-Procedural Communication: A Lesson in Human Factors
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Problem:
According to the Joint Commission, from 1995-2005 communication was identified as a key issue in the root causes of Sentinel Events. Poor communication between healthcare providers (HCP) is attributable to several factors: rotating caregivers, lack of familiarity with other team members, human limitations such as memory and need to multitask, fatigue, stress, and differences in level of training and experience of HCP. Communication must be improved in order to decrease risk to the patient.

Evidence:
In an effort to improve communication and patient safety, The Joint Commission (TJC) implemented a Universal Protocol. This protocol contains three parts: conduct a pre-procedure verification process, mark the procedure site, and "Time Out" before starting the procedure.

Strategy:
Our tertiary healthcare system in Central Texas took these requirements and developed goals to improve patient safety, communication between team members and the comfort level of HCP for expressing concerns. Our plan was to place whiteboards in each procedure room. These boards were, at a minimum, standardized with TJC Universal Protocol requirements. They could then be customized to fit each department's needs.

Practice Change:
A person was designated to complete the whiteboard. During “Time Out” the whiteboard is used as a template, key information is communicated to all team members. Agreement is reached before the procedure begins.

Evaluation:
Procedural nursing were surveyed for communication changes. Verbal feedback was generally positive; however, some staff felt that writing on the whiteboard was redundant since the nursing documentation had most of the information already on it.

Results:
Treatment record revised to include all “timeout” components.

Recommendations:
Taking this feedback into consideration, the Treatment Record was revised to arrange the information similar to the whiteboard. A wall checklist was developed for a "Time Out" template, but did not require further documentation.

Lessons Learned:
Seek input from staff utilizing the board to help with customizations. Increases buy-in.

Bibliography
Taggart B, retrieved on March 1, 2009. Applying Human Factors Training to Patient Safety
The Joint Commission, retrieved online March 1, 2009.