Importance behind communication in the emergency department

ASSIGN BUSTER

In the emergency department (ED) 80% of the time communication dealings is responsible for the occupation of health care professionals (Creswick, Westbrook, & Braithwaite, 2009). Communication is the vital key to any profession, but in the case of a congested environment such as the ED it may be the margin between life and death for a patient. Startling statistics show that 12% of errors in the ED are because of poor communication (Creswick et al., 2009). Like in any profession, there is a hierarchy, but a lot of this stems from the training obtained in school; with the medical school curriculum differing from that of a nurse. In medical school it has been viewed that collaboration with others outside their own profession and leadership has been neglected. In contrast to nurses who go through intensive training in patient-family relationship building. Last, are the direct barriers experienced by the patients through language limitations and directions upon discharge. Using my experience and acquired journals I will evaluate communication barriers experienced in the emergency department. Communication in the ED is essential between doctors and nurses since they have an effect on both patient diagnosis and quality of care.

Experience

In this episode of House I witnessed the life of the hospital administrator Dr. Lisa Cuddy. Although the episode was centralised around her daily events, it also displayed some of the barriers that she, Dr. House, nurses and other health care workers face when there is a lack of communication. One particular event dealt with the misplacement of medication shipment records. In various House episodes there was a lack of collaboration between Dr. House and the nurses, whom he treats inferior (Egan and Alexander,

2010). In reality I do believe there is a hierarchy issue between health care professionals which can affect communication.

The Curriculum

Health care communication is instructed differently in both the physician and nursing profession. The impression is that doctors are very independent where collaboration between allied health professionals occurs between nurses. The medical school curriculum often disregards leadership and teamwork skills. A study conducted by O'Connell & Pascoe (2004) found that up until the 21st century leadership and teamwork skills have been largely disregarded. As a result, it has impacted the way physicians practice today. An intervention conducted by O'Connell & Pascoe (2004) consisted of 8 universities in the United States who either included courses or seminars on teamwork and leadership. Topics discussed in seminars included the psychology of teams and leadership (conflict resolution and negotiation), clinical experience (primary care as team care, discharge planning), leadership and management in organizations (O'Connell & Pascoe, 2004). All medical students who participated in the seminars reported positive outcomes, and at the University of Pittsburgh " 84% felt similarly that they learned about effective working relationships among health care providers" and " 67% of the students had observed an incident in which team-based care had a positive influence in the care of a patient" (O'Connell and Pascoe, 2004). Conversely nursing education believes communication is essential to quality of care (Zavertnik, Huff, & Munro, 2010). Presently communication skills are taught to nurses through lectures and labs, but it has been revealed by studies that it would be more effective that both medical

students and nursing students would benefit from lectures and role playing components. As a result, it has been shown that nurses who have participated in those studies had a positive correlation in gathering more information from the patient; thus improving patient relationship and increasing background information required for diagnosis (Zavertnik et al., 2010).

The Process

Lack of communication creates barriers between health care professionals as well as patients. The ED is a complex system of procedures and vital information links. The process involves multiple steps from the beginning of when the patient is triaged to possible admission to a hospital bed. The process consists of four steps for the patient: triage, testing and evaluation, handoffs and admission (Eisenberg et al., 2005). Between each transition there is vital link which informs the next health care professional, and/or patient in regards to the next steps in determining diagnosis. This demonstrates the need for physician and nurse collaboration. The process in the emergency department commences with a trip to the triage. It is the triage nurse who is responsible for documentation of the patient’s story and concluding on present symptoms the severity of illness. What is documented on the chart by the triage nurse is a guideline for both the nurse and doctor in regards for proceeding with diagnosis and the ordering of laboratory tests. A communication barrier triage encounters is the lack of patient history; forcing them to rely solely on the patient’s story and any staff who have had previous encounters with the patient (Eisenberg et al., 2005). Another obstacle they must face (due to patient loads) is the need to address the

most pressing complaint of the patient and overlooking minor symptoms which could unfortunately later evolve to a sicker patient (Eisenberg et al., 2005). After triage the patient is sent for tests either to confirm or further look into a physician's diagnosis. The patient's first encounter with the physician can create a new barrier if the patient's story does not match what is documented on the chart. For this reason chart documentation is of great importance and serves as guideline for health care workers.

