Communication

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The Question:

In nursing, will the use of SBAR-R and Team Drills enhance communication, collaboration, assist in cultural competence and improve patient safety as compared to historical methods of communication?

Communication

Defined as:

"a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior" (Merriam-Webster, 2011)

Collaboration

Defined as:

> "working together to achieve a goal, It is a recursive process where two or more people or organizations work together to realize shared goals,.... (this is more than the intersection of common goals seen in co-operative ventures, but a deep, collective, determination to reach an identical objective)" (Wikipedia, 2011).

Recognition of a Problem with Patient Safety

- In 1999, the quality and safety report, *To Err is Human*, was issued by the Institute of Medicine (IOM).
- This report identified 98,000 deaths annually as a result of medical error.
- This report forced an acknowledgement of whole system errors being the cause of the problem instead of individual practitioner incompetence.
- The second report, in 2001, *Crossing the Quality Chasm,* "recommends a redesign of the American health care system" (IOM, 2011).

(Yoder- Wise, 2011, p.26-27)

Identification of the Cause

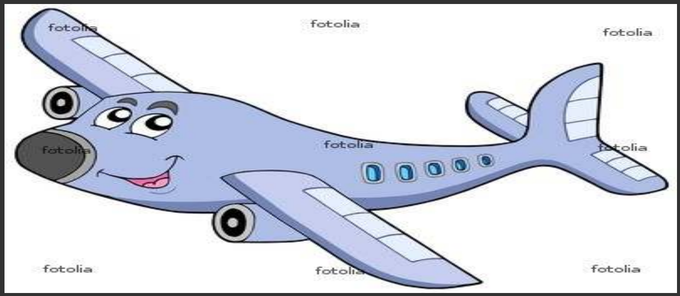
In 2004, the Joint Commission (TJC) identified 70% of all sentinel events were a result of communication failures, with 75% of these events resulting in patient death (Beckett & Kipnis, 2009, p. 19). This trend continues with communication being recognized as the second leading cause of sentinel events from 2004 through 2011; second quarter (TJC, 2011, p. 27).

Safety Culture

With increasing awareness of the incidence of errors in healthcare, beginning in 2003, the idea of safety culture emerged (Blegen et al. 2010, p. 346).

"Safety culture is thought to be the shared values, attitudes and behaviour of all staff in health facilities in regard to giving safety priority over efficiency, improving care provider communication and collaboration, and creating a system that learns about and learns from errors and problems" (Blegen et al., 2010, p. 346).

History of creating safety culture in industry.



- Based on improvements in airline safety in the 1970's and 1980's (Donahue et al., 2011, p. 206), in 2004, TJC recommended team training to improve teamwork and improve communication (Holt, 2010).
- The airline industry has made a massive industry-wide overhaul of cockpit philosophy labeled crew resource management (CRM) after studies "that repeatedly confirmed the disastrous, often fatal consequences of crew members remaining silent for fear of challenging the captain's authority" (Ashcroft, 2005, p. 77).
- This CRM philosophy encourages team members to be active and equal partners (Ashcroft, 2005, p. 77).

