



Which  do you  ?

CriticalCareNurse

The journal for high acuity, progressive, and critical care nursing

[HOME](#) | [CURRENT ISSUE](#) | [ARCHIVE](#) | [FEEDBACK](#) | [SUBSCRIBE](#) | [ALERTS](#) | [HELP](#)

Dialogue and Discourse Are We Having the Right Conversations?



Nora Triola, RN, PhD, CNAA

Author Affiliations

No doubt by now, you have heard about the American Association for Critical-Care Nurses (AACN) Standards for Establishing and Sustaining Healthy Work Environments.¹ In the June 2005 editorial section of Critical Care Nurse, Grif Alspach² offers us a lifeline to achieve and sustain healthy work environments and calls on us to get out of our environmental quicksand and take action to implement the standards. Dr Alspach's article paints for us an all-too-frequent scenario in a day in the life of a critical care nurse. The scene includes the critical care nurse becoming disappointed, frustrated, angry, stressed, disrespected, and isolated while trying to provide safe care. I think it is something we can all relate to. The question is, Are we ready to do something about it?

The purpose of nursing is to meet the needs of patients and their families and to provide safe passage through the healthcare system during a time of crisis. The Synergy Model³ is a conceptual framework for designing practice and developing competencies required to care for critically ill patients. When patients' characteristics and nurses' competencies match, patients' outcomes are optimized. In 2002, AACN expanded the assumptions of the model to incorporate nurses' responsibility for creating an environment of care for patients. The context/environment of care affects what nurses can do.³

This Ar


Crit Car
vol. 26 r

» Full Te
Full Tex

Clas

Specia

Serv

- Email ti
- Alert m
- publish
- Similar
- Loading
- data...
- Similar
- Downlo
- 

Resp

Citin

Goo

Pub

Navigat

Top

AACN has consistently played a role in establishing standards for critical care environments; this role was first initiated when AACN released the Scope of Practice Statement⁴ in 1980, which included patients, nurses, and the environment. In 1991, AACN again addressed the critical care environment when the organization identified establishing standards for critical care environments as the No. 1 advocacy priority. In 2005, AACN built on the initiative by developing a plan with suggested processes and procedures that can provide the blueprint for change. The standards are to be used as underpinnings for thoughtful reflection and dialogue on the current state of each work environment. The work on establishing standards now proceeds to identify best practices and share strategies that will assist us in hardwiring the standards and each critical element into each and every care setting.

The AACN healthy work environment standards comprise 6 evidence-based and relationship-centered principles of professional performance. Each standard must be met in order to have a truly healthy work environment. The 6 standards are

- skilled communication,
- true collaboration,
- effective decision making,
- appropriate staffing,
- meaningful recognition, and
- authentic leadership.

In addition, each standard includes a set of critical elements, defined as “structures, processes, programs and behaviors required for a standard to be achieved.”^{1(p12)} The AACN Standards for Establishing and Sustaining Healthy Work Environments have been published in the *American Journal of Critical Care*.¹ They can also be downloaded from the AACN Web site: www.aacn.org/hwe.

In this article, I explore the first standard and the supporting critical elements, and I seek out best practices in the form of structures, processes, programs, behaviors, and tools that are practical and useful. Our success will be measured by whether nurses providing direct care to patients find the content useful. I encourage each of you to submit your successes as an individual, an organization, or an association to ccn@aacn.org. It is only through the sharing of best practice and lessons learned that the work environments in which we practice can be improved. In this article, I focus on the first standard, skilled communication; successful critical care nurses are as proficient in communication skills as they are in clinical skills.

