Mindful Communication: A Novel Approach to Improving Delegation and Increasing Patient Safety

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Abstract

The realities of the healthcare environment pose numerous challenges for professional registered nurses in providing quality and safe care. In many models of care nurses increasingly rely on unlicensed assistive personnel as members of the healthcare team. In these models of care, nurses remain accountable for outcomes even though they need to delegate some direct care to the unlicensed personnel. Effective delegation that results in quality and safe outcomes depends on the right communication. Delegation, **safety, and quality of care** are inextricably linked. Communication between the registered nurse (RN) and the unlicensed personnel can be threatened by poor quality information that is untimely or unclear. Under these conditions the care delivered may be inappropriate or missed resulting in adverse outcomes. **Information quality**, mindful communication (**mindfulness**), and mutual trust within the **relational context of the delegation** are explored as mechanisms to improve the quality of the information and communication between RNs and unlicensed personnel, thus improving the effectiveness of the delegation. **Nursing implications** are provided.

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...changes in reimbursement models...healthcare workforce shortage, and a rising case-mix acuity have combined to create the perfect storm...

The Institute of Medicine (IOM), in setting the agenda for quality healthcare in America, has identified fundamental healthcare delivery changes that are needed to improve the quality of care. Processes that improve coordination of care and team effectiveness are at the core of these changes to help achieve care that is safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001). However, changes in reimbursement models with declining reimbursement rates, a current and projected healthcare workforce shortage, and a rising case-mix acuity have combined to create the perfect storm, jeopardizing the delivery of safe and effective care. At the same time that this perfect storm is brewing, the public is calling for greater transparency of healthcare outcomes. Registered nurses (RNs) are the healthcare providers who give the care that positively influences healthcare outcomes (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). The increasing need for professional registered nurses to achieve these outcomes represents a contradictory and competing demand to both increase quality and constrain healthcare costs. One institutional response to the constraints and challenges to provide safe and effective care has been to design alternative models of nursing care that utilize greater numbers of unlicensed personnel.

Regardless of the method of assignment or care delivery system (such as primary or team nursing), most nursing care is delivered within a group practice model where coordination and continuity of care depend on sharing common practice values and establishing communication pathways (Brennan & Anthony, 2000). Within these models of care, the registered nurse is accountable for the delivery of nursing care and patient outcomes. However, care delivered exclusively by professional registered nurses is economically prohibitive. To achieve a cost effective model of care delivery, RNs must depend on, and delegate to the unlicensed assistive personnel (UAP) who assist them in providing direct care (Kleinman & Saccomano, 2006). The RN's ability to delegate effectively is essential for obtaining safe outcomes and quality care.

Delegation consists of a series of competencies that require a complex skill set and are guided by professional principles. Delegation is the "transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome" (American Nurses Association [ANA], 2005, p.4). Delegation is a decision making process. The ANA and the National Council for State Boards of Nursing [NCSBN] (2006) have issued a joint statement explicating the delegation process to aid the registered nurse in assigning the right task, to the right person, at the right time, with the right directions and communication, and the right supervision and evaluation. The literature is replete with anecdotal narratives of delegation, delegation practices, and nurses' skill in delegation that is guided by these 'rights' of delegation. There is less, but consistent, empirical evidence to explain the link between the five rights of delegation and quality outcomes, particularly in regard to the 'right communication' (Anthony, Standing, & Hertz, 2000; Anthony, Standing, & Hertz, 2001; Standing & Anthony, 2008) and the relational aspects intrinsic to the delegation process (Barter, McLaughlin, & Thomas, 1997; Orne, Garland, O'Hara, Perfetto, & Stielau, 1998; Potter & Grant, 2004; Standing & Anthony, 2008).

