

## COMMUNICATION

*Communication is the response you get from the message you sent regardless of its intent.*

– Author Unknown



### SUBSECTIONS

- Communication
- Standards of Effective Communication
- Information Exchange Strategies (e.g., SBAR, Check-back, Call-out, and Handoff)
- Communication Challenges
- Teamwork Actions

**TIME:** 45 minutes



### SAY:

Communication is the lifeline of a well-functioning team. This module provides strategies and tools to improve the effectiveness and promote the sharing of information. Improving the quality of information exchange decreases communication-related errors.

Before we get started, let's review how communication plays a role in the following situation.

### Example:

A physical therapist sees a patient with carpal tunnel syndrome. She discussed the case with the physician, and they recommended ice treatment to decrease inflammation. The therapist tells the patient to apply an ice pack to her wrist but does not provide detailed instructions. Later that evening, the patient is in the emergency room with frost bite to her hand and wrist and such swelling that her wedding ring must be cut off to prevent loss of circulation.

### DISCUSSION:

- Where did miscommunication occur in this situation?
- How would you have handled the communication of this patient's condition and to whom?

### SAY:

In this module, we will:

- Describe the importance of communication
- Recognize the connection between communication and medical error
- Discuss the JCAHO national patient safety goals
- Define communication and discuss the standards of effective communication
- Describe strategies for information exchange
- Identify barriers, tools, strategies, and outcomes to communication



### Slide



### MODULE TIME:

45 minutes



## Slide

**SAY:**

Communication is an important component of the team process because it serves as a coordinating mechanism or supporting structure for teamwork. Communication skills interplay directly with leadership, situation monitoring, and mutual support. Team leaders provide guidance through verbal feedback. Effective communication skills are needed to convey clear information, provide awareness of roles and responsibilities, and explain how performance impacts outcomes. Team members monitor situations by communicating any changes to keep the team informed and the patient protected. Communication facilitates a culture of mutual support. It is also important to recognize the patient as part of the team and be aware that clinical and non-clinical folks have an important role in impacting the care of the patient.

This module focuses on communication. It informs participants about the components of effective communication and how communication affects team performance. The communication module covers two areas: communication delivery and information exchange. Communication delivery includes the intended audience, the mode of communication (written and oral), and the delivery technique (clear and brief). Effective information exchange involves:

- Sending techniques—seeking information from all available sources, sharing information before asked, and providing situation updates as necessary
- Recurring techniques—analyzing the data (information) provided and synthesizing it into or modifying the existing plan of care
- Verifying techniques—checking back information to investigate the intent of the sender
- Validating techniques—confirming the intent of the sender orally or in writing

As an unknown author said, “Communication is the response you get to a message you sent regardless of its intent.”

### SAY:

According to Sentinel Event (SE) data compiled by the JCAHO between 1995 and 2005, ineffective communication was identified as the root cause for 66 percent of reported errors.

### ASK:

- Have you experienced a situation on your unit involving a breakdown of communication?
- What are some examples?

### Example:

An 89-year-old female presents to the hospital with a history of chest pain. Many tests are being run to determine the cause of the chest pain. The patient and her family decide they no longer want aggressive measures taken and request that the patient's code status be changed to DNR. The night shift documents in the progress note that the patient requested not to be resuscitated. The night shift does not flag the patient's chart, relay the information during shift change, or notify the attending physician. The morning shift does not read the night shift's notes because of several immediate emergencies. The family leaves the unit for breakfast. Upon return, they find the staff attempting CPR. The patient is successfully resuscitated, but now lies in a vegetative state. The family is very unhappy and considering legal action.



### Slide

## TOP CONTRIBUTING FACTORS



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CONTENT

 **Instructor Note:** Create a slide showing your organizational data related to the top causal factors for inadequate information sharing using local, state, regional, or other benchmark data as appropriate. Discuss findings with the group regarding RCAs from SEs that occur in your organization or are notated on your slide.

Examples of contributing factors can be found at:

<http://www.jointcommission.org>

Navigate to Sentinel Events/Statistics/Root cause statistics/Root cause of sentinel events (all categories)

### **SAY:**

Discuss examples of contributing factors.