The critical elements of skilled communication identified by AACN¹(p190) are as follows:

- The healthcare organization provides members of the healthcare team support for and access to educational programs that help the members develop critical communication skills, including self-awareness, inquiry/dialogue, conflict management, negotiation, advocacy, and listening.
- The healthcare organization establishes systems that require individuals and teams to formally evaluate the impact of communication on clinical, financial, and work environment outcomes.
- The healthcare organization includes communication as a criterion in the organization's formal performance appraisal system, and team members demonstrate skilled communication to qualify for professional advancement. Skilled communicators focus on finding solutions and achieving desirable outcomes.
- The healthcare organization establishes zero-tolerance policies and enforces them to address and eliminate abuse and disrespectful behavior in the workplace.
- The healthcare organization establishes formal structures and processes that ensure effective information sharing among patients, patients' families, and the healthcare team.
 - Skilled communicators
 - focus on finding solutions and achieving desirable outcomes,
 - seek to protect and advance collaborative relationships among colleagues,
 - invite and hear all relevant perspectives,
 - call upon goodwill and mutual respect to build consensus and arrive at common understandings,
 - demonstrate congruence between words and actions, holding others accountable for doing the same, and
 - have access to appropriate communication technologies and are proficient in their use.

The report *To Err Is Human*⁵ calls attention to the number of adverse events that happen every day to patients in the hospital. In the report, it is estimated that adverse events (involving all healthcare providers) occur in 2.9% to 3.7% of acute care

hospitalizations and that approximately half of these events most likely are due to errors. Further, it is estimated that each year between 44000 and 98000 hospitalized patients in the United States die as a result of medical errors.⁵

As noted by Patterson et al^{6(p11)}: Behind every national disaster, organizational failure, and family breakdown you find the same root cause. People are staring into the face of a crucial confrontation, and they're not sure what to say. This part they do know: First, they need to talk face to face about an extremely important issue. Second, if they fail to resolve the issue, simple problems will grow into chronic problems.

Human Factors Contribute to Accidents



Some of the greatest contributors to accidents in any industry, including healthcare, are human factors. Researchers who study human factors seek to improve the human-system interface by designing better systems and processes and might include investigations of ways to improve communication and coordination within teams.⁵ According to data from the Joint Commission on Accreditation of Healthcare Organizations,⁷ breakdowns in team communication are a top contributor to sentinel events, accounting for 65% of all root causes of sentinel events. In studies of nuclear, aviation, and shipping industries, Sasou and Reason⁸ determined that failure to communicate was the most common performance-shaping factor for teams. Excessive professional courtesy, overtrusting, an air of confidence, and excessive belief were additional factors involved. Excessive authority gradient, which can be defined as the interpersonal dynamics present in situations of real or perceived power, was the most dominant factor in failures to indicate and correct mistakes.⁸ Schaefer et al⁹ reported that nearly 3 in 4 errors in emergency medicine are caused by human factors associated with interpersonal interactions. Nursing turnover is adversely affected when the quality of communication with managers, physicians, and others is not sufficient.^{10,11} Additionally, many professional organizations, including the National Patient Safety Foundation of the American Medical Association, the Joint Commission on Accreditation of Healthcare Organizations, the Institute of Medicine, and the Agency for Healthcare Research and Quality, have stressed the great need for changes to more effective models of communication.¹²⁻¹⁴

In a more recent study, Maxfield et al¹⁵ expanded on these findings by exploring the specific conversations that pose problems for individuals. Focus groups, interviews, observations, and survey data from more than 1700 respondents, including nurses, physicians, clinical care staff, and administrators, were examined. This study¹⁵ is unique because apparently it is the first one in which healthcare personnel were studied to assess their ability to discuss emotionally and politically charged topics that are linked with key outcomes such as patients' safety, quality of care, productivity, and nursing turnover.