Theories behind Poor Communication In Healthcare

Leininger Cultural Care Theory

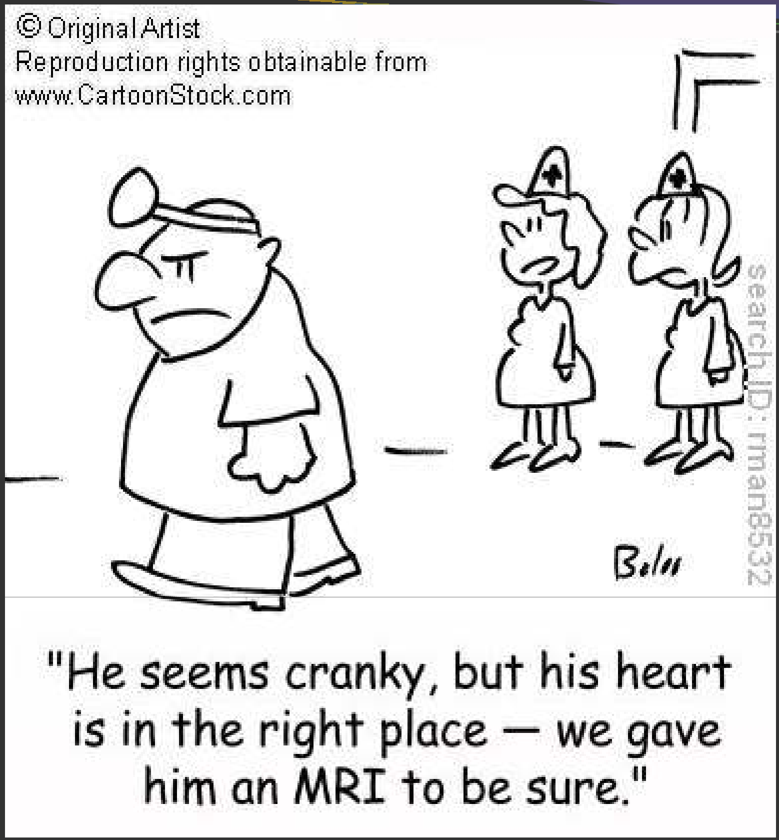
- Mannahan describes medicine and nursing as belonging to different cultures (2010, p. 71).
- Scott and Gerardi identify subcultures exist between the various professional groups within the hospital (2011, p. 60).
- Identification of these different cultures links communication between the various subgroups in healthcare to Leininger's Cultural Care Theory.
- Leininger refers to ethnocentrism as the view that one's own way is best and this suggests we must "see beyond" our own culture to effectively communicate and achieve cultural competence (Mannahan, 2010, p. 72).

Campinha-Bacote's Model of Cultural Competence in Health Care Delivery

This theory expands on Leininger's theory adding :

- Awareness – know thy own self, background and bias
- Knowledge – know the educational foundation of the diverse group you are looking at.
- Cultural Skill – the ability to conduct a cultural assessment.
- Encounters – working directly with culture to change existing beliefs.
- Desire – Genuine caring and desire to become culturally competent.

(Mannahan, 2010, p. 73)



While nurses "frequently discuss physicians issues with one another, nurses seldom venture outside of nursing culture to resolve differences" (Mannahan, 2010, p. 72)

Leadership Theories

Traditional Hierarchy

Historically, hospital leadership is based on a hierarchy.

- Physicians direct patient care while nurses carry out their orders (Mannahan, 2010, p.74).
- Casanova et al. as cited in Mannahan suggests that physicians see collaboration with nurses as "undermining the physician's authoritarian role" (2010, p. 74).
- In a study by Rice et al., physicians were accustomed making decisions independently and having their orders carried out without discussion (2010. p. 356-358).

Complexity Theory

(Teamwork Inspirational, n.d.)

Complexity Theory

- This is a promising new theory adopted by healthcare organizations and nursing in which there is a partnership in communication and decision making among the healthcare team without regard to hierarchy (Yoder-Wise, 2009, p. 12).
- "Teams make fewer mistakes than do individuals (Smith-Jentsch et al. 1996, Salas and Canon-Bowers 2000)" as cited in Miller, Riley and Davis (2009, p. 248).

Conflict Resolution

5 types of Conflict Resolution

- Competition – win-lose style.
- Collaboration – best method. Strives to meet needs of all parties.
- Compromise – find some middle ground. Both sides give a little.
- Avoidance – denying, delaying or avoiding conflict.
- Accommodation – surrendering one's needs to meet needs of the other party.

(Pavlakis et al., 2011, p. 243)

- As cited in Rice et al., nurses “have adopted various strategies to passively resist or work ‘around’ the power structure (Fagin & Garelick, 2004; Keddy et al., 1986; Simpson, 2007)” (2010, p. 358).
- In a study done in Cyprus, nurses chose avoidance as their primary style of conflict resolution more than other healthcare professions in the study (Pavlakis et al., 2011, p. 245).

