EDITORIAL

Communication: The First Tool in Risk Management for Long-Term Care

Healthcare professionals have long appreciated the relationship that communication plays in the risk of liability. However, despite that awareness, communication issues remain at the core of most litigation. Nowhere is this more critical than in the long-term care setting. Residents in nursing homes have typically experienced one or more transitions in care; they are usually frail and vulnerable; they present with multiple medications and significant potential for adverse medication events; and are at increased risk of adverse outcomes such as falls, pressure wounds, and functional decline. The involved families are already stressed at the time their loved one is admitted to the nursing home. As described by Dr. Winn in this issue, they could feel angry, guilty, or overwhelmed. They, too, have experienced the same transitions of care that the resident recently experienced. They have seen multiple healthcare professionals and have often gathered “bits and pieces” of their loved one’s medical story, but could have significant areas of misunderstanding and distrust. Any of these factors alone would present special communication challenges. However, not only do the families and patients bring their own challenges for communication, but the very structure of long-term care seems to pose barriers to a dynamic exchange of understanding. Information is shared in a variety of ways and often without full context of the presenting problem. The reporting of resident information is usually hierarchical, with the certified nursing assistant passing observational data to the floor nurse, who could share it with the charge nurse, who could then pass it on to the Director of Nursing or the attending physician. Most physician communication is not accomplished face-to-face and is often brief and task-focused (eg, reporting a change, requesting an order, or reporting a lab result). The purpose of this commentary is to review the common methods of communication in the nursing home and examine how each could be better used to manage the common and challenging clinical and social issues that present in this setting.

Any discussion of risk management logically begins with a risk/benefit analysis of the given intervention. The same holds for communication methods in long-term care. All too often the clinicians and nursing home staff use the communication vehicle most readily available without significant thought as to the limitations of each. Table 1 summarizes the potential advantages and disadvantages of various methods of communication. Verbal exchange is probably the most frequently used because it is immediate and flexible. Little appreciation is given to the specific pitfalls that accompany face-to-face “simple talking.” Verbal orders that are given on site (such as at the nurses’ station) are prone to error and offer particular, unrecognized risk. As opposed to a telephone call, in which direct engagement of both parties is more predictable, the verbal order process assumes that: (1) you have the listener’s attention; (2) the listener even knows the problem or patient to whom the order addresses; (3) the listener will remember what was requested and accurately transmit the order; and (4) the clinician giving the order will verify the written transcription in a reasonable time to correct potential errors. Verbal communication with patients, families, and nursing staff can result in increased risk when it occurs in a hurried manner, without background information from both sides, when distractions complete for the attentions of the listener, and when decisions are documented from memory or are not documented at all. Residents and families are at particular risk for filtering and drawing their own conclusions from the information heard. Without an assessment of understanding, both parties could assume they know what the details and conclusions were, but could be significantly disparate when actually evaluated.

Telephone conversations represent another alternative to face-to-face verbal communication. Although attention can be better assumed (although not guaranteed), conversations are often short and cryptic. There is frequently an assumption that the clinician or nurse receiving the call has all the information that the speaker does. If the desire is to reach a specific end point (ie, an order for a new problem), the speaker can easily “skip” details to get quickly to the final goal of getting the order and getting on with the task. To be fully successful, both parties must focus on providing and extracting sufficient data to make the dialogue meaningful, and therefore the final outcome of action meaningful. Like with face-to-face communication, the missing element from a risk management perspective is usually adequate and accurate documentation. Unless the listener is scribing the conversation in process, the final recording is left to memory and dependent on attention and other distractions. Recall of complex discussion and multiple orders almost ensures some degree of omission or error. To avoid this potential error, the person receiving the information should conclude the call by

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The emergence of fax transmissions has allowed for quick and permanent documentation with the same flexibility as a telephone call. However, because of its ease and flexibility, many nursing homes use the fax option whether the issue is a routine notification or an urgent message. The primary risk of the fax message is that it is one-sided and offers little to no context other than what is included in the message. Understanding of the background issues is usually assumed by the sender. Mere transmission of data such as abnormal laboratory values must not be used as a substitute for information-sharing that leads to actual problem-solving. The other significant liability risk of fax transmissions is the incorrect assumption that the intended receiver actually received the information in the same timeframe that the sender intended. Although the faxing of a toxic phenytoin level could remove the physician notification “task” from the nurse’s list, the fact that it was sent after office hours does not result in information-sharing or the correction of the clinical concern. With the implementation of the HIPAA regulations, it is now critical that the sender knows who the receiver of the personal information is and has some method to verify that. Ideally, both the physician and nursing facility must work together to create a specific fax policy that defines what is faxed, when faxes are acceptable, and how to verify receipt and obtain response when needed.