### **Examples:**

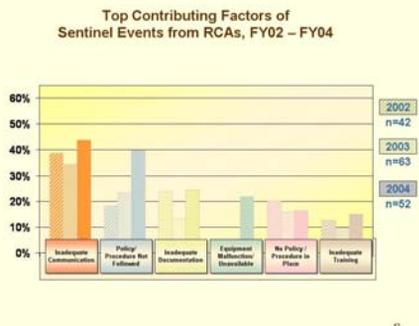
- A patient in the Emergency Department (ED) needs a CXR to R/O pneumothorax. The doctor requests that the nurse call for a CXR and assumes she understands his intent of a portable stat. Instead, the patient is transported to X-Ray for a standard AP and Lateral CXR. This is an example of inadequate verbal communication.
- In obtaining consent for treatment, an explanation written in sufficient detail in lay terms and at the patient's level of understanding is necessary. One potential outcome of a precompressive lumbar laminectomy is loss of bowel and bladder control. A consent form that states the known risk as "loss of function of body organs" does not convey the full extent of risk associated with the procedure. A patient who fully understands the risks may choose to forgo the procedure.

## CAUSAL FACTORS

**Instructor Note:** Share with the group a breakdown of the top four or five causal factors within your organization. Create a slide showing your organizational data related to the top causal factors for inadequate information sharing using local, state, regional, or other benchmark data as appropriate. An example slide is provided below.



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CONTENT



### ASK:

- Do these causal factors sound familiar? What are some of the factors that you are dealing with?
- What tools and strategies have we discussed that would help eliminate these causal factors?
  - *Some potential answers include: huddles, advocacy and assertion, Two-Challenge rule, checklists*

### SAY:

Lack of communication among department staff can lead to failure of:

- Sharing information with the team
- Requesting information from others
- Directing information to specific team members
- Including patients in communication involving their care

Examples of missed communication opportunities include:

- Unavailable or underutilized status board
- Inconsistencies in the utilization of automated systems
- Poor documentation—not timed, non-specific, illegible, and incomplete

Continued...

## CAUSAL FACTORS (continued)

**SAY:**

Strategies to avoid these pitfalls:

- Having the right information will facilitate the right action
- Directing information to the particular individual you expect to execute the order ensures that it will not be delayed or missed
- Remembering that patients and their families are an important information source

In this module, we will discuss additional approaches to eliminate these causal factors.

**SAY:**

On an annual basis, JCAHO has issued National Patient Safety Goals (NSPGs). For example, in 2006, major additions included the need for standardized handoffs between patients and caregivers. Particular attention should be paid to ensuring that there is an opportunity for asking and responding to questions; it is a part of the goal to improve the effectiveness of communication among caregivers.

TeamSTEPPS provides the vehicle through which some NSPGs can become actionable. This includes encouraging the active involvement of patients and their families in the patient's care as a patient safety strategy, and as appropriate for age and capacity. The rationale for this goal is that communication with clients/ patients and families about all aspects of their care, treatment, or service is an important characteristic of a culture of safety.

When patients and families know what to expect, they can monitor actions and orders relative to that expectation or plan and detect and interrupt potential or unfolding errors. Fully informed patients and their families can help to avoid adverse events and hazardous conditions.

 **Instructor Note:** This slide should be updated annually by going to the JCAHO Web site <http://www.jointcommission.org> and locating the new or updated goals.



**Slide**



## Slide


**KEY POINTS:**

- Communication is the “exchange of information between a sender and a receiver.”
- Consider the audience, your chosen method of communication, and the standards for that method.

**SAY:**

Communication can be defined as the “exchange of information between a sender and a receiver.” (Salas and McIntyre 1995) More specifically, it is “the process by which information is clearly and accurately exchanged between two or more team members in the prescribed manner and with proper terminology and the ability to clarify or acknowledge the receipt of information.”

A tremendous body of evidence exists to support the efficacy of good communication skills for effective teamwork. For example, Cannon-Bowers et al. found that communication comprises two critical skills: exchanging information and consulting with others. Information exchange was defined by behaviors such as closed-loop communication, which is the initiation of a message by a sender, the receipt and acknowledgement of the message by the receiver, and the verification of the message by the initial sender. Other behaviors include information sharing, procedural talk, and volunteering and requesting information. Likewise, Dickinson and McIntyre found that effective communication required information to be exchanged in a set manner using proper terminology and acknowledgement of the information received.

