Patient safety - the impact of communication in nursing

Throughout this essay I am going to look at how team communication and collaboration are key factors in patient safety. I shall look at the factors that lead to communication failure. I am going to critically analyse how communication tools can impact on patient safety and look at the benefits and barriers and the challenges that arise from the implementation of these tools can be overcome. I shall look at the challenges I've discussed and with reference to experiences from my own clinical practice discuss how the communication tools I have used in practice affected patient safety.

Providing safe patient care is a challenge in today's health care environment. Even with the many advances in technology basic, effective, interpersonal communicationInterpersonal communication is the process of sending and receiving information between two or more people. Types of Interpersonal Communication

This kind of communication is subdivided into dyadic communication, Public speaking, and small-group communication.

….. Click the link for more information. remains essential to the provision of safe patient care, (Friesen, 2007). Communication failures have been cited as the leading cause of inadvertent patient harm. Communication failures include issues such as insufficient information, faulty exchanges of existing information, ambiguous and unclear information and lack of timely and effective exchange of patient information. Increasing recognition of these issues has made improving teamwork and communication a priority for advancing patient safety and quality of care. Effective interaction between team members has been associated with greater efficiency and decreased

workloads, improved clinical outcomes, reduced adverse drug events, reduced patient morbidity, improved job satisfaction and improved patient satisfaction, (Velji & Baker, 2008).

It is well recognised that the increased perception and complexity of patients' needs in a busy surgical or medical ward presents challenges for both nursing and medical staff. The National Patient Safety Agency (2007) suggested that effective communication is a key factor in improving clinical practice and patient outcome. Hospitals consist of multiple complex systems that rely on rules, contingencies, expectations and multiple inter-professional communications for patient care. Within these complex care delivery systems, nursing plays a primary role in ensuring patient safety. Effective communication amongst healthcare providers is crucial for ensuring that patients receive safe, high-quality care. However, within most healthcare settings, effective communication is hampered by a number of barriers Discussions about patients are often conducted within a busy work environment in which providers are dealing with many patients and numerous tasks. Instructions are sometimes communicated over the phone, rather than in person. In emergency situations, information has to be presented quickly, and in an attempt to present information in a concise way, information can be missed, which can lead to inappropriate interventions that directly affect patient outcomes. Rosenstein & O'Daniel, (2006) state that efforts to improve health care safety and quality are often jeopardised by the communication and collaboration barriers that exist between clinical staff. It is critically important that clinicians have

standardised communication tools and create an environment in which individuals can speak up and express concerns.

“ When a team needs to communicate complex information in a short period of time, it is helpful to use structured communication techniques to ensure accuracy.” (Lingard & Espin, 2005)

Many factors can contribute to communication failures. When implementing communication tools into practice there will be benefits as well as barriers and challenges to overcome. Efforts to improve health care safety and quality are often jeopardised by the communication and collaboration barriers that exist between clinical staff. There can be many barriers between different clinical groups as well as differences within the professional hierarchy. Doctors and nurses often have different communication styles in part due to differences in training. Nurses are taught to be more descriptive of clinical situations, whereas physicians learn to be very concise. Rosenstein (2007) expresses that even though doctors and nurses interact numerous times a day, they often have different perceptions of their roles and responsibilities to patient needs, and thus different goals for patient care. Standardised communication tools are very effective in bridging these differences in communication styles. A further common barrier to effective communication and collaboration could be hierarchies. Sutcliff’s research in (2000) shows us that communication failures in the medical settings arise from hierarchical differences, concerns with upward influence, role conflict, ambiguity and struggles with interpersonal power and conflict. Communication is likely to be inaccurate or withheld in situations where there are hierarchical differences between two

communicators, particularly where one person is concerned about appearing incompetent or inexperienced, does not want to offend the other, or perceives that the other is not open to communication. In health care environments characterised by a hierarchical culture, physicians are often at the top of that hierarchy. Consequently, they may feel that the environment is collaborative and that communication is open while nurses and other direct care staff perceive communication problems. Haig, Sutton & Whittington, (2006) state that hierarchal differences can often come into play and weaken the collaborative interactions required, to ensure that the proper treatments and care are delivered appropriately. When hierarchy differences exist, people on the lower end of the hierarchy could feel distressed or uneasy at speaking up about problems or concerns. Intimidating behaviour by individuals at the top of a hierarchy can hinder communication and give the impression that the individual is unapproachable. Effective leadership flattens the hierarchy, creates familiarity makes it feel safe and encourages staff to speak up and participate. Teaching the skills of how to speak up and creating the dynamic where teams will express their concerns is a key factor in maintaining patient safety. In all interactions, cultural differences can also exacerbate communication problems. For example, in some cultures, individuals may refrain from being assertive or challenging opinions openly. As a result, it is very difficult for nurses from such cultures to speak up if they see something wrong. In cultures such as these, nurses may communicate their concern in very indirect ways. Cultural barriers can also hinder nonverbal communication. For example, some cultures ascribe specific meaning to eye

contact, certain facial expressions, touch, tone of voice, and nods of the head which others may not be able to interpret correctly.