### SPECIFIC AREAS FOR PLANNED COMMUNICATION

Pressure wounds are an undesired outcome and are often attributed to poor care by families and surveyors. Specific communication steps are required between staff–staff, staff–physician or midlevel practitioner, and physician–patient/family to optimally manage the wound care. When one aspect of this communication fails, the entire care outcome is placed at risk. Staff–staff communications include appropriate assessment documentation, documentation of care plan goals, documentation of treatment orders, and regular documentation of the response to treatment. However, communication also needs to be more “alive” than just documentation. Verbal information needs to be shared between the team and between shifts with the intent to keep care focused on all the domains that are necessary for optimum skin care. Staff–clinician communication must include thorough and accurate assessments, review of risk factors and necessary interventions to address those risk factors, clarification of treatment plans and treatment goals, and responses to the treatment. Communication must occur at frequent enough intervals to report changes, particularly if the wound is worsening. Verbal sharing of information is very useful and allows for bidirectional discourse. However, written communication is essential to provide an adequate record. Lastly, early communication with the family regarding skin issues can help minimize anger and “surprise.” This communication goes well beyond the typical “notification of responsible party” and should include discussion of the resident’s specific risk factors, goals of treatment and whether the wound is even likely to heal, and treatment plans in words that the family will understand. When the wound fails to respond to treatment, the family should be told sooner rather than when the ulcer has progressed to stage IV.

Falls and fall-risk shares similar requirements and strategies for communication as those described for pressure ulcers. Assessments must be shared with all the providers of care, and interventions must be discussed and implemented. Fall events need to be communicated to the physician in the context of recent history, events related to the actual fall, and medications currently used. All too often, “falls without injury” is simply reported as isolated events and without contextual information. Such notification, again, merely completes a task requirement and is not communication that tends to support dialogue and care improvement. Families also should not be merely notified of falls, but provided an interactive dialogue to clarify history of falls, uncover unknown risk factors, identify previously tried interventions, and engage the family in active problem-solving.

Informed consent for psychoactive medications and physical restraints implies functional communication. However, this function, much like that described for “falls without injury,” is

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>Verbal</td>
<td>Understanding is often assumed</td>
</tr>
<tr>
<td>Flexible</td>
<td>Prone to background distractions</td>
</tr>
<tr>
<td>Allows for immediate response</td>
<td>No “record”; is dependent on memory</td>
</tr>
<tr>
<td>Allows for bidirectional exchange</td>
<td>Significant “filtering” by both parties often occurs and could be unrecognized</td>
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<tr>
<td>Written</td>
<td>Perception of time-consuming; therefore can be hurried and incomplete</td>
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<tr>
<td>Permanent</td>
<td>Statement could be responded to out of context</td>
</tr>
<tr>
<td>Flexible (eg, fax)</td>
<td>Assumption often that receiving party actually received and read message</td>
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<tr>
<td>Allows for broader explanation</td>
<td></td>
</tr>
<tr>
<td>Nonverbal</td>
<td>Powerful (but could not be recognized)</td>
</tr>
<tr>
<td>Powerful</td>
<td>Can elicit strong defensive reaction</td>
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<tr>
<td>Can provide emotional link</td>
<td>Can override actual verbal message</td>
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<td>Can enhance message and make it “real”</td>
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**Table 1. Advantages and Disadvantages of Common Methods of Communication**
usually a task function that involves more permission-seeking than an actually exchange of information. True informed consent must include the specific behaviors or risks, the planned intervention, and the benefit/burden of the requested intervention. Such communication should be both verbal, to allow for interaction and questions, as well as written. Verbal communication should also include a discussion of alternatives tried or considered. Written communication must be in the form of documentation and should include the specific physician order, a summary of the risk/benefits discussed and with whom the conversation was held, and who was the decision-maker. It is of great value to provide the family or responsible party with a summary of the risk/benefits of the specific intervention requested.