Change Theories

- Changing a culture is difficult (Mannahan, 2010, p. 72).
- The desire to maintain the status quo is powerful (Mannahan, 2010, p. 77).
- Changing oneself is easier than changing another. Yet nurses resist changing their behavior as they perceive relationship difficulties as originating with physicians (Mannahan, 2010, p. 77).
- There must be a perceived benefit to change (Rice et al., 2010, p. 350).

Management Change Theory

This theory by John p. Kotter includes eight steps for change:

1. Establish a sense of urgency
2. Create a powerful guiding coalition
3. Develop a vision
4. Communicate the vision
5. Empower others to act on the vision
6. Plan and create short-term wins
7. Consolidate improvements and produce more changes
8. Institutionalize new approaches

(Borkowski, 2005) as cited in (Beckett & Kipnis, 2009, p. 20)

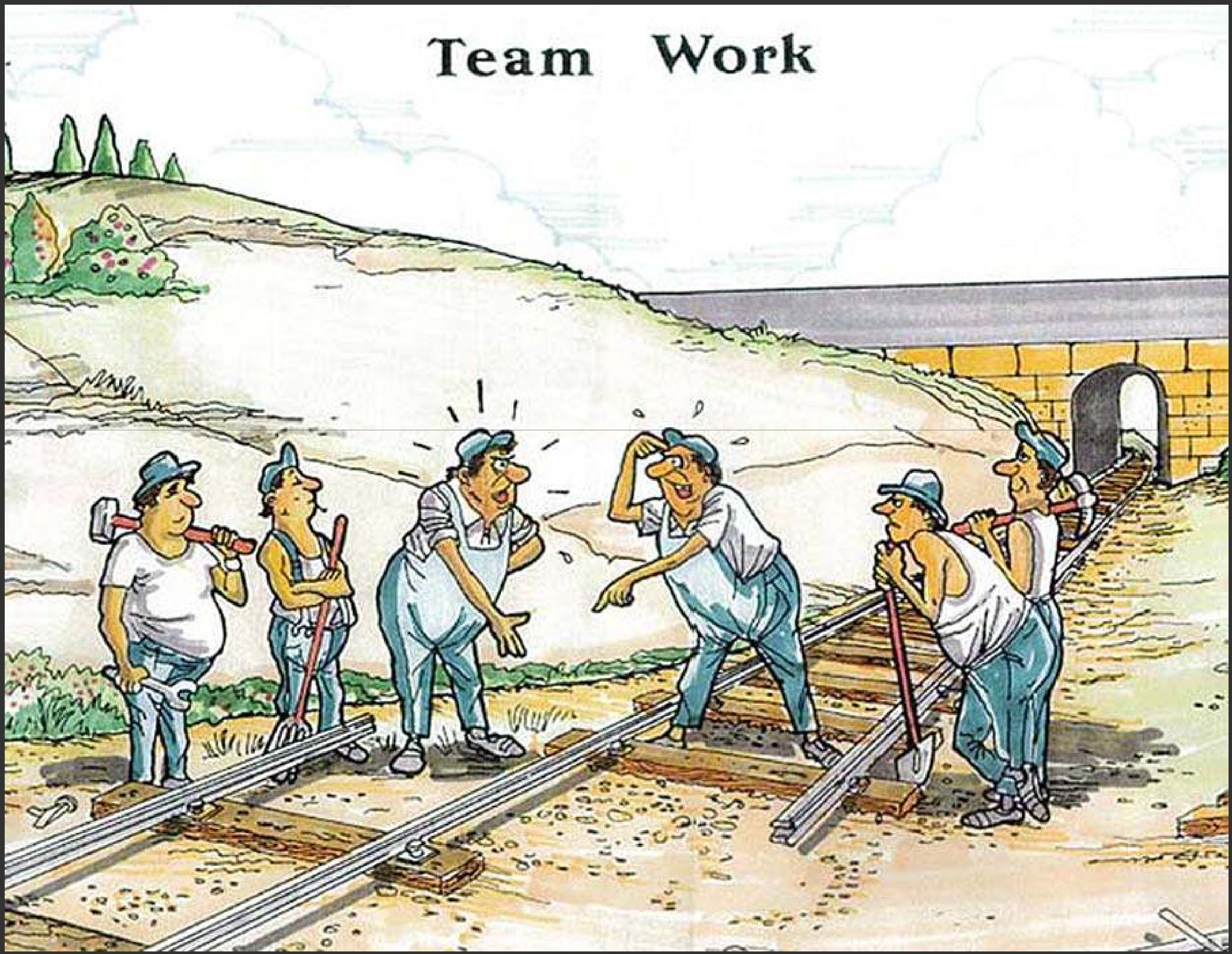
Lewin's Force-Field Model of Change

Three Stages

1. Unfreezing – become aware of the problem and see the advantages for change.
2. Experiencing the change – "incorporation of what is new" (Yoder-Wise, 2009, p. 327)
3. Refreezing – Acceptance and use of the new behavior

(Yoder-Wise, 2009, p. 327, Mannahan, 2010, p. 77)

Assessment of the Causes of Poor Communication among the Health Care Team


Team Work

Identifying reasons for breakdown of communication

- Physicians focus on the content of the message.
- Nurses place more value on the relationship aspect of the message.
- Physicians are self-employed and see patients throughout the hospital.
- Nurses work in one unit and identify more with the subculture of the unit.
- Fast paced work environment and limited time increases need for clear, relevant and concise communication.

(Mannahan, 2010, p. 74).

- "The complexity and rapidity of change in patient status makes interdisciplinary … collaboration a necessity (Schmalenberg et al., 2005, p. 508).
- Historical Medical Hierarchy (Rice et al., 2010, p. 355).

Different Educational Backgrounds and Training

- Different levels of education lead to communication problems (Pavlakis et al., 2011, p. 246).
- "Literature shows that nurses and physicians are taught different communication styles in their educational programs" (Beckett & Kipnis, 2009, p. 20).

1. Nurses are taught to be detailed and descriptive without diagnosing.
2. Physicians are taught to express themselves briefly with just the facts.

(Haig, Sutton, & Whittington, 2006, as cited in Beckett & Kipnis, 2009, p. 20).

- Because of the differences in disciplines, most medical units function as a collection of individuals (Knox & Simpson, 2004 as cited in Miller, Riley, & Davis, 2009, p.248).