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Over the past several decades, our understanding of the structure and practices of delegation has increased. Despite this evolutionary understanding, the issues related to inadequate delegation in clinical practice have not been resolved. With the current healthcare emphasis on safety and quality, exploring delegation from the perspective that successful (or unsuccessful) delegation influences quality and safety outcomes is of unprecedented importance. Thus, the purpose of this article is to explore how the 'right communication' provides an explanatory framework for effective delegation by describing how information quality, mindful communication, and environmental and relational contextual factors, singly and in combination, may directly and indirectly impact safety and quality of care. The article provides rationale for the conceptual basis for linkages among safety, information quality, mindful communication, and contextual influences and illustrates these linkages with examples discussed in the educational classes on delegation taught by one of the authors (KV). We begin by providing an overview of the relationship between safety and the quality of care. Next we discuss information quality, mindfulness, and the relational context of delegation. We conclude by reviewing the nursing implications of appropriate delegation for safe care.

Safety and Quality of Care

Safety is foundational to quality care (Aspden, Corrigan, Wolcott, & Erikson, 2004). Safe delegation depends on appropriate planning and execution of the delegated task (Standing & Anthony, 2008). While nurses may delegate the tasks of direct care, they remain accountable and responsible for the outcomes. Failures in either planning (plan is not adequate) or execution (actions don't go as intended) may result in errors that threaten safety and quality (Reason, 1990). If delegation is ineffective, subsequent care can be inappropriate or missed resulting in poor outcomes (Kalish, 2006).

Two recent healthcare trends illustrate the inextricable linkages among delegation, safety, and quality. The first trend represents the financial reality where decreased reimbursement is increasingly tied to less than optimal outcomes. Hospitals no longer are being reimbursed by Medicare for unfavorable outcome conditions that are deemed preventable. Of the ten conditions identified by the Inpatient Prospective Payment System

Fiscal Year 2009 Final Rule (Centers for Medicare & Medicaid Services, 2008) as being avoidable, five can be regarded as being influenced by the effectiveness of delegation practices. These outcome conditions include catheter-associated urinary tract infection, stage III or IV pressure ulcers, manifestations of poor glycemic control, deep vein thrombosis/pulmonary embolism, and falls. Activities such as turning, ambulating, personal care, and blood sugar checks are typically delegated practices. When these care activities are missed, either delayed or omitted, the probability of untoward and costly outcomes increases (Kalish, Landstrom, & Hinshaw, 2009). For example, if turning and/or ambulating is missed, the likelihood of developing a pressure ulcer increases as does the likelihood of developing a deep vein thrombosis, both of which reduce the quality of care and reimbursement.

The second trend linking delegation, safety, and quality is the increase in mandated public reporting of hospital performance, which is now required by a number of states (see Ohio Hospital Compare, 2009). Public reports of outcome conditions also reflect nurses' contributions to outcomes and are sensitive to delegation practices. With hospital reimbursement contingent on outcomes and easily obtainable public performance reports, missed care, which might otherwise have remained unknown, becomes public information. Registered nurses have public accountability for providing safe care (ANA, 2005); this accountability is becoming increasingly scrutinized as consumers ask more questions. More than ever, the challenge for nurses in their daily practice is to view safety as a focus of all actions and not a byproduct of care (Gaba, 2000). Weaving the fabric of safety into all nursing practice, including that of delegation, is essential.

Information Quality

There has been little written that describes how information quality and communication during delegation can impact safety. Yet information is critical to providing safe care (Aspden et al., 2004). Of the five rights of delegation, the 'right communication and direction' is the cornerstone of delegation and may arguably be the most instrumental in shaping quality and safety outcomes. The 'right communication and direction' is defined by the NCSBN (2005) as communication that clearly and concisely describes the delegated task and that includes how the task is to be done and the timing and nature of observations to be made. Although this definition provides guidance for communication, it does not address the nature of information quality which is a necessary precursor for good communication. The 'right communication' in the delegation process can be threatened by the information itself and the context in which it occurs. Specifically, when the nature of the information between the RN and the UAP is not communicated in a timely way or the meaning of the information is uncertain, the likelihood of information not being passed on to other care providers increases (Anthony & Preuss, 2002; Preuss, 1998). Subsequent care can be inappropriate, missed, or delayed resulting in poor outcomes.