*Change of condition* notification could relate to “simple” issues such as skin tears or life-threatening conditions such as acute respiratory distress. Much of our present formal communication regarding change-of-condition is driven by regulation and also tends to be seen as task compliance (eg, faxing the list of residents with significant weight loss for the month). Any communication regarding a change of condition must include a context of related history and assessment. Goals of care should also be discussed, particularly for potentially serious conditions. Using verbal communication allows for dialogue and expanded understanding. However, nursing staff documentation of such verbal exchange must include the issues, brief synopsis of the discussion, with whom the discussion was made, and the decisions reached. This documentation should include these same elements whether it is between nursing staff and family, nursing staff and physician, or physician and family. Proactive discussion with the family by the physician and/or midlevel practitioner will enhance family understanding and tends to reduce the predicted escalation of calls if the situation should continue or worsen. Early discussions with the family allow the clinician to provide information and readdress the goals of care.

*End-of-life care* is probably the best example of how comprehensive communication must take many forms, could require multiple steps, requires frequent assessment of understanding, and is best accomplished when all members of the care team are involved in one way or another. Families or patients could use written documentation in the form of an advanced directive. However, if these directives are incomplete or are not reviewed by the physician and the care team, they can do little to serve to communicate the true wishes or values of the individual. Discussions regarding terminal care and end-of-life choices involve some degree of emotional overlay by all parties. It sparks at core feelings of fear, grief, endings, and even guilt. If acknowledged, these emotions can allow the decisions to be rich with human experience and compassion. When ignored, the result could well be conflict, anger, and distrust on the part of the family, resident, and healthcare team. When possible, end-of-life discussion should occur in stages. The first step is to “set the stage,” making sure that the present situation and prognosis is understood. Second, a readressing of the goals of treatment and the wishes and values of the individual must be shared. Even with apparent conflict in the goals of treatment, open discussions can find common ground where all parties can agree (eg, “We all want Mom to have her pain managed as well as we possibly can”). A key next step is to clearly identify the decision-maker, if not the patient. At this point, the communication must move to which decisions are immediate versus those that will need to be made in the future. Sometimes just allowing the decision-maker to hear the issues without making an immediate choice is necessary. If so, and if the clinical situation allows, it is most helpful to have multiple, shorter interactions or a period of time to allow for questions, digesting of information, and ultimate decision-making. Lastly, and perhaps the most critical step, is to review the information gathered and shared, as described previously, and allow the family/patient to restate what they heard and understand; and then to restate to the family what the clinician understands the choices to be. Such “double-checking” not only allows for verification, but also for validation of the patient’s/family’s concerns, beliefs, and wishes. Documentation, to be truly valuable to the end-of-life care process, must be much more that a list of what the patient/family wants and does not want. Statements that clarify long-term goals and values should be added. A “do-not resuscitate (DNR)” order is not as helpful as a statement that outlines that although a patient “does not want CPR, they would want such things as pneumonia treated, if the physician believed there was a chance of recovery.” Asking the patient/family to define personal terms such as “vegetable” or “no more quality of life” is equally critical to this process. Finally, documentation must include who made the decisions, when they were made, and how they were shared (telephone vs. meeting vs. written document).

**SUMMARY**

The nursing home environment is rich in its opportunity to share both information and personal experiences. Much of this “sharing” is mandated by rules and regulations and thus, is often seen as a task to be done instead of an opportunity to truly expand the other’s understanding of the problem and seek to involve both parties to find a better solution to the presenting problem. Our focus on mandated documentation has often resulted in “fictitious compliance” rather than “true compliance.” Documentation is intended to be used as the record of the information exchange and communication rather than the very method by which communication is accomplished. Because of the complex nature of care of nursing home residents and the overlay of emotions that families often bring, the long-term care setting could be one of the most challenging of healthcare settings in which to create true dialogue between all involved. Furthermore, the specific syndromes that are so common to this frail population require specific information-gathering and sharing. When these steps are overlooked and a negative outcome occurs, the all-too-frequent result is blame, assumptions of cause and effect, and anger. Our first step to improve care and reduce liability risk begins with open dialogue, meaningful exchange of information, validation of others’ voices, assessment of understanding on both sides, and accurate transcription. All of this falls
under the often-assumed, but frequently poorly understood, tool of communication.

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REFERENCES

9. Medication Management Tool Kit, American Medical Directors Association; March 2003.