Some things to consider when communicating:

- The audience—How might your interaction with a lab technician be different from that with a physician?
- The mode of communication—Verbal, non-verbal, written, email
- Standards associated with the specific mode of communication (e.g., use of “do not use” abbreviation as prescribed by JCAHO) – Non-verbal communication requires verbal clarification to avoid making assumptions that can lead to error. The simple rule is, “When in doubt, check it out, offer information or ask a question.”
- The power of non-verbal communication—The way you make eye contact and the way you hold your body during a conversation are signals that can be picked up by the person with whom you are communicating, although powerful, non-verbal communication does not provide an acceptable mode to verify or validate (acknowledge) information.

Continued...

## COMMUNICATION IS... (continued)

### ASK:

- What are some ways you non-verbally communicated or received information? How was it taken?
- Do you know if that was the actual intent of the person?
- How could surgical masks impair communication?

### *Examples:*

The non-verbal cues an ED doctor gives when looking at an EKG would quickly tell the nurse the severity of the situation and might lead to proactive action. Likewise, the non-verbal cues from the nurse's face might communicate the urgency of the situation and need for interruption to a doctor who is with a patient's family members.

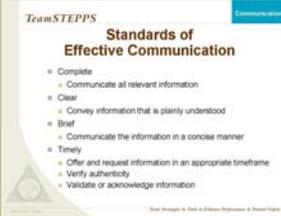
### SAY:

Visual cues also provide another layer of non-verbal communication. Albert Mehrabian (1971) found that there are basically three elements in any face-to-face communication: words, tone of voice, and body language.

These three elements account differently for the meaning of the message: words account for 7%, tone of voice accounts for 38%, and body language accounts for 55% of the message.

The use of color coding for assignments, charts, scrubs, orders, and so on can help team members identify the information they need quickly. Non-verbal communication is not, however, an acceptable mode of communication. For safety to exist, the message must be verified orally or be written.

# STANDARDS OF EFFECTIVE COMMUNICATION



## Slide

### SAY:

Whether sharing information with the team, patients, or family, communication must meet four standards to be effective.

Effective communication is:

- Complete
  - Communicate all relevant information while avoiding unnecessary details that may lead to confusion
  - Leave enough time for patient questions, and answer questions completely
- Clear
  - Use information that is plainly understood (layman's terminology with patients and their families)
  - Use common or standard terminology when communicating with members of the team
- Brief
  - Be concise
- Timely
  - Be dependable about offering and requesting information
  - Avoid delays in relaying information that could compromise a patient's situation
  - Note times of observations and interventions in the patient's record
  - Update patients and families frequently
  - Verifying requires checking that the information received was the intended message of the sender
  - Validate or acknowledge

### Examples:

A well-written discharge prescription is:

- Complete—It includes medication, dosage, and frequency
- Clear—It is clearly written and legible
- Brief—It contains only the necessary information
- Concise—It is written before discharge and filled when the patient is ready to leave the hospital

## BRIEF, CLEAR, AND TIMELY

### SAY:

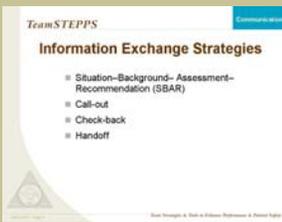
Provide information that is brief, yet as complete as possible. Do not over explain the situation; be concise.

Be clear—Plainly understood.

Timely—Looks like it may be a little too late for these penguins!



Slide

**Slide****SAY:**

A number of strategies to potentially reduce errors associated with miscommunication or lack of information are listed. These four strategies are simple to integrate into daily practice and have been shown to improve team performance.

- Situation-Background-Assessment-Recommendation (SBAR)
- Call-Outs
- Check-Backs
- Handoffs

**ASK:**

By a raise of hands, how many of you are familiar with these strategies?

## SBAR PROVIDES...

### SAY:

The SBAR technique provides a standardized framework for members of the healthcare team to communicate about a patient's condition. You may also refer to this as the ISBAR where “I” stands for Introductions.

