Role of communication and teamwork in improving patient safety - literature revie...

Sociology, Communication

Improving patient safety

A myriad of studies have identified lack of teamwork and communication breakdowns within the process of care provision as the major causes of critical/sentinel incidents and even loss of life that is otherwise preventable. A meta-analytic review of 11 such studies established that of the 2, 677 critical incidents reported in the various studies, 49% had occurred due to poor non-technical skills; 20% of these were attributed to poor communication and teamwork. Lack of communication regarding initiation of new therapies and failure to effectively communicate a patient’s priorities to other members of the health care team were among the many instances of communication breakdowns cited in the study (Nemeth 2008, p. 120). In light of the pervasiveness of these happenings, it is imperative that this paper adequately addresses the topic on the role of teamwork and communication in improving patient safety.

Objectives

The aim of this literature review is to evaluate the role of team work and communication in improving patient safety.

Discussion

A team refers to a group of people working together towards achieving a common purpose for which they hold themselves jointly responsible (Joint Commission Resources 2008, p. 2). Characteristics of effective teams include a shared purpose, well articulated performance goals, a common approach, joint accountability and complementary skills.

A study by the Joint Commission Resources (2002 as cited in Joint Commission Resources 2008, p. 2) attributed medical errors to individualized decision making and performance of tasks amongst health care professionals. In their report, they cited that 30% of the medical errors identified in the study would have been preventable if the members of the health care team had simply checked on what the other was doing. Subsequent studies have accentuated on the fact that teamwork fosters the cross-monitoring of each other's tasks (Joint Commission Resources 2008, p. 2). Considering the fact that individual members of health care teams are tasked with making vital decisions and partaking in actions that significantly impact on the well-being of the patient, the cross-monitoring of functions associated with teamwork becomes an essential tool for the maintenance and continuous improvement of patient safety.

An array of studies has focused on the aspect of shared responsibility characteristic of effective teams. Findings from these studies indicate that by fostering a shared sense of responsibility in the provision of health care, teamwork greatly contributes to the improvement of patient safety (Carayon 2007, p. 265). A shared sense of responsibility implies that members in the team have to be cognizant of and be committed to working together to achieve the team goals and each member holds himself/herself as being jointly responsible for the team's results. Consequently, individual members of a team will focus their energies on the realization of the same goal which in this case is improving the safety of patients (Cosby et al. 2009, pp. 157-158).

Facilitating the development of coherent work practices as well as integrated

patterns of behaviors among the team members that promote effective task performance is another function of teamwork in improving patient safety that was identified by the Joint Commission Resources (2002) study. Coherent work practices and integrated behavior patterns are achieved through the creation of awareness among all the team members of the overall mission and goals of the team as well as clear understanding of the individual roles and responsibilities of other team members. Conversely, members of the team are able to anticipate and therefore complement each other's individual roles with the outcomes manifesting in improved patient safety and subsequently improved patient outcomes (Cosby et al. 2009, pp. 157-158).

Evidence from research findings shows that effective and efficient communication among members of health care teams as well as between health care providers and patients significantly reduces medical errors and hence promotes patient safety (Stebbing et al, 2007 cited in Scharfstein et al. 2009, p. 418). By facilitating the timely reliance of information to the concerned health care provider, for example to a physician in case of an emergency communication greatly enhances patient safety by ensuring that the patients needs are attended to in a timely manner (Kleinman 2007, p. 177).

Another role of communication in improving patient safety identified in various studies is to facilitate the efficient transfer of knowledge, authority and responsibility during hand-offs and delegation of tasks. By preventing communication breakdowns that are often characteristic of transitions in care, effective communication ensures that incoming health care providers

have adequate information on the condition of the patients they are to attend to at the time of the transition as well as the plans and expectations for these patients. The latter aspect has in particular been shown in an array of studies to dramatically decrease the number of medical errors associated sentinel events that more than often have catastrophic effects on patients. Strategies that standardize communication during delegation have particularly been found effective in reducing communication breakdowns (Pillow 2007, p. 7).

Teamwork has also been shown to enhance communication between team members. With poor communication being one of the frequent causes for medical errors, improved communication between team members has a mitigating effect on the frequency of adverse effects that result from communication breakdowns (Joint Commission Resources and Smith 2005, p. 87).

Teamwork and improved communication are amongst the measures that have been recommended as effective in engendering a culture of safety within health care settings. Team members in these organizations are committed to promoting excellence in performance and hence work together to dramatically decrease medical errors. By holding themselves jointly accountable for patient safety, team members work synergistically to promote excellence in the performance of duty (Joint Commission Resources 2008, p. 1).

However, despite the previous evidence-based findings, a gap of knowledge still exists because these studies focused on all types of teams. To be more congruent with the types of teams found within the health care settings,

further research focusing on the role of teamwork and communication in improving patient safety within the contexts of both dynamic and static teams found in health care settings needs to be done.

A major weakness in majority of these studies is their reliance on description as opposed to the use of statistical measures like correlation analysis that would have enabled the comparison of the impact of teamwork and communication, for example by comparing the number of sentinel events that occurred before and after teamwork and communication had been implemented. Multiple regressions would also have been useful to remove the effects of any confounding factors like the experience of the health care worker that would have significantly influenced the patient safety.

In conclusion therefore, the roles of teamwork and communication in improving patient safety include promoting a culture of safety, engendering a sense of shared responsibility, facilitating the development of coherent work practices and integrated patterns of behaviors among team members. In addition, they foster the timely reliance of information to the relevant team members and efficient transitions of care during hand-offs to incoming health care staff. Moreover, teamwork enhances communication between members of the team and hence mitigates medical errors resulting from communication breakdown. However, a gap of knowledge exists because these findings are not fine-tuned to either the dynamic or static kinds of groups that are found within health care settings. Moreover, more reliable statistical measures need to be utilized in the assessment of the impact of communication and teamwork on patient safety.

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