- Team training, communication and collaboration skills are barely taught in school (Rice et al., 2010, p. 358).
- "Overlapping but differing bodies of knowledge serve as barriers" (Rice et al., 2010, p. 358).

Inferences/Implications to Nursing Practice

Demonstration of RN competence/professionalism

Schmalenberg et al. as cited in Mannahan says, “physicians consistently cite competence as essential to trust and respect” (2010, p. 73).

How do we demonstrate our competence?

- Identify ourselves and approach physicians with confidence and professionalism
- Through our level of education (BSN or greater)
- National certification
- Use of evidence based practice
- In our knowledge and in the way we disseminate the information needed by the interdisciplinary team (demonstrating culture competence to the other members of the team)

(Mannahan, 2010, pp. 72-76, Rice et al., 2010, p.352, Schmalenberg et al. 2005, p. 509)

Responsibility/Role of the RN in a Health Care Team

- Nurses are the most stable member of the healthcare team for each individual patient as physicians and other members have responsibilities to other units and outside the hospital.
- This places the RN in the role of ensuring patient safety.
- "Nurses have a key role in assuring effective team performance through the transfer of critical information" (Miller et al., 2009, p. 254).
- Proficiency in team training requires practice. Remember this is not taught in school.

(Miller et al., 2009)

Use of Standardized Communication

- "In other industries in which communication failures can have serious consequences- such as aviation, rail and the military- one safety initiative has been the use of standardized communication during the transmission of information (Marshall et al., 2009, p. 137).
- The advantages to this are novices have a set structure to follow to avoid omission of important information and the recipient knows what to expect (Marshall et al., 2009, p. 137). (**Think SBAR-R,** – Situation, Background, Assessment, Recommendation, Response)

Standardized Communication

- A standardized form of communication such as SBAR-R has been shown to be effective “across disciplines even where cultural barriers and differences in educational preparation and training have traditionally been impediments to effective interdisciplinary communication” (Donahue et al., 2011, p. 207).
- But studies have shown SBAR-R is not enough. A more comprehensive educational program on communication and teamwork strategies is needed (Beckett & Kipnis, 2009, p. 20).