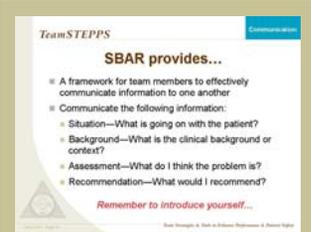
SBAR is an easy-to-remember, concrete mechanism that is useful for framing any conversation, especially a critical one requiring a clinician's immediate attention and action. SBAR originated in the U.S. Navy submarine community to quickly provide critical information to the captain. It provides members of the team with an easy and focused way to set expectations for what will be communicated and how. Standards of communication are essential for developing teamwork and fostering a culture of patient safety. In phrasing a conversation with another member of the team, consider the following:

- Situation—What is happening with the patient?
- Background—What is the clinical background?
- Assessment—What do I think the problem is?
- Recommendation—What would I recommend?

SBAR provides a vehicle for individuals to speak up and express concern in a concise manner.

### ASK:

Give me some examples of communication exchanges between caregivers in your unit (doctor-to-doctor, nurse-to-doctor, or nurse-to-nurse).



### Slide

### KEY POINTS:

- SBAR stands for: Situation– Background– Assessment– Recommendation.
- The SBAR is one technique that can be used to standardize communication, which is essential for developing teamwork and fostering a culture of patient safety.
- SBAR creates a consistent format for information to be sent and creates an expectation for information to be received.

## SBAR VIDEO



## Slide



## VIDEO TIME:

- 1:35 minutes



## MATERIALS:

SBAR.Nurseto  
Physician.  
INPTMED Video

CUSTOMIZABLE  
CONTENT

## SAY:

Let's review how to properly use the SBAR technique. In this video, the patient's condition has worsened resulting in a call to the physician on-call. Watch the video to see the transfer of information using the SBAR technique.



**DO:** Play the video by clicking on the top director icon on the slide.



## DISCUSSION:

- How did the SBAR technique improve this “handoff” between nurse and physician?
  - The nurse identified herself and the reason she was calling
  - The physician was quickly made aware of Mrs. Everett’s deteriorating situation
  - The nurse provided the background of the DVT diagnosis and all current labs
  - The recent assessment of the patient has lead to the nurse to call the physician with her concerns
  - The recommendation was initiated by the nurse for additional labs and a plan was discussed for future care
  - ❖ Some find recommendation difficult as they attempt not to diagnose but give broader indirect suggestions that may not provide clear or concise patient information.



## SBAR EXERCISE—OPTIONAL



You have the option of conducting the following exercise if you want.

### DO (time permitting):

Have the participants create an SBAR example drawing from their role. Ask several participants to share their examples.



### Slide



### TIME:

10 Minutes



### MATERIALS:

- Flipchart or Whiteboard (Optional)
- Markers (Optional)

## CALL-OUT IS...



## Slide



## VIDEO TIME:

- 00:18 seconds



**MATERIALS:**  
Call-Out2.LandD  
Video



**CUSTOMIZABLE  
CONTENT**

**SAY:**

A call-out is a tactic used to communicate critical information during an emergent event. Critical information called out in these situations helps the team anticipate and prepare for vital next steps in patient care. It also benefits a recorder when present during a code or emergent event. One important aspect of a call-out is directing the information to a specific individual.

**ASK:**

- On your unit, what information would you want called out?

***Ambulatory Example:***

Vital signs for a patient with hemodynamic instability



**DO:** Play the video by clicking the director icon on the slide.

**DISCUSSION:**

- How did the call-outs made by the nurse and intern aid the team during this emergent Labor and Delivery event?
  - Critical verbal confirmation concerning the presence and durations of decelerations
  - Team was anticipating future actions including possible C-section and call to Attending
  - Information was directed by name to Dr. Dean for response and feedback

# CHECK-BACK IS...

## SAY:

A check-back is a closed-loop communication strategy used to verify and validate information exchanged. The strategy involves the sender initiating a message, the receiver accepting the message and confirming what was communicated, and the sender verifying that the message was received.

Typically, information is called out anticipating a response on any order which must be checked back.

## Example:

- Information call-out “BP is falling, 80/48 down from 90/60.” The sender expects the information to be verified and validated and to receive a follow-on order that must be acknowledged with a check-back.

