Communication

Patricia A. Kraemer

Ferris State University

Abstract

This paper identifies the need to improve communication between the interdisciplinary healthcare team based on the findings of the Institute of Medicine and the Joint Commission. This difficulty with communication is considered from the idea of individual subcultures existing between healthcare professions and Leininger's Cultural Care Theory. This theory is then expanded with the Campinha-Bacote model of cultural competence. The paper examines barriers to achieving cultural competence and effective communication. Three primary research studies are reviewed with the suggestion of how this research meets the demand for improvement in collaboration and what improvements need to be made.

Communication

Ineffective communication between the healthcare team has been identified as a leading cause of patient safety issues (Mannahan, 2009, p. 71). 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). The trend continues with poor communication being recognized as the second leading cause of sentinel events from 2004 through 2011; second quarter (TJC, 2011, p. 27). This alarming cause of patient safety issues, nationally and globally, has led to efforts to improve the way all members of a healthcare team communicate (Rice et al., 2010, p.350). "Collaborative communication and teamwork are essential elements for quality care and patient safety" (Becket & Kipnis, 2009, p.19).

The purpose of this paper is to examine the surrounding issues of ineffective communication between the healthcare team, specifically between nurses and physicians, identify theories affecting communication and investigate current studies that are being looked at to improve healthcare communication and improve patient safety. In particular, to be explored is the question: in nursing, will the use of a structured communication tool such as SBAR-R (situation, background, assessment, recommendation and response) and collaborative communication education enhance communication, collaboration, assist in cultural competence and improve patient safety as compared to historical methods of communication?

Theory Base

The Institute of Medicine (IOM), TJC and other regulatory agencies "have created standards demanding the problem of poor nurse-physician communication be resolved ….a fresh approach to an old problem is needed" (Mannahan, 2010, p. 71). Mannahan looks at ineffective communication within the healthcare team from a cultural perspective and suggests "cultural

competence" is needed for the diverse cultures of nurses and physicians to function effectively (2010, pp. 71-72). To understand how cultural competence affects communication in the healthcare team, she cites Leininger's Cultural Care Theory and then expands that theory with the Campinha-Bacote model (Mannahan, 2010, p.73). Leininger's idea of ethnocentrism or seeing that one's own way is best calls for one to see beyond their own culture to achieve cultural competence (Mannahan, 2010, p.72). The Campinha-Bacote model identifies five constructs of cultural competence, awareness, knowledge, cultural skill, encounters, and desire as necessary to "design strategies to bridge cultural differences between nurses and physicians"(Mannahan, 2010, p.73). Mannahan (2010) states that nurses and physicians are already educated to work with culturally diverse populations and we must just expand this concept to include the cultures of working groups (p. 73). She then looks at the five constructs necessary for cultural competence and identifies the barriers to effective communication between the cultures of physicians and nurses. Traditional hierarchy and roles, self-awareness, educational differences, demonstration of nurse competency and resistance to change are identified as recurring barriers to cultural competence affecting communication (Mannahan, 2010).

Historically, leadership in healthcare is based on a traditional 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 to making decisions independently and having their orders carried out without discussion (2010, pp. 356-358). Yoder-Wise identifies the Complexity Theory as a promising new theory in leadership being 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 (2009, p. 12). Instead of leadership starting from the top down, there is an idea of teams making the decisions for patient care. "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).

The first construct of the Campinha-Bacote Model of Cultural Competence in Health Care Delivery is to be self-aware (Mannahan, 2010, p. 73). In order to do so, one must be aware of how one handles oneself in interaction with others or conflict resolution. Management theory states there are five 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.

(Vivar, 2005 as cited in Pavlakis et al., 2011, p. 243). Pavlakis et al. then goes on to say one must strive for collaboration as it best meets the needs of all parties in finding a mutually beneficial solution (2009, p. 243).

The change necessary to improve communication between nurses and physician is going to be hard because as Mannahan states to change a culture is difficult and the desire to maintain the status quo is powerful (2010, pp. 71-77). 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). In order to modify behavior, there must be a perceived

benefit to change (Rice et al., 2010, p. 350). A look at the Management Change Theory by John P. Kotter identifies the eight steps necessary 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).

Assessment of the Healthcare Environment

Much research is being done after the demand for change by the IOM and TJC. A study done in Canada by Rice et al.(2010), started with a basic communication intervention of identifying oneself, defining one's role, sharing the issue, and asking for feedback (p. 352). This intervention was meant to be simple and brief enough to not interrupt the workflow (Rice et al., 2010, p352). Support was obtained from management and training was then implemented to senior staff. This senior staff would then be responsible for training and acting as ward intervention leaders for the junior members of their profession (Rice et al, 2010. 352). The conclusion of this study was the intervention was not successful because despite its design to be brief and simple, it was a huge change for many in a busy work environment (Rice et al., 2010). Despite initial support, senior members did not have time to communicate the intervention so many junior staff in the wards studied were still unaware of the intervention (Rice et al., 2010, p.