Team Drill Study
High Reliability

In a study to measure achieving high reliability, four competencies for effective interdisciplinary team work by an RN were indentified and examined.

1. Situational Awareness – awareness of entire situation not just task at hand
2. Closed-loop communication – Acknowledgement of communication by the receiver and then affirmed by the sender
3. SBAR-R – Situation, Background, Assessment, Recommendation, Response
4. Shared Mental Model – Team articulation of the problem to ensure everybody is "on the same page".

(Miller et al., 2009, p. 250)

Team Drill Study (continued).

This study showed nurses had not mastered the skills needed to constitute high reliability. Performance on this standardized communication drill was variable. (Remember in the airline industry expects 100%.)

Conclusion by authors, Miller et al., is that nurses need both individual and team training to make significant improvements in safety.

(Miller et al., 2009, p. 254)

Barriers identified for future studies on communication

- Traditional hierarchy and resistance to change
- Lack of the perceived benefit to change
- Overlapping but different bodies of knowledge
- A greater commitment at all levels of health care (Administration, physicians, nurses, and other members of the multidisciplinary team).
- Personal commitment and belief in the problem
- Lack of cultural competence
- Time commitment
- Financial

Personal Experience

I was the participant in the first "Emergency Simulation Team Drill in Maternity" at Munson Medical Center, February, 2011. We took the "Teamwork and Patient Safety Attitudes Questionnaire" with permission of authors, Kaissi, Johnson and Kirschbaum, (2003) as cited in Holt (2011) prior to the simulated drill and then repeated the questionnaire one month after. Participants were Nurses, Physicians, and med-students. Participation was required and financially compensated.

Personal Experience (continued)

This drill "created a trusting, respectful atmosphere to communicate in a timely manner" and we will now hold them annually (Holt, 2011).

Based on my research for this project on communication, I will recommend that the future team drills in Maternity use a more standardized form of communication based on the four competencies for effective interdisciplinary team work identified by Miller et. al. (2009, p. 250).

And we are proud to announce our "drill" was accepted for publication in the National Nursing Practice, October 2011.

ANA Standards

1. Assessment
2. Diagnosis
3. Outcome Identification
4. Planning
5. Implementation
6. Evaluation

(American Nurses Association, 2004, pp. 21-32)

Fundamental to Standards

The themes addressed by the ANA and spanning all areas of nursing practice include:

- Maintaining a safe environment
- Assuring continuity of care
- Coordinating the care across settings and among caregivers
- Managing information
- Communicating effectively

(American Nurses Association, 2004, p. 4)

This presentation encompasses these themes of critical thinking basic to the nursing process.

QSEN
Quality and Safety Competencies

These quality and safety competencies are met by the study of improving communication within the healthcare team.

- Teamwork & Collaboration – "Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care" (Teamwork & Collaboration, 2011).
- Quality Improvement – "Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems" (Quality Improvement, 2011).
- Safety – "Minimizes risk of harm to patients and providers through both system effectiveness and individual performance" (Safety, 2011).

Conclusion

- Despite our differences, all is not lost between physicians and nurses as there are many shared values (Mannahan, 2010, p, 77).
- Seeing beyond our own culture and experience and understanding each other is key to the common goal of quality patient care (Mannahan, 2010, p. 72).
- A "greater commitment to collaboration at all levels and stages of health care training and provision may be necessary in order to change a seemingly well-entrenched status quo"(Rice et al. 2010,p. 359).

