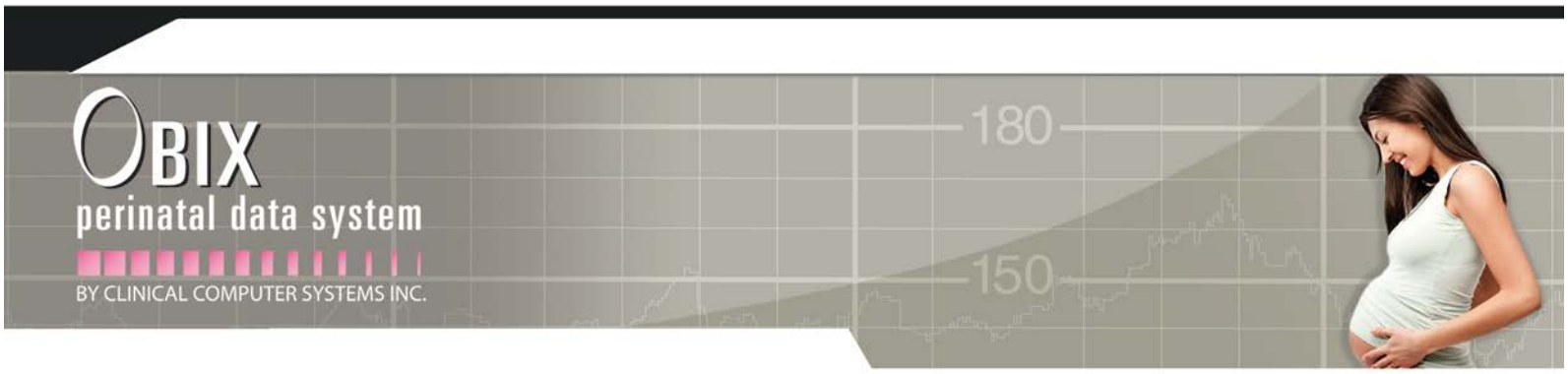

Improving Employee Communication: The Key to Patient Safety

By: Rosanne McMahon

Contrary clinical differences are a fact of life, but only in an obstetrical (OB) unit could it result in an adverse outcome for two patients—mother and baby. Despite advances in medicine, technology, and the implementation of workplace teams, there is still potential for error. Keeping obstetric patients safe can be a challenge, but a key solution may be as simple as instituting and maintaining clear team communication.

Many clinicians can recall a situation when they didn't feel empowered to speak up despite imminent danger to their patients. This may be the result of different perspectives on clinical management, age, experience, or a person's role within the organization. Remaining silent in an OB unit can not only result in unfortunate patient outcomes, but in extreme cases, lead to a medical malpractice suit.

During labor and birth there is a need for ongoing precise communication among team members. The source of a breakdown can be very complex, since a variety of people are involved in a patient's care over an extended period. Traditional clinician training, intimidation, lack of established protocols, and the absence of comprehensive documentation tools, can negatively impact the mobilization of a medical team's response.

Typically, physicians, midwives and nurses train in isolated silos. This can create challenges when communicating with those outside of their discipline. Cross-functional team training to reinforce the importance of actively listening to the concerns of others, and sharing the responsibility in reporting accurate assessments of patients, is vital. Safety risks can be significantly minimized when clinicians speak up, share insights and rapidly intervene if unsafe situations occur.

Confrontation can be uncomfortable, especially when there is an institutional hierarchy reporting structure. Clinicians often have differing views about what constitutes the best or safest care in common obstetrics situations. For some, questioning a decision or asking for clarification may create conflict. Others might view

this as a positive way of building engagement among team members and facilitating crucial dialogue should an emergency arise. In a healthy work environment, the request for additional understanding should never be viewed as a challenge to someone's expertise.

In the absence of a clear chain of command, it can be difficult to quickly resolve urgent issues pertaining to patient care and treatment. This can be eliminated by implementing departmental protocols. It's not uncommon to find resistance to these measures from clinicians who claim superiority of experience and intuition over evidence and standardization. However, following formal guidelines in a critical situation is an effective way to set fundamental expectations, decrease response time, and improve communication among team members.

Electronic health records (EHRs) are an additional communication component in an OB unit. They provide clinicians with a patient's comprehensive medical history and ensure key information is legible and not overlooked. They include maternal risk assessments, vital signs, uterine and fetal heart rate trends, tests ordered, and results. Additionally, they eliminate disjointed communication among clinicians, especially during shift changes. EHRs are also archived and stored electronically. They can easily be retrieved if legal issues pertaining to a patient's outcome arises.

Effective communication is the hallmark of safe and reliable patient care. While some undesired outcomes are inevitable, many errors are preventable. Employers need to be committed to enhancing timely and accurate communication across their organization, but especially within an OB unit where multiple patients can be simultaneously impacted. Patient safety is everyone's responsibility.

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