> Communication between the RN-UAP dyad in providing direct care is a key factor in patient safety.

Communication between the RN-UAP dyad in providing direct care is a key factor in patient safety. Poor quality communication leads to poor quality information resulting in poor outcomes. Review of the literature suggests that delegation issues and the tasks that are delegated have not changed much over the years (Crawley, Marshall, & Till, 1993; Krapohl & Larson, 1996; Orne et al., 1998; Parsons, 2004; Salmond, 1995; Standing, Anthony, & Hertz, 2001). However, the context and work environment in which these tasks occur have changed dramatically.

Over the past several decades, the hospital work environment has become more chaotic and uncertain. Uncertainty in the work place is a combination of nurses' increasingly complex work and the unstable environments in which this work occurs (Daft, 2004). Complexity arises from the nurses having to integrate and make sense of events and interactions among teams of people and unfamiliar patterns (Ebright, Carter Kooken, Moody, & Latiff Hassan AL-Ishaq, 2006). As nurses struggle to make these connections, they are continually faced with multiple demands that increase work complexity and threaten breakdowns in

communication and communication processes (Ebright, 2003). Instability, on the other hand, has to do with rapidly changing patient conditions that may be either subtle or dramatic (Daft, 2004). The degree of uncertainty in nurses' work is linearly related to the amount of information available for decision making. Insufficient information about patients or the environment of care hinders the provider's ability to predict causally related conclusions. When the probabilities of various alternatives are difficult to ascertain, missed or delayed care occurs, elevating the risk of poor outcomes. When the RN, who maintains the responsibility for outcomes, has a deeper understanding of information quality and the environmental, contextual influences that occur during delegation, the adverse impact of uncertainty on quality and safety outcomes is minimized.

The quality of information needed for the 'right communication' to guide care decisions is determined by two related characteristics: one is information decay and the other is information saliency (Anthony & Preuss, 2002). In a highly complex and unstable environment, such as healthcare, where patient conditions change rapidly, information can lose its value and decay quickly. When information decays, it is no longer relevant to the situation (Anthony & Preuss, 2002; Preuss, 1998) and can result in poor decision making. In the delegation process, frequent communication between the RN and UAP is essential for monitoring whether the existing information is current. When new information arises but is not passed on, decision making that is based on old or incomplete information is more likely to result in adverse events.

The second characteristic of communication is the salience of the information, i.e., whether or not the meaning and the importance of the information is clear (Anthony & Preuss, 2002; Preuss, 1998). "When the information can be interpreted in more than one way, the clarity of its importance will not be self-evident…. and may only make sense in the context of other knowledge about the patient" (Anthony & Preuss, 2002, p. 211). UAPs and RNs come from diverse cultural, educational, and experiential backgrounds that shape the meaning of information (Dreachslin, Hunt, & Sprainer, 2000). In the delegation process, the UAP may have difficulty in differentiating what is meaningful information (Barter, et al., 1997). Therefore, the 'right communication' must include sharing the information in a way that the salience of it is known to both the nurse and the unlicensed personnel at the time the activity is delegated. If at the time of delegation, the meaning of the information is not clearly communicated, such that it could be interpreted in several ways, the delegation process is more likely to break down resulting in poor outcomes.

In the following example, the meaning of information between the RN and UAP is not clearly communicated and results in delayed care. The nurse observes that a patient is lethargic and represents a change from an earlier assessment. The RN, after obtaining the vital signs and preparing to notify the physician, asks the UAP to obtain a blood sugar. The RN is thinking the patient may be hypoglycemic, but does not express the rational for this blood sugar level check to the UAP. The UAP checks the time and notes that there is only 20 minutes until he/she needs to begin checking the blood sugar of all assigned patients before lunch. The UAP decides to add this patient to the list of routine blood sugar checks. A few minutes later the nurse requests the results from the blood sugar check, but it is unavailable. If the nurse would have communicated the meaning and urgency of the request and included a timeframe for completion, the UAP would have known a-priori the meaning of the request and the information would have been available for decision making. Instead, one of two situations may result. The first might be delayed physician notification that postpones treatment. The second might be that the conversation with the physician does not include the result of the blood sugar test, another situation that might result in missed or inappropriate care.

Delegation, by its very nature, has much to do with information sharing about the task and the context in which the task takes place. Information to guide decisions is handed off from one person to another and then back again. As the nurse provides information to the UAP and the UAP provides feedback to the RN, the flow of information is reciprocally interdependent. In each of these interactions, there is a hand-off of information, and a progressive loss of information can occur if certain information is not conveyed. If the value of the information is no longer timely or its meaning is unknown, the chance for losing information increases (Anthony & Preuss, 2002). One strategy to lessen the potential for information loss is feedback from the delegated activity. Bidirectional RN and UAP feedback is a critical to delegation. It deters the

negative consequences of lost information by minimizing information decay and optimizing information salience. In the absence of feedback, the downward spiral is set into motion. If the information is forgotten, missed, or not conveyed, the information is lost for future decision making, leading to the missing of essential care, increasing errors, and/or jeopardizing patient safety (Kalish et al., 2009).

The following example illustrates how delayed feedback results in lost information with safety repercussions. Consider this example of skin care and the importance of timely intervention. An UAP is assigned to bathe a patient who, thus far, has had no evidence of skin breakdown. While doing the bath the UAP notices redness, particularly on the bony prominences. The UAP knows this is something that should be reported to the RN. Although the UAP makes a mental note to tell the nurse who has delegated the care about the reddened areas, the UAP observes the patient is up and ambulating during the day and does not perceive an urgency to report. It is quite possible the UAP and the nurse could be working together for hours, yet not communicate regarding the reddened skin until the change of shift, in which case an early opportunity to begin an intervention to prevent further breakdown would be delayed. This change of shift reporting decreases the chance that the nurse will intervene immediately but instead is likely to pass on this message verbally to next nurse, who will assess and intervene when that nurse begins his/her care. In this situation the time delay from information acquisition to intervention is delayed, increasing the risk of additional tissue injury leading to skin breakdown. In situations where information is not passed on in a timely manner, the impact of missed care may not be apparent until after discharge and thus not known to the nurse (Kalish, 2006).

Balancing the benefits of standardized policies with the need for adaptability is new to healthcare.

In healthcare, and specifically in nursing practice, we have a long tradition of using standardization to improve efficiencies by decreasing variation. Delegation practices have not changed much over the years and delegating tasks that are routine and standard remains commonplace (Marthaler & Huber, 2010). Institutional policies that provide guidance around delegation practices continue to be developed. However, when policies become prescriptive, an unintended consequence of a policy may be an automatic communication that inadvertently leads to a mindless approach to carrying out the policy (Burgoon, Berger, & Waldron, 2000; Krieger, 2005). This is because policies promote a routine way of interpreting information and behaving that limits opportunities for action and thus fosters an inclination toward a single-minded outcome (Hoy, Gage, & Tarter, 2006; Krieger, 2005). Yet the healthcare environment is complex, unstable, and uncertain; and these are all conditions that require flexibility, openness, and adaptation. Balancing the benefits of standardized policies with the need for adaptability is new to healthcare.

In a recent Robert Wood Johnson report on transforming patient care (2009), one Midwestern hospital purged 40% of its policies to allow their nursing patient care providers to respond with more freedom and creativity to a changing census and changing patient needs by exercising their clinical judgment (Robert Wood Johnson, 2009). Characteristic of fluid and dynamic conditions necessitate the continuous shifting of workload demands that place heavy information loads on nurses' cognitive abilities and requires them to 'stack,' in a given order, care information they will act on later (Ebright, Patterson, Chalko, & Render, 2003). Ebright (2009) has conceptualized stacking as a cognitive, decision-making process that occurs as a result of changing demands and continuous reprioritization for nursing care. Effective stacking requires nurses to be mindful and able to make sense of situations about the flow of work amidst changing situations (Ebright, 2009). As work becomes increasingly complex and chaotic, RNs must continuously redefine their 'stack' of work to be done (Ebright, 2009).

