JOGNN CLINICAL ISSUES

Communication and Teamwork in Patient Care: How Much Can We Learn From Aviation?

Audrey Lyndon

Objective: To identify evidence on the role of assertiveness and teamwork and the application of aviation industry techniques to improve patient safety for inpatient obstetric care.

Data Sources: Studies limited to research with humans in English language retrieved from CINAHL, PubMed, Social Science Abstracts, and Social Sciences Citation Index, and references from reviewed articles.

Study Selection: A total of 13 studies were reviewed, including 5 studies of teamwork, communication, and safety attitudes in aviation; 2 studies comparing these factors in aviation and health care; and 6 studies of assertive behavior and decision making by nurses. Studies lacking methodological rigor or focusing on medication errors and deviant behavior were excluded.

Data Synthesis: Pilot attitudes regarding interpersonal interaction on the flight deck predicted effective performance and were amenable to behavior-based training to improve team performance. Nursing knowledge was inconsistently accessed in decision making. Findings regarding nurse assertiveness were mixed.

Conclusions: Adaptation of training concepts and safety methods from other fields will have limited impact on perinatal safety without an examination of the contextual experiences of nurses and other health care providers in working to prevent patient harm.
JOGNN, 35, 538-546; 2006. DOI: 10.1111/J.1552-6909.2006.00074.x

Keywords: Assertiveness—Communication—Patient safety—Perinatal safety—Safety attitudes—Teamwork

Accepted: May 2005

High-risk domains are those in which error and accident have potentially catastrophic consequences (Gaba, 2000; Knox, 2003; Rochlin, 1999). Health care organizations are high-risk domains by virtue of their increasing patient acuity, technical complexity, and fundamental dependence on human beings to execute care (Institute of Medicine [IOM], 2004). Communication problems are consistently identified as a leading cause of system breakdown in patient care (IOM, 2000, 2001, 2004; Simpson & Knox, 2003). Likewise, the July 2004 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) *Sentinel Event Alert* highlighted the significant contribution of communication problems to potentially preventable perinatal morbidity and mortality (JCAHO, 2004).

In other high-risk domains (such as aviation and nuclear operations), safe operations are characterized by a collective sense of agency for maintaining safety and a mutual understanding that all team members will state their observations, opinions, and recommendations, and actively solicit and consider input from other team members (Knox, 2003; Rochlin, 1999; Simpson & Knox, 2003). In health care, however, fundamental and longstanding problems with interprofessional relationships have been well documented (Espin & Lingard, 2001; Iacono, 2003; Thomas, Sexton, & Helmreich, 2003; West, 2000; Zwarenstein & Bryant, 2004).

The major thrust of the patient safety movement has been toward replacing the focus on individual culpability for error ("blame and shame" culture) with a systematic search for, and elimination of, the organizational problems that allow human errors to result in patient harm (IOM, 2000, 2001, 2004; Simpson & Knox, 2003; West, 2000). However, Rochlin (1999)

 © 2006, AWHONN, the Association of Women's Health, Obstetric and Neonatal Nurses

proposed that a single-minded focus on neutralizing error and risk interferