When Communication Fails

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 Communication is the key for patient safety and effective care delivery within any heath care setting. It is the responsibility of the health care professional to assume their complementary roles and cooperate with each other through proper voicing of ideas and concerns, sharing the liabilities for problem solving and making important health decisions in order to carry out effective plans for delivering the patient care. It is imperative to inculcate the practice of collaboration among physicians, surgeons, nurses, anesthetists and other health care specialists. The communication enhances the awareness and knowledge of the medical team regarding each other’s skills and analyzing their roles. This practice assists in decision making process in the cases of critical cases such as that of Bromiley Case.

 Studies over time have established that the social, interpersonal and organizational structures within health care systems add to the communication failures and it has been implicated as one of the major contributor to the adverse medical events and patient outcomes. It has also been found out that there the verbal communication among different health care staff remains inconsistent which eventually leads to complicated cases. Several health care staff is used to have poor communication and ineffective teamwork due to the toxic culture of low expectations developed within health care settings. The lack of communication leads to medical errors because albeit conscientious health care specialists tend to ignore the potential red signals and other clinical discrepancies. However, it is needed to consider such indicators as worrisome and a questionable stance over their objective of delivering care with safety (O’Daniel & Rosenstein, 2008).

 There are several proposed models in order to enhance the clinical experiences and considering the implications of the human factors. The mental models, according to the theory of Senge, emphasize that these are the assumptions, generalizations or visuals ingrained in one’s consciousness that effect one’s understanding about the world. These factors influence their actions based on either generalization or complicated theories. Within a clinical setting, two individuals with conflicting mental models can impede the ability to learn and bring innovation in the choices. Since a wrong mental model can ultimately lead to a wrong action, a contradictory model among two people would make them interpret the same issue in different ways. In such situations, there exist communication gaps and lack of team work. These conflicts can be overcome by focusing on the Learning Organization and its five components i.e. personal mastery, team learning, shared vision, mental models and systems thinking. These objectives help in the preventing and coping with the severe complications and adverse events that might occur due to lack or failure of communication.

 TeamSTEPPS program has discussed standardized techniques for effective communication. The first strategy is SBAR which is used for communicating serious information that might need immediate consideration and actions based on patient’s condition. This technique includes to understand the patient’s situation, clinical background, assessment of the problem and recommendations and requests. Another strategy is Call-Out in which critical information is simultaneously provided to the all the team members. Check-Back is a method of conforming if the information conveyed has been understood by the receiver. While Handoff provides opportunity to ask several questions to clarify and confirm the information transferred (AHA, 2015). It has been contemplated through research that following these protocols and ensuring the proper channel of communication within a clinical setting can prevent medical complications. It is important to deliver all the information to all the team members. The observations and recommendations by the nurses and other staff should not be ignored, rather their say should be given due attention. A collaborative team can avoid aby adverse clinical events by maintain the flow of communication in the health care setting.

**References**

AHA. (2015). *Improving Patient Safety Culture through Teamwork and Communication: TeamSTEPPS®*. American Hospital Association.

O’Daniel, M., & Rosenstein, A. H. (2008). Professional Communication and Team Collaboration. In R. G. Hughes (Ed.), *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK2637/