Managing ongoing stacking has implications for delegation through its relationship to RN-UAP communication and information-sharing practices. If stacking is insensitive to changing situations, the amount and type of information that is recalled and shared can be limited (Stasser & Titus, 1987) and is more likely to increase information decay, salience, and loss. In complex environments, revisiting delegation in light of what is routine and standard practice in juxtaposition with the 'right communication' is warranted.

The recent emphasis on healthcare safety has refocused discussions from that of standardized care to that of 'mindful communication' as a strategy to improve safety and quality outcomes. In delegation, the right communication is mindful communication.

Mindfulness

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Mindfulness is a state in which there is keen awareness of the situation; it is being 'in the moment,' and a way of directing or focusing attention of everyday tasks to the present moment (Baer, Smith, & Allen, 2004). Mindfulness stems from traditions in Eastern meditation and has been studied and practiced in Western cultural contexts, often from the perspective of intervention practices in medical and mental health settings, to address a broad range of issues (Baer et al., 2004). For instance, mindfulness serves as the foundational principle in a widely used, structured, stress-reduction-therapy package that combines mindful meditation with yoga to reduce stress, depression, and anxiety (Praissman, 2008). In addition to its use as a clinical intervention, mindfulness has been studied in a variety of communication contexts; however, its development from an interpersonal-interactions perspective that resides within a safety framework in organizations is limited (Krieger, 2005; Weick, Sutcliffe, & Obstfeld, 1999/2008).

In mindful communication, the interaction among those who are engaged in the communication process focuses on attending to, responding to, and perceiving information (Krieger, 2005). It is an active process where information is continually updated and evaluated. In mindful communication, being present to the timing, nature, and context shapes information sense making (Krieger, 2005; Langer, 1997). In information-rich environments, such as hospitals, mindful communication is not related to the amount of information but to the attention that is allocated to the meaning of the information (Hansen & Hass, 2001). Mindful communication implies that the information is processed and communicated in a mindful way. Langer (1989, 1997) has asserted that mindfulness is related to a state of alertness and active awareness of everyday tasks that changes how information is processed. Thus, in mindful communication information is continually analyzed and categorized; it allows for dynamic and transparent information processing, distinctions that allow for new interpretations to emerge and an awareness of multiple perspectives (Langer).

When mindful communication is integrated as a principle of delegation, it involves more than knowing the facts regarding the care plan. Mindful communication practice is recognizing the significance of the facts and how they pertain to the patient situation. When nurses engage in mindful communication, information processing is redirected, resulting in a unique set of decisions and actions. Historically, RNs have relied on job descriptions and delegated skills lists to guide delegation practices. As noted above, hospitals value standardization as a means to improve safety through consistent practices. Paradoxically, however, overreliance on standards that results in routine interpretations and behaviors may jeopardize patient safety when nurses do not engage in mindful communication about the task at hand.

To illustrate the potential disconnect between standardization and mindful communication, consider the following example of nurses routinely assigning care tasks to an unlicensed personnel without being alert to and aware of the current situation. It is common and standard to delegate the task of obtaining a blood sugar level to a UAP. A nurse delegates this task on all diabetic patients, not thinking about the patient newly diagnosed with diabetes who requires teaching and skill mastery for checking his/her own blood sugar. A nurse practicing with a mindful approach would be more aware of and alert to this situation, knowing the importance of the information needed by the patient. Processing the information that the patient is newly diagnosed would afford the nurse the opportunity to develop a unique set of decisions and actions that would best prepare the patient for self-care by the time of discharge.

A nurse practicing mindfulness while doing diabetic teaching would be aware of all the variations the patient will experience when going home. Continuing with this illustration, the nurse will make sure that the patient knows there are different sizes of syringes and the reason why a specific size syringe was chosen. The nurse will recognize that in the home environment the handling of used syringes is different. Because the patient at home will no longer have a convenient needle box on the wall, the nurse and patient will have to think through syringe and needle handling in the patient's unique home environment. They will need to address the following questions during the diabetic teaching process:

- Does the patient live in a household with children or pets where syringes will need to be secured?
- Does the patient's occupation require travel and what are the implications of traveling on checking and monitoring blood sugar?
- Is the patient terrified of needles but hesitant to speak up and explain this inability to self-administer the injections due to fear or else to a physical limitation, such as poor eyesight.

A nurse not practicing mindfully will only assure that the patient can perform the injection technique and will not consider all the factors a given patient will face at home so as to ensure quality and safety of management. Additionally, the UAP who understands the importance of considering the patient's perspective will be able to make more sense of the patient's responses and behavior and recognize the importance of sharing salient patient comments with the RN. In contrast, delegation of ritualized tasks, where information is 'just passed on' raises the risks for unfavorable outcomes.

Mindfulness is an antecedent to the kind of quality of information that positively links to patient safety.

Mindfulness is an antecedent to the kind of quality of information that positively links to patient safety. If a RN delegates a task but fails to explain the rationale (salience) behind the delegated task or the outcome expected, the unlicensed personnel may not share the same mental model that shapes the outcomes of delegation. In this case the degree of mindfulness assumed by the unlicensed personnel may vastly differ from that of the RN. When shared mindfulness is incorporated into the delegation process, the RN and UAP jointly attend to, respond to, and perceive information correctly (Krieger, 2005). As a result, the shared and mutually understood information improves the information quality to plan and execute nursing care and thus increases the potential for improved outcomes.

The following example illustrates the link between mindfulness and communication quality. A nurse assumes responsibility for care of a patient who is actively dying. Knowing that frequent turning of the patient aids in respiratory comfort, the nurse asks the UAP to turn the patient every two hours. The UAP considers the request based on personal knowledge and experience of what is 'usual.' Frequent turning is most often associated with decreasing the chance of skin breakdown. The UAP makes a decision not to turn the patient believing that at this point comfort is more important than preventing skin breakdown. The intent of the turning request was neither transparent nor congruent between the RN and UAP; thus the communication was not mindful. While each was individually mindful of the situation, the interpersonal interaction, where information was shared and sought, did not result in a mutual state of mindfulness, thus leading to decisional errors and poorer outcomes (Krieger, 2005).

Relational Context of Delegation

At the heart of the effectiveness of delegation is the interpersonal relationship between the RN and UAP (ANA, 2005; Barter et al., 1997; Orne et al., 1998; Potter & Grant, 2004; Standing & Anthony, 2008). Relationships have an important role in providing safe care by improving coordination, collaboration, and communication (Reina, Reina, Rushton, & Hylton, 2007). Foundational to a good relationship is trust (Reina et al., 2007), a key dimension of the delegation relationship (Quallich, 2005; Standing & Anthony, 2008). Trust is related to attitudes, behaviors, and importantly, the degree of information that is shared (McNeish & Mann, 2010; Robert, Dennis, & Hung, 2009). It is the willingness to be vulnerable (or to rely on) to another

with the expectations that the other will act in a certain way that is not detrimental. Trust occurs under conditions of uncertainty and interdependence with an expectation that an action will be performed (Mayer, Davis, & Schoorman, 1995; Rousseau, Sitkin, Burt, & Camerer, 1998). RNs and UAPs work side by side in environments of high uncertainty. By virtue of their common goal to accomplish quality and safe patient care, they have a dynamic and reciprocal interdependence on each other. Communication depends on trust (Reina et al., 2007), and RNs and UAPs depend on each other for communication that is accurate, timely, and meaningful.

...a delegation relationship that is built on trust is a proactive strategy to improve safety...