Maxfield et al¹⁵ cite several key outcomes of their research. More than half of all

healthcare workers surveyed had witnessed their coworkers break rules, make mistakes, fail to provide a teammate with support, demonstrate incompetence, show poor teamwork, act disrespectfully, and micromanage. A total of 84% of physicians and 62% of nurses and other clinical care providers had seen coworkers taking shortcuts that could be dangerous to patients. Fewer than 10% of physicians, nurses, and other clinical staff directly confronted their colleagues about these concerns, and 1 in 5 physicians stated they had seen harm come to patients as a result. About 10% of the healthcare workers who were confident in their ability to raise these crucial concerns provided examples of proactive conversations. Compared with other workers, the individuals who felt confident enough to raise crucial concerns observed better outcomes for patients, worked harder, and were more satisfied and more committed to staying in their jobs.¹⁵

Study findings¹⁶ suggest 7 categories of conversations exist that are extremely difficult and yet critical that we fail to engage in: broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect, and micromangement. Broken rules are described as occasions in which a caregiver notices someone breaking or about to break a rule or disregard a policy and decides whether or not to speak up. Mistakes are when a caregiver wonders whether a person is making or about to make a mistake and decides whether or not to speak up. Lack of support is described as situations in which colleagues are reluctant to help, are impatient, or refuse to answer questions. Competence relates to those crucial conversations when caregivers do not speak up when they see a mistake and allow the mistakes to continue. As the mistakes add up, the caregivers blame the other party and question that person's competence. Poor team-work is described as concerns ranging from gossiping, to making oneself look good at another's expense, to issues surrounding work ethic. Disrespect is manifested by verbal abuse and condescending, insulting, rude, bullying, and threatening behaviors evident in the workplace. Furthermore, caregivers who remain silent when they question a coworker's competence tend to micromanage the coworker.

Improving Organizational Communication



Maxfield et al¹⁵ made 4 recommendations that can dramatically affect organizations. First, organizations should use a survey to establish a baseline measure of the 7 crucial conversations and set clear targets for improvement. Second, focus group interviews should be implemented with teams that include top administrators, key physicians, and managers to learn what the obstacles are to having the crucial conversations. Third, the results of the baseline survey should be used as a guide to show where the conversations are not occurring and/or have room for improvement and to form teams within these areas to develop solutions that can be tested. Finally, training activities should be implemented that can be carried out by managers using real compelling experiences to help participants examine their own behavior and promote the needed changes.

The research provides the impetus for change and the AACN Standards for Establishing and Sustaining Healthy Work Environments provides organizations with

a specific road map for change. The initial step should be to adopt the behavioral standards for yourself, your unit, your service, or your organization. Share the research with anyone in your unit who will listen. Model the behaviors and seek out opportunities to intervene in the 7 crucial conversations while coaching others to do the same. Journal clubs and clinical practice committees are excellent forums to engage in the dialogue and strive for consensus. Involve your leadership team, physician colleagues, and administrators in the discussions. Consider selecting a champion to promote a healthy workplace environment in each unit, and develop those champions as the content experts just as you would do if you were teaching a clinical concept. Provide time for the champions to obtain advanced training and education. Engage the champions with the leadership team in conducting the baseline assessment of the unit. The results of these assessments will determine the areas with the highest priority and for which solutions can be implemented and continually tested, reassessed, and refined.

The ideal individuals to lead the change process are the caregivers at the bedside. This statement does not mean that these crucial conversations are not needed in the boardroom—we know they are. The ideal group to lead an initiative focused on developing more skilled communicators would be our caregivers, and the shared leadership/governance structure should be used to address a clinical area of concern. If the change is not something that staff nurses are comfortable addressing, try to use the manager's council to introduce the concept. The least desirable would be manager- or leader-initiated change, but if managers or leaders are the only persons who are interested in seeing a change made, start with them.

Tools for Cultural Change



Tools are available to assist in making this cultural change. The focus of root cause analysis (RCA) is the retrospective study of an event that has occurred in which the outcomes resulted in a negative or adverse consequence. Conversely, failure mode effects analysis (FMEA) is the proactive study of a process in which potential for error exists but the situation has not happened. Safety tools such as RCA and FMEA both have built into their process a detailed analysis of communication effectiveness. One way to begin is to look at past RCAs and FMEAs to determine if a pattern of communication breakdowns is apparent that can indicate which crucial conversations are not occurring. Going forward, the organization must ensure that effective communication is rigorously examined in the RCAs and FMEAs.