355). The status quo hierarchy affected communication with physicians as they were “unwilling to elicit input from other professions” (Rice et al., 2010, .p. 356). This hierarchy also explains passive resistance on the part of the nurses and other health professional as they have “adopted strategies… to work around the power structure (Fagan & Gareleick, 2004; Keddy et al., 1986; Simpson, 2007)” (as cited by Rice et al., 2010, p. 358). Authors conclude that a greater commitment to collaboration at all levels may be necessary for change (Rice et al., 2010, p. 359). Analysis shows no adaptation of the cultural competence necessary to work effectively with other members of the health care team.

In another study of five perinatal units in Northern Arizona, more commitment to improving communication was shown by nursing and the results were better when a combination of SBAR and Collaborative Communication Education was taught to all nursing staff in sixteen one-hour sessions (Beckett & Kipnis, 2009, p. 21). These classes included “team building and collaboration strategies, positive communication techniques, communication styles, empathy, and problem-solving strategies” (Beckett & Kipnis, 2009, p. 21). Despite resistance from physicians (they attended a twenty minute presentation and did not participate in surveys), “statistically significant changes were noted in communication, teamwork, and the safety climate” (Becket & Kipnis, 2009, p. 26). In this study, nurses committed to doing their part to become aware of the culture outside their own and learn to communicate effectively.

Finally, in a study involving the entire multidisciplinary team, “in situ” drills were videotaped and analyzed to evaluate nursing performance during critical events (Miller, Riley, & Davis, 2009, p. 248). The competencies for effective interdisciplinary teamwork of situational awareness, closed loop communication, SBAR-R, and shared mental model were evaluated (Miller, Riley & Davis, 2009, p. 250). The researchers felt that “team composition variability is

the prime impediment to the high reliability required for consistent care" (Miller, Riley & Davis, 2009, p. 254). The basis of their reasearch suggests that nurses are the most consistent member of the team for their individual unit and because of this should be in the leadership role. The results of this study suggested, "nurses have not achieved the performance required to constitute high reliability" (Miller, Riley & Davis, 2009, p. 254). Miller, Riley and Davis conclude that nurses need more training in team communication.

In identifying the nurse as the most consistent member of the healthcare team, Miller, Riley and Davis, suggest, "nurses are at the sharp edge of ensuring patient safety" (2009. P. 248). Mannahan agrees that physician time with patients is brief and they often practice on more than one unit or even hospital while nurses spent entire shifts with their patients (2010, p.75). The root cause of patient safety issues is given to us by the Joint Commission (TJC), as previously identified, that 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). It is time nursing owns their share in improving patient safety and becomes aware of their ethnocentricity. "Nurses have a key role in assuring effective team performance through the transfer of critical information" (Miller et al., 2009, p. 254).

Implications

Schmalenberg et al. as cited in Mannahan says, "physicians consistently cite competence as essential to trust and respect" (2010, p. 73). Nurses need to command trust and respect by identifying ourselves and approaching physicians with confidence and professionalism, by our level of education (BSN or greater) and through national certification. Our use of evidence based practice and knowledge and the way we disseminate the information needed by the interdisciplinary team will exhibit 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). Nursing needs to commit to ensuring team communication through education. Work needs to be done with standardized communication techniques shown to be reliable in other industries (Marshall et al., 2009, p. 137) along with collaborative communication education (Beckett & Kipnis, 2009, p. 21). Further studies need to be done on the best methods of communication techniques needed to improve collaboration between the healthcare team. Moreover and perhaps most importantly, teamwork needs to be emphasized in the education of both nurses and physicians, where both are "educated as individuals and trained separately" (Henriksen & Patterson, 2007 as cited by Miller et al., 2009, p. 248). Benner is cited in Mannahan's article that "one's professional role is likely attained during professional education and early in practice" (2010, p. 74). Work on teamwork early in education can set patterns for a lifetime of professional practice.

Recommendations

It is not difficult to see how communication encompasses the themes of critical thinking basic to the nursing process addressed by the American Nurses Association (ANA) and spanning all areas of nursing practice. These 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)

In addition, these quality and safety competencies of the Quality and Safety Education for Nurses (QSEN) are met by 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).

The barriers to achieving effective communication are identified in this paper as traditional hierarchy and resistance to change with a lack of the perceived benefit to change. In addition, there is an overlapping but different bodies of knowledge between members of the healthcare team. There needs to be a greater commitment at all levels of health care (administration, physicians, nurses, and other members of the multidisciplinary team) including a time and financial commitment to learning communication techniques and developing a team approach to patient care. Personal commitment and belief in the problem are necessary to overcome the lack of cultural competence. Fortunately, despite our differences, not all is 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 are keys 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

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.

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

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.

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

Yoder-Wise, P. S. (2011). *Leading and managing in nursing (fifth edition).* St. Louis, Missouri: Mosby, Inc.