Mutual trust, such as that in the delegation relationship, evolves and is strengthened over time and occurs as a result of day-to-day shared experiences (McNeish & Mann, 2010). As trust increases, so does the frequency of communication, the amount of information, and the richness of information that is shared (Abrams, Cross, Lesser, & Levin, 2003; McNeish & Mann, 2010). Stasser & Titus (1985; 1987) have contended that once information is shared, it is more likely the sharing will be repeated. Extending this assumption to delegation, in the presence of a trust relationship, more information will be shared within and across multiple RNs and UAPs and thus less information will be lost. The utility of information sharing resides in the active awareness of the meaning of information that is derived through open dialogue. In a trusting relationship, there is a reciprocal relationship between trust and mindfulness, such that trust is necessary for mindfulness and mindfulness reinforces trust (Hoy, Gage, & Tarter, 2006). Both require openness, honesty, and awareness.

Information communicated within the RN and UAP relationship can be one of several types. Information that is objective and discrete, such as the value of a blood test, is easily retrievable in the medical record and therefore may not be particularly influenced by trust. On the other hand, information that is tacit or learned through personal experiences with the patient is information that is more sensitive to the trust relationship. Sharing tacit information relies on mutual trust and influences the timely transmission, meaning, and importance for future decision making (Kang, Kim, & Chang, 2008). Therefore a delegation relationship that is built on trust is a proactive strategy to improve safety because the information itself and the conditions under which it is communicated leads to greater clarity for planning for care. In a trusting relationship timely and meaningful patient information is more likely to be shared and less likely to be lost or not communicated. Care is mindfully planned, and missed care is avoided. When RNs and UAPs have a positive and trusting relationship, they rely on each other, and become interpersonally mindful of information that is most likely to result in a scenario that benefits the patient.

Nursing Implications

Delegation is here to stay.

Delegation is here to stay. As the healthcare system becomes more sensitive to cost escalation, there will be a greater number of unlicensed personnel providing direct care. At the same time, accountability for outcomes will continue to lie with the professional, registered nurse. Outcomes are dependent on having the 'right communication' which transforms care. Right communication depends on having information that lends itself to safe outcomes. Communication pitfalls that exaggerate information decay, and also salience and information loss, set up a negative cascade in which poor information quality leads to ineffective delegation and contributes to missed care and poorer safety outcomes. This article has explored, in a new way, how mindfulness and trusting relationships address the barriers to poor information quality and communication and create conditions for the 'right communication' within the delegation process.

The covenant of safe care between patients and nurses can only be maintained when nurses practice mindful awareness of the saliency and time-sensitive nature of the information they are responsible for managing and communicating. The nurse is uniquely positioned to assess the ever-changing, often

overwhelming amount of information bombarding the patient care experience. The registered nurse's ability to filter, stack, and communicate this information hinges on knowledge, experience, and a mindful presence.

The nurse is uniquely positioned to assess the ever-changing, often overwhelming amount of information bombarding the patient care experience. The challenge to improve patient safety and outcomes has mandated providers, educators, administrators, and researchers to a closer look at the structure and processes of care delivery. Mindful communication embedded in the framework of safety, and delegation offers us an opportunity to critique our existing beliefs and practices. Breaking blind reliance on standardized practice and educating nurses to act based on professional judgment with an acute mindfulness of the situation will ultimately result in a safer environment that is unique to each patient. Mindful communication as a safety practice is relatively unexplored in healthcare, and specifically nursing. Refinement of this concept is needed as is a 'peeling the onion' approach to develop and refine its theoretical and empirical foundation. As safety is a fundamental societal contract, mindful communication is a fundamental part of the fabric of professional nursing practice.

Delegation is integral not only to patient care but also to safe patient care. Chaotic environments are fertile ground for error that is grounded in poor information. Navigating the complex and uncertain healthcare environments that exist today requires high quality information. Developing cultures that support active awareness and value seeing information from new perspectives is the antithesis to a culture that values automated actions and undermines effectiveness. When RNs and UAPs have a trusting relationship, and enter into shared mindful communication as a necessary condition for delegation, there is a higher quality of work with less chance for unintended consequences. As nurse learn and practice the skills of delegation, they develop a fuller understanding the 'right communication' and the context in which it occurs, an understanding that is critical to safe outcomes.

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