References

- Ashcraft, K. L. (2005). Resistance through consent? Occupational identity, organizational form, and the maintenance of masculinity among commercial airline pilots. *Management Communication Quarterly, 19*(1), 67-90. doi: 10.1177/0893318905276560
- American Nurses Association. (2004). *Nursing: Scope and standards of practice.* Silver Spring, MA: Nursebooks.org
- Beckett, C. D., & Kipnis, G. (2009). Collaborative communication: Integrating SBAR to improve quality/patient safety outcomes. *Journal for Healthcare Quality, 32*(5), 19-28.
- Blegen, M. A., Sehdal, N. L., Alldredge, B. K., Gearhart, S., Auerbach, A. A., & Wachter, R. M. (2010). Improving safety culture on adult medical units through multidisciplinary teamwork and communication interventions: the TOPS Project. *Quality & Safety in Health Care, 19,* 346-350. doi:10.1136/qshc.2008.031252
- Bloom, Goldfaden,Berkowitz, Donnelly, Fried, & Forte (2009). Google image/Patient Safety. Retrieved from http://www.google.com/imgres?q=patient+safety&hl=en&client=firefox-a&rls=org.mozilla:en-US:official&biw=1440&bih=697&gbv=2&tbm=isch&tbnid=IbAsxBHXhpGbMM:&imgrefurl=http://www.njattyblog.com/medical-malpractice/new-jersey-passes-patient-safety-act/&docid=Rgaw9xcZPq_eRM&w=144&h=144&ei=WQB2TsyzDoPegQes4ZH4DA&zoom=1&iact=hc&vpx=749&vpy=240&dur=130&hovh=115&hovw=115&tx=96&ty=56&page=1&tbnh=115&tbnw=115&start=0&ndsp=21&ved=1t:429,r:3,s:0

References

- CartoonStock.com (n.d.) Kind Hearted Cartoon 1. Retrieved from http://www.google.com/search?tbm=isch&client=firefox-a&rls=org.mozilla%3Aen-US%3Aofficial&hl=en&source=hp&biw=1440&bih=697&q=patient+safety&gbv=2&oq=patient&aq=3&aqi=g10&aql=&gs_sm=c&gs_upl=1839l4972l0l12318l7l7l0l1l1l0l252l1033l0.4.2l6l0#hl=en&client=firefox-a&rls=org.mozilla:en-US%3Aofficial&gbv=2&tbm=isch&sa=1&q=doctor+and+nurse+cartoon+he+has+a+heart&pbx=1&oq=doctor+and+nurse+cartoon+he+has+a+heart&aq=f&aqi=&aql=&gs_sm=s&gs_upl=52552l65248l4l67754l43l35l1l23l23l3l191l1461l3.8l11l0&bav=on.2,or.r_gc.r_pw.&fp=8e9dec844d2f1702&biw=1440&bih=697
- Collaboration. (2011). In *Wikipedia, the free encyclopedia.* Retrieved from http://en.wikipedia.org/wiki/Collaboration
- Communication. (2011). In *Merriam-Webster's online dictionary.* Retrieved from http://www.merriam-webster.com/dictionary/communication
- Donahue, M., Miller, M., Smith, L., Dykes, P., & Fitzpatrick, J. J. (2011). A leadership initiative to improve communication and enhance safety. *American Journal of Medical Quality, 26*(3), 206-211. doi: 10.1177/1062860610387410
- Holt, K. (2010). *Emergency simulation team drills in maternity.* Manuscript accepted for publication in National Nursing Practice Network, October, 2011.
- Institute of Medicine of the National Academies. (2011). *Crossing the quality chasm: A new health system for the 21st century.* Retrieved from http://iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

References

- The Joint Commission, Office of Quality Monitoring. (2011). *Sentinel Event Data: Root Causes by Event Type, 2004-Second Quarter 2011.* Retrieved from http://www.jointcommission.org/assets/1/18/se_root_cause_event_type_2004_2Q2011.pdf
- Mannahan, C. A. (2010). Different worlds: A cultural perspective on nurse-physician communication. *Nursing Clinics of North America, 45,* 71-79. doi:10.1016/j.cnur.2009.10.005
- Marshall, S., Harrison, J., & Flanagan, B. (2009). The teaching of a structured tool improves the clarity and content of interprofessional clinical communication. *Quality and Safety in Health Care, 18.* 137-140. doi: 10.1136/qshc.2007.025247
- Miller, K., Riley, W., & Davis, S. (2009). Identifying key nursing behaviours to achieve high reliability. *Journal of Nursing Management, 17,* 247-255.
- Pavlakis, A., Kaitelidou, D., Theodorou, M., Galanis, P., Sourtzi, P., & Siskou, O. (2011). Conflict management in public hospitals: the Cyprus case. *International Nursing Review, 58*, 242–248.
- Quality Improvement. (2011). In QSEN- Quality and Safety Education for Nurses. (2011). Retrieved from https://fsuvista.ferris.edu/webct/cobaltMainFrame.dowebct?appforward=/webct/viewMyWebCT.dowebct