Perceptions and Collaboration

Equally important are the perceptions and interpretations of a patient's story by the nurse and the physician (Eisenberg et al., 2005). This too correlates to the training both received in professional school. Nurses are more observant; having spent more time with the patient whereas doctors are more technically focused. An example would be found in the study conducted by Eisenberg et al. (2005), in a case where a patient was tired and presence mentally was slightly off. The doctor concluded that this was due to the patient's lifestyle and lack of sleep, however the nurse concluded that the patient was a drug user. This presents the issue on the hierarchy in the workplace where the doctor-nurse relationship is affected by the doctor's authority in regards to patient diagnosis. Different perceptions affect patient diagnosis and overall care and are susceptible to medical errors. The same accounts for medication dispense where Creswick et al. (2009) found that " most staff (67. 9%) agreed that if doctors and nurses talked more frequently, there would be fewer medication errors" (p. 5). Nurses are often afraid to question the doctor's diagnosis, and go about it in an indirect manner. As said by Eisenberg et al. (2005) " There are no scheduled points of formal

face-to-face interaction between nurses and physicians, who rely instead on the patient's chart as their primary medium of communication" (p. 402). Another perception issue deals with doctors and nurses views on the term collaboration. A doctor may view it as cooperation in " following orders" instead of nurses being a part of the diagnosis process (Creswick et al., 2009), whereas nurses may view it as the complete opposite. With this in mind, Creswick et al., (2009) observed communication networks in the ED. In general, all health care workers frequently addressed coworkers within their profession. It was found that the ED staff relied most on the senior nurse and doctor for advice, and in particular the senior doctor for medication advice. In addition, it was not surprising that the profession that had the highest linkages were the nurses with 69% and 45% between doctors- therefore reinforcing the notion that doctors are more independent. The study also proceeded with an intervention where doctors, nurses, nurse practitioners and medical directors were placed in small teams. The intervention confirmed physicians found a greater collaboration and communication with nurse practitioners. In contrast to nurses who experienced a neutral impact, and only experienced better communication with the nurse practitioners. All in all the articles suggest that nurse-physician collaboration have a positive effect on the both the system and on overall quality care for the patient.

Patient Barriers

An aspect to help address the growing diverse population is by implementing translators and improving medical instructions upon discharge. In the United States where those who receive federally funded services, limited English proficiency (LED) patients are entitled to interpreters. Although that is not

the case, the services are rare to be found and the same applies to Canadian emergency departments. Green et al. (2005) found that patients who experienced language barriers rated their overall health care experience poor, and faced medication problems. The general characteristics of LEP patients who used interpreters were those who were younger and recently immigrated to the United States. Among the Asians selected for the study, Green et al. (2005) results showed that the use of an interpreter improved overall communication with their health care provider as well as satisfaction with the care received. Although there was a correlation with high ratings given to an interpreter and quality of care experienced, LEP's faced another issue of personal comfort; where disclosure of more intimate health care issues was suppressed from the interpreter and health care provider. Overall results were constructive, and likewise introduced the need for collaboration between interpreters and physicians (Green et al., 2005). Moreover patients also experienced disconnect upon discharge; some who felt that the ED was a quick fix, or were not satisfied with the quality care received. Whereas patient-physician communication is usually limited only to diagnosis, it is the nurse practitioner (NP) or nurse who stepped in and established a relationship with the patient beyond hospital doors. " The nurse practitioners promoted the use of disease specific pathways. They also provided concurrent inpatient and discharge education for patients" (Vazirani, Hays, Shapira, & Cowan, 2005). Where in the ED the NPs role are not clear, it is evident that in Vazirani et al. (2005) intervention study NPs have created their own platform for patient care upon discharge, and thus contributing to the overall quality of care experienced by the patient.

Conclusion

Taking into account the journals I have reviewed, I have drawn the conclusion that the overall quality of care experienced by patients is determined by a complexity of communication networks within the ED. While networking among those in the same profession may be more favourable for the professional it may also cost lives if medical advice is not sought outside of their spectrum. The " physician dominance and nurse deference" (Vazirani et al., 2005, p. 74) relationship needs to be broken starting at the root of the problem where both health care providers educational curriculum should include interventions on teamwork and leadership. Physician and nurse collaboration is key to helping reduce communication errors which account for 28% of errors in the ED (Creswick et al., 2009). Language interpreter services should be made more available and should become a standard unit in all Canadian EDs; thus improving patient's satisfaction and physician relationship. In summary, miscommunication in the ED affects the quality of care provided and may inflict more costs on the health care system if preventable errors are continued to be made.