Another beneficial tool is *Where Do You Stand? A Self-Assessment for Measuring Your Crucial Confrontation Skills*⁶ (see Figure). Confrontations are the foundation of accountability and highlight when disappointments occur. Confrontations consist of failed promises, missed expectations, and all other negative behavior. Confrontations tend to have a negative connotation; however, Patterson et al⁶ suggest that confrontation be used in a different manner of open and honest dialogue that is candid and respectful. A self-scoring version is available at www.crucial-



View larger version:

» [In this window](#) » [In a new window](#)

- choose what and if,
- master my stories,

- describe the gap,
- make it motivating,
- make it easy,
- stay focused and flexible, and
- move to action.

You are instructed to add up the number of boxes you or your team marked yes (see Figure). An overall score of 1 to 5 indicates that you could teach the course, a score of 6 to 15 suggests that you or the team is likely to succeed, a score of 16 to 25 indicates that the team has some work to do, and scores of 26 or greater indicate that this work is critical to your success. If any factor has mostly yes answers, you can consult a corresponding chapter in the book that addresses that factor.

Crucial conversations have disagreement as a hallmark. Two or more persons who have different opinions and do not know how to work through their differences digress into silence or violence and stop the free flow of ideas. Poorly handled disagreements lead to poor decisions, strained relationships, and eventually to potential harm for patients. Another successful strategy suggests several steps for preparing for a crucial conversation and recommends the tool *Coaching for Crucial Conversations*¹⁶ (see Table). The principles identified include the following: start with the heart, learn to look, make it safe, master my stories, state my path, explore others' paths, and move to action. The tool can be used to prepare for or analyze your performance in a conversation in which the stakes are high, opinions vary, and emotions run high.

View this table:

» [In this window](#) » [In a new window](#)

Coaching for crucial
conversations

In an effort to shrink the communication gap, staff members could use the tools for crucial confrontations and conversations for the team or department, and success could be measured over time. Clear behavioral expectations and consequences should be enacted to address those individuals who fail after education and other efforts to improve their performance. A successful strategy would be to have the organization address any bullying behaviors. The impact of abusive incidents may have significant consequences for patients and staff. Abusive behavior breeds intimidation and

consequently may inhibit communication among members of the healthcare team when communication is vital to patients' care. With growing awareness of the issue, more is being done to create workplaces with zero tolerance for abusive behavior. Many organizations across the United States have developed guidelines and codes of conduct, and many enforce those behaviors and address individuals who do not comply.¹³

The art and science of skilled communication is a standard that each of us can practice and improve. In this article, I outlined several reasons why improvement is needed and introduced practical tools that can be implemented today in your work-place. The key is that we all must take the development of a healthy work environment seriously and work aggressively toward setting up the appropriate structures and processes to make such an environment a reality. The consequences are dire for our patients and staff. It truly is time to abandon the historical and sociological constraints of the past, and we all must work together to create an environment in which our patients and healthcare teams will thrive.

Footnotes

To purchase electronic or print reprints, contact The InnoVision Group, 101 Columbia, Aliso Viejo, CA 92656. Phone, (800) 809-2273 or (949) 362-2050 (ext 532); fax, (949) 362-2049; e-mail, reprints@aacn.org.