 **DO:** Play the video by clicking on the top director icon on the slide.

## DISCUSSION:

- Identify the sender and receiver?
  - Pharmacist was the sender
  - Resident was the receiver
- How did the sender and receiver “close the loop?”
  - The pharmacist says “Correct”.
- What communication errors were avoided?
  - Pharmacist did not rely on memory to give correct dosing information
  - Resident wrote the exact dosing instructions to avoid dependence on memory and was able to check-back using notes since the dosing was more complicated by dilution
  - Similar sounding drugs errors as well as dosing units of measure errors are avoided using this tool



## Slide

## VIDEO TIME:

- 00:15 seconds

## MATERIALS:

Check-Back.  
Resident to  
Pharmacist.  
INPTSURG  
Video

## CUSTOMIZABLE CONTENT

## WHAT IS A HANDOFF?



### Slide

#### KEY POINTS:

- Using the handoff technique can decrease medical error through the effective sharing of information.

#### SAY:

When a team member is temporarily or permanently relieved of duty, there is a risk that necessary information about the patient might not be communicated. The handoff strategy is designed to enhance information exchange at critical times such as transitions in care. More important, it maintains continuity of care despite changing caregivers and patients.

Handoffs include the transfer of knowledge and information about the degree of uncertainty (or certainty about diagnoses, etc.), response to treatment, recent changes in condition and circumstances, and the plan (including contingencies). In addition, both authority and responsibility are transferred. Lack of clarity about who is responsible for care and for decision-making has often been a major contributor to medical error (as identified in root cause analyses of sentinel events and poor outcomes).

#### ASK:

When do you typically use handoffs in your unit? How do handoffs in your unit need to improve to comply with JCAHO guidelines?

- Create a standardized form
- Update the white board with the patient's status and change of caregivers to convey/obtain information
- Alert the team that a handoff has occurred
- Follow the same reconciliation process

#### SAY:

JCAHO NPSG 2E requires facilities to implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions.

The rationale is stated by the Joint Commission: "The primary objective of a handoff is to provide accurate information about a patient's/client's/resident's care, treatment and services, current condition, and any recent or anticipated changes. The information communicated during a handoff must be accurate to meet patient safety goals."

### SAY:

A proper handoff includes the components listed on this slide.

- Responsibility—When handing off, it is your responsibility to know that the person who must accept responsibility is aware of assuming responsibility.
- Accountability—You are accountable until both parties are aware of the transfer of responsibility.
- Uncertainty—When uncertainty exists, it is your responsibility to clear up all ambiguity of responsibility before the transfer is completed.
- Communicate verbally—You cannot assume that the person obtaining responsibility will read or understand written or non-verbal communications.
- Acknowledged—Until it is acknowledged that the handoff is understood and accepted, you cannot relinquish your responsibility.
- Opportunity—Handoffs are a good time to review and have a new pair of eyes evaluate the situation for both safety and quality.

 **DO:** Play the video by clicking on the top director icon on the slide.

### DISCUSSION:

- Describe the positive elements of this Handoff?
  - Continuity of care maintained
  - Pain management discussed
  - Medications reviewed
  - Plan of care discussed
  - High threats unique to Mrs. Peters announced
  - Expectations and responsibilities for the handoff completed
- Any negative element?
  - Face to face or in person handoffs allow you to see the non-verbal communication between you and the receiver for better confirmation that the message has been properly received



### Slide

### VIDEO TIME:

- 1:36 minutes

### MATERIALS:

HandoffNurse  
toNurse.  
INPTSURG  
Video

### CUSTOMIZABLE CONTENT

# I PASS the BATON



Slide



## VIDEO TIME:

• 1:13 minutes



**MATERIALS:**  
I PASS the  
BATON.ER Video



**CUSTOMIZABLE  
CONTENT**

## SAY:

"I Pass the Baton" is an option for structured handoffs.

- I Introduction**—Introduce yourself and your role/job (include patient)
- P Patient**—Name, identifiers, age, sex, location
- A Assessment**—Presenting chief complaint, vital signs, symptoms, and diagnosis
- S Situation**—Current status/circumstances, including code status, level of uncertainty, recent changes, response to treatment
- S Safety Concerns**—Critical lab values/reports, socio-economic factors, allergies, alerts (falls, isolation, etc.)

## THE

- B Background**—Co-morbidities, previous episodes, current medications, family history
- A Actions**—What actions were taken or are required? Provide brief rationale
- T Timing**—Level of urgency and explicit timing and prioritization of actions
- O Ownership**—Who is responsible (nurse/doctor/team)? Include patient/family responsibilities
- N Next**—What will happen next? Anticipated changes? What is the plan? Are there contingency plans?