Communication methods and tools are potential sources of innovation for healthcare teams, enhancing teamwork and reducing risk. Leonard and Permanente (2004) developed a communication tool that has proven to be one of the most valuable, collectively known as SBAR; Situation, Background, Assessment and Recognition. The SBAR technique organizes communication into four types of information. First, the provider briefly describes the situation; for example, who the patient is, where the patient is located and a description of the problem. Secondly, relevant background information is communicated, diagnosis at admission, recent vital signs, and other clinical information. The final two pieces are the provider’s assessment of the situation, such as how severe the problem is, and an initial recommendation of what should be done and the plan of care needed.

The SBAR tool provides a framework for communication between members of the health care team about a patient’s condition. It is used to help create mechanisms useful for framing any conversation, especially critical ones, requiring a clinician’s immediate attention and action. It allows for an easy and focused way to set expectations between members of the team for what will be communicated and how, which is essential for information transfer and cohesive teamwork. It can also be used effectively to enhance handovers between shifts or between staff in the same or different clinical areas. The SBAR tool provides a standardised means for communicating in patient care situations; it is effective in bridging differences in communication styles and helps to get all team members using the same

approach, providing a common structure for communication and it can be used and applied in any clinical area, (Denham, 2008). SBAR also presents guidelines for organising relevant information when preparing to contact another team member, as well as the framework for presenting the information, appropriate assessments, and recommendations.

The tool can be used to shape communication at any stage of the patient's journey, from the content of a GP's referral letter, consultant to consultant referrals through to communicating discharge back to a GP. When clinical staff use the tool in a clinical setting they can make a recommendation which ensures that the reason for the communication is clear. This is particularly important in situations where staff may be uncomfortable about making a recommendation i. e. those who are inexperienced or who need to communicate up the hierarchy.

As well as SBAR there are a variety of other communication tools devised to help promote and ensure patient safety. Some tools were designed to be used in any clinical area while others were developed for a specific purpose. Surgical procedures are undertaken in many healthcare settings, these procedures are undertaken in day surgery units and on an outpatient basis as well as during inpatient care. Adverse events occur in approximately 10% of hospital admissions. Approximately 40% of these events are associated with surgery. The National Patient Safety Agency found that between October 2006 and September 2007, over 128, 000 reports of patient safety incidents from surgical specialties were reported to its National Reporting and Learning System. In November 2008 the NPSA also released a warning over wrong site neurosurgery, with 15 cases occurring between January 2005

and September 2008, (Peyton & Soar, 2009). These incidents varied from incorrect treatment or procedure to misplaced patient notes. Not all incidents were serious, but some led to patient harm or death and most could have been prevented. Problems in communication and information flow, as well as workload and competing tasks have a measurable negative impact on team performance and patient safety. Clinical staff have frequent interruptions, usually multi-task and often work with incomplete information about the tasks they are expected to undertake. Clinical uncertainty and occasional surprise add to this complex situation. It is also often assumed that safety checks have been completed by others without confirming they have actually taken place. Increased team working and the implementation of fail-safe systems are therefore necessary to help prevent human error. Hospitals are under ever increasing pressure to develop sound hospital systems that are put in place to prevent catastrophic, harmful events. This is where surgical communication tools can play a vital role in ensuring no harm, or avoidable mistakes, take place during surgical procedures.

The WHO Surgical Safety Checklist is an important development, which may help to prevent a number of these surgical errors. The World Health Organisation (WHO) Surgical Safety Checklist launched June 2008, and was adapted by the National Patient Safety Agency (NPSA). One of the key error prone areas that the surgical checklist can help is that of wrong site surgery. Panesear and Cleary (2009) state that wrong site or wrong patient incidents are rare, but the consequences can result in considerable harm and psychological damage to the patient. Research by Haynes (2009) indicates that the use of a simple checklist can substantially and significantly reduce

risk of morbidity and mortality associated with surgery. The Checklist is a tool to improve preoperative safety for patients and improve communication and teamwork. The checklist has five steps of; Briefing, Sign In, Surgical Pause, Sign Out and De-brief which improve patient safety through enhanced team performance. Having more than one step and a whole team present at each step, increases the reliability of the tool. Adding briefings before the lists starts and de-briefings at the end of the list, in addition to the Checklist, further improves communication between the team. The better the team communication, the better the chance of highlighting any errors or inaccuracies.

The WHO Safety Checklist incorporates the surgical pause as well as the surgical safety briefs. Incorporating more than one communication tool with another should help improve patient safety by repeating the safety checks at different stages throughout the procedure. The surgical pause rule provides that, except in life-threatening emergencies requiring immediate resuscitative measures, once the patient has been prepared for the elective surgical procedure, and immediately prior to the initiation of any procedure, the team will pause and the physician performing the procedure will verbally confirm the patient’s identity, the intended procedure and the correct surgical/procedure site. The physician’s operative report or procedural notes must reflect that the pause and the confirmation took place. This Surgical Pause tool was issued by the Board of Medicine in 2006 and seeks to prevent wrong site, wrong side and wrong patient surgeries.