References

- Rice, K., Zwarenstein, M., Gotlib-Conn, L., Kenaszchuk, C., Russell, A., & Reeves, S. (2010). An intervention to improve interprofessional collaboration and communications: A comparative qualitative study. *Journal of Interprofessional Care, 24*(4), 350-361. doi:10.3109/13561820903550713
- Safety. (2011). In QSEN- Quality and Safety Education for Nurses. (2011). Retrieved from https://fsuvista.ferris.edu/webct/cobaltMainFrame.dowebct?appforward=/webct/viewMyWebCT.dowebct
- Schmalenberg, C., Kramer, M., King, C. R., Krugman, M., Lund, C., Podusk, D., & Rapp. D. (2005). Excellence through evidence: Securing collegial/collaborative nurse-physician relationships, part 2. *Journal of Nursing Administration, 35*(11), 507-514.
- Scott, C., & Gerardi, D. (2011). A strategic approach for managing conflict in hospitals: Responding to the joint commission leadership standard, part 1. *The Joint Commission Journal on Quality and Patient Safety, 37*(2), 59-69.
- Teamwork & Collaboration. (2011). In QSEN- Quality and Safety Education for Nurses. (2011). Retrieved from https://fsuvista.ferris.edu/webct/cobaltMainFrame.dowebct?appforward=/webct/viewMyWebCT.dowebct
- Teamwork Inspirational. (n.d.) Clip art/Teamwork. Retrieved from http://www.google.com/imgres?q=teamwork+clipart&um=1&hl=en&biw=1440&bih=697&tbm=isch&tbnid=kdYOoixavtYMiM:&imgrefurl=http://teamworkinspirational.com/clip-art/&docid=p3Ykimst2JwxTM&w=500&h=500&ei=q41zTqPHD8GosQKGqoWMBQ&zoom=1&iact=hc&vpx=478&vpy=180&dur=7986&hovh=225&hovw=225&tx=117&ty=105&page=1&tbnh=155&tbnw=163&start=0&ndsp=20&ved=1t:429,r:2,s:0

References

- Vijay for Victory (2008). Team work explained. Retrieved from http://www.google.com/imgres?q=bad+teamwork&hl=en&client=firefox-a&sa=X&rls=org.mozilla:en-US:official&gbv=2&biw=1440&bih=697&tbm=isch&tbnid=TLXaTuFr49uVSM:&imgrefurl=http://www.vijayforvictory.com/fun/team-work-explained-3/175/&docid=3iWYkY6SLFflcM&w=900&h=696&ei=0aN0TvSeOMjqgQeYtsHODA&zoom=1&iact=hc&vpx=1144&vpy=188&dur=224&hovh=197&hovw=255&tx=155&ty=111&page=1&tbnh=140&tbnw=181&start=0&ndsp=21&ved=1t:429,r:6,s:0
- Viskova, K. (n.d.). Cartoon airplane. *Fotolia.* Retrieved from http://www.google.com/imgres?q=airplane+cartoon&um=1&hl=en&biw=1440&bih=697&tbm=isch&tbnid=B5rDathvenBn7M:&imgrefurl=http://us.fotolia.com/id/13218189&docid=UBYpLuDV92RviM&w=400&h=309&ei=2WBzTta1M-eMsAKWud2LBQ&zoom=1&iact=hc&vpx=579&vpy=401&dur=1102&hovh=197&hovw=255&tx=94&ty=218&page=1&tbnh=134&tbnw=173&start=0&ndsp=19&ved=1t:429,r:15,s:0
- Yoder-Wise, P. S. (2011). *Leading and managing in nursing (fifth edition).* St. Louis, Missouri: Mosby, Inc.