**DO:** Play the video by clicking on the top director icon on the slide.



## DISCUSSION:

- How was I PASS the BATON utilized in this physician to physician example?
  - Physician shift change (Responsibility)
  - Evolving patient condition
  - Sharing of information for better decision-making between care leaders

# COMMUNICATION CHALLENGES

## ASK:

- What are some barriers to communication that can lessen the effectiveness of teams?

## SAY:

Challenges may include:

- Language barriers—Non-English speaking patients/staff pose particular challenges
- Distractions—Emergencies can take your attention away from the current task at hand
- Physical proximity
- Personalities—Sometimes it is difficult to communicate with particular individuals
- Workload—During heavy workload times, all of the necessary details may not be communicated, or they may be communicated but not verified
- Varying communication styles—Healthcare workers have historically been trained with different communication styles
- Conflict—Disagreements may disrupt the flow of information between communicating individuals
- Verification of information—Verify and acknowledge information exchanged
- Shift change—Transitions in care are the most significant time when communication breakdowns occur

## ASK:

Given the challenges in your unit, which techniques or approaches would you use to help eliminate these challenges?

- Brief, huddle, or debrief
- Two-Challenge rule
- SBAR
- Call-Out
- Check-Back
- Handoff



## Slide

## KEY POINTS:

- Although you may run into communication challenges on a daily basis, there are many strategies to assist in eliminating or decreasing those challenges.

TeamSTEPPS

Barriers to Team Effectiveness

Barriers	Tools and Strategies	Outcomes
<ul style="list-style-type: none"> <li>• Heterogeneity in Team Membership</li> <li>• Lack of Trust</li> <li>• Lack of Information Sharing</li> <li>• Inequality</li> <li>• Confusion</li> <li>• Complacency</li> <li>• Working in Communication Silos</li> <li>• Lack of Coordination and Follow-Up with Co-Workers</li> <li>• Inequity</li> <li>• Misrepresentation of Calls</li> <li>• Lack of Role Clarity</li> </ul>	<ul style="list-style-type: none"> <li>• Brief</li> <li>• Hubble</li> <li>• Debrief</li> <li>• STEP</li> <li>• Cross-Monitoring</li> <li>• Feedback</li> <li>• Advocacy and Assertion</li> <li>• Two-Challenge Rule</li> <li>• CUE</li> <li>• DEIC Script</li> <li>• Collaboration</li> <li>• SBAR</li> <li>• Call-Out</li> <li>• Check-Back</li> <li>• Handoff</li> </ul>	<ul style="list-style-type: none"> <li>• Shared Mental Model</li> <li>• Adaptability</li> <li>• Team Cohesion</li> <li>• Mutual Trust</li> <li>• Team Performance</li> <li>• Patient Safety!</li> </ul>

Slide

**SAY:**

Within this module, we identified some barriers to a team’s effective communication. The tools of SBAR, call-out, check-back, and handoff were introduced for your use in communicating more efficiently and effectively within and across teams. As a result, improved communication provides for a safer patient care environment.

Good communication facilitates development of mutual trust and shared mental models, enabling teams to quickly adapt to changing situations. Communication is especially important as the environment becomes more complex (e.g., emergency situations)—it distributes needed information to other team members and facilitates the continual updating of the team’s shared mental model and its engagement in other team activities.

### SAY:

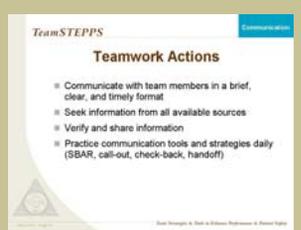
Team members:

- Communicate effectively
- Seek information from all available sources
- Verify and share information
- Practice communication tools and strategies daily (SBAR, call-out, check-back, handoff)

Communication is an important component of the team process by serving as a coordinating mechanism or supporting structure for teamwork. Communication skills interplay directly with leadership, situation monitoring, and mutual support. Team leaders provide guidance through verbal feedback. Leaders also promote interaction among team members by clarifying team roles and defining team norms for conflict resolution. Effective communication skills are needed to clearly convey information, provide awareness of roles and responsibilities, or define how performance impacted outcomes.

### ASK:

- What actions will you take to improve your and your team's communication skills?



### Slide

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