Another strategy to help improve patient safety in surgery is the use of theatre briefings and debriefings. These discussions, initiated and led by the

surgeon, are intended to prevent and alleviate adverse events by promoting communication through improved teamwork. Specifically, they encourage any team member to speak up if they perceive a problem that could result in patient harm. The briefing consists of introductions by name and role of each theatre team member, a surgical pause, and discussion of expectations for the operative plan, paying special attention to potential problems that could be encountered. The team leader also conducts debriefings at the end of the case to note lessons learned for future patients and procedures. Peyton and Soar (2008) state that preliminary evidence suggests that preoperative theatre briefings are associated with an improved safety culture, reductions in wrong-site/wrong procedure surgeries, early reporting of equipment issues, and reduced operational costs. Although briefings and debriefings are not end all solutions to the problem of errors or inefficiencies in theatres, they help to minimise errors by allowing personnel to discuss potential problems before they lead to potential or actual harm. Safety briefings are a straightforward tool designed to help multidisciplinary teams communicate safety problems and concerns. They increase staff awareness of safety, encourage more open communication about safety issues, and over time assist in creating a culture of safety while helping to reduce errors, (The Health Foundation, 2009). Safety briefs can also be used on the ward as well as the operating theatre. Patient safety briefings are an easy, efficient tool to share information. The purposes of these briefings are to keep members of the clinical unit informed, anticipate needs, and make appropriate plans. Any member of the team can institute unit-based patient safety briefings, but often the charge nurse orchestrates them. Briefings are conducted at a designated place at predetermined times and should last no more than 5

minutes. They give the team a chance to communicate and discuss any problems, thoughts or put ideas forward. It also gives the team a chance to discuss previous problems brought up and how they can overcome them; with a view to use the briefings to bring a more effective and efficient way of managing patient safety concerns.

During the clinical placements I have experienced whether it be on a hospital ward or in the community I know that nothing is as crucial as the safety of the patients in your care. Safety precautions and tools are used on a daily basis, numerous times a day by a variety of clinical staff. As I am now a third year student nurse with many different clinical experiences, it is important that I not only understand the vital importance of using these communication tools properly and precisely but also gain the confidence to communicate information verbally as well as non-verbally. During my placements I have come across most of the communication tools that I have discussed previously. The SBAR Tool is one I have come across most frequently. In every clinical area I have been in SBAR was used on a daily basis; in handovers, transfers, discharges, updates, safety briefs and referrals. It seems to be adopted through clinical practice and staff then go on to use it subconsciously after a period of time. It is a very effective tool if used correctly, but only if implemented by all members of staff on the ward. I have had some experience using SBAR and find it a very easy tool to implement and an extremely beneficial skill to have. I can adopt it to different situations and I find it a good base for starting handovers and transfers. On my current clinical placement I work in our triage area with a number of emergency admissions every day. With every admission into

triage, SBAR is used several times; when receiving the emergency handover over the phone, handing over to the medical team, writing in the patient's notes, handing over to the nurse on the ward once the patient is transferred and recording the handover onto the dictaphone for the nurse next on shift. In my opinion it definitely encourages communication between staff and as a student has increased my confidence in participating in handovers. It is a useful tool for both verbal and non-verbal types of communication due to the fact it can be used for a variety of different situations in numerous clinical settings. In my opinion it helps break the actual and perceived barriers between clinical staff and allows the understanding that communication between staff from different areas should be of a high standard and easily exchanged due to the use of this common model. While observing staff at work in a busy ward environment, and how the passing of information between for instance the doctor and nurse can be difficult at times and even miscommunicated, it makes it clear to me that structured use of communication tools can lead to improved patient health and safety and should be common practice in all clinical situations.

My experience with the surgical safety tools has been more limited but I am still aware of the importance they are to patient safety and how necessary it is to have frequent checks from the beginning to the end of the operation or procedure as well as having a variety of staff present at each check. I have had experience with completing pre-operative charts which is the beginning of these surgical safety checks. That would be the first time you check the patient identity, procedure, pre-op checklist and consent form. Without having the WHO surgical safety checklist and the other surgical safety tools

in place, communication between staff would be less efficient and would probably take more staff time. In my opinion all the communication tools I have discussed are extremely significant and all have their own place within healthcare. From my experience I have observed that is critical that staff use these communication tools to help play their own part in maintaining patient safety and encourage others to do too. On a busy medical or surgical ward, where there are lots of admissions and emergencies and staff have to carry out numerous tasks, I have learnt that effective communication is essential as when staff are extremely busy, information can be missed, forgotten and wrongly communicated. The communication tools that I have discussed can and do all play a part in ensuring and assisting patient safety if used correctly and if applied appropriately and correctly by staff throughout healthcare.