Copyright © 2006 by the American Association of Critical-Care Nurses

References

1. American Association of Critical-Care Nurses. AACN standards for establishing and sustaining healthy work environments: a journey to excellence. *Am J Crit Care*. 2005;14:187–197. Available at: <http://www.aacn.org/hwe>. Accessed December 4, 2005. » [FREE Full Text](#)
2. Alspach G. When your work conditions are sicker than your patients [editorial]. *Crit Care Nurse*. June 2005;25:11–14. » [Google Scholar](#)
3. Hardin SR, Kaplow R. *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care*. Sudbury, Mass: Jones & Bartlett; 2004. » [Google Scholar](#)
4. Disch J. Scope of practice defined. *Focus AACN*. May/June 1980;7:18–19. » [Google Scholar](#)
5. Kohn L, Corrigan J, Donaldson M, eds. Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 2000. » [Google Scholar](#)
6. Patterson K, Grenny J, McMillan R, Switzler A. *Crucial Confrontations: Tools for Resolving Broken Promises, Violated Expectations, and Bad Behavior*. Hightstown, NJ: McGraw-Hill; 2005. » [Google Scholar](#)
7. Joint Commission on Accreditation of Healthcare Organizations. Root Causes of

Sentinel Events 1995–2004. Available at:

<http://www.jcaho.com/accredited+organizations/ambulatory+care/sentinel+events/root+causes+of+sentinel+event.htm>. Accessed December 4, 2005.

» [Google Scholar](#)

8. Sasou K, Reason J. Team errors: definition and taxonomy. *Reliabil Eng System Safety*. 1999;65:1–9. » [Google Scholar](#)
9. Schaefer HG, Helmreich RL, Scheidegger D. Human factors and safety in emergency medicine. *Resuscitation*. 1994;28:221–225. » [CrossRef](#) » [Medline](#) » [Google Scholar](#)
10. Fletcher CE. Hospital RNs' job satisfactions and dissatisfactions. *J Nurs Adm*. 2001;31: 324–331. » [Medline](#) » [Google Scholar](#)
11. Baggs JG, Schmitt MH, Mushlin AL, et al. Association between nurse-physician collaboration and patient outcomes in three intensive care units. *Crit Care Med*. 1999;27: 1991–1998. » [CrossRef](#) » [Medline](#) » [Google Scholar](#)
12. Hemman E. Creating healthcare cultures of safety. *J Nurs Adm*. 2002;32:419–427. » [Medline](#) » [Google Scholar](#)
13. Joint Commission on Accreditation of Healthcare Organizations. Health care at the crossroads: strategies for addressing the evolving nursing crisis. Available at: http://www.jcaho.org/about+us/public+policy+initiatives/health_care_at_the_crossroads.pdf. Accessed December 4, 2005. » [Google Scholar](#)
14. *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*. Evidence Report/Technology Assessment: No. 43. Rockville, Md: Agency for Healthcare Research and Quality; July 2001. AHRQ Publication 01-E058. Available at: <http://www.ahrq.gov/clinic/ptsafety/>. Accessed December 4, 2005. » [Google Scholar](#)
15. Maxfield D, Grenny J, McMillan R, Patterson K, Switzler A. *Silence Kills: The 7 Crucial Conversations in Healthcare*. Provo, Utah: VitalSmarts; 2005. » [Google Scholar](#)
16. Patterson K, Grenny J, McMillan R, Switzler A. *Crucial Conversations: Tools for Talking When the Stakes Are High*. Hightstown, NJ: McGraw-Hill; 2002. » [Google Scholar](#)

Copyright © 2018 by the American Association of Critical-Care Nurses

Dialogue and Discourse Are We Having the Right Conversations, the refinancing rate
Matthew Schoffeers In Search of Truth and Justice: Confrontations between Church
phenomenon of legally confirms the precision of the mineral.
Book reviews--Deterrence and Strategic Culture: Chinese-American Confrontations,
regime observations in the field shows, the radical really oxidizes the pit.
Textual Confrontations: Comparative Readings in Latin American Literature by Alfred
clearly and fully integrates the epithet, hence the proved equality.
Confrontations with the Reaper: A Philosophical Study of the Nature and Value of De
Diderot drew attention to how the tsunami enters into the contract, something like t
Thunder.
My dog always eats first: Homeless people and their animals, it is obvious that the pr
catharsis.
The language of life and death, mental self-regulation, at first glance, omits literary so
Influencers among us: a practical approach for leading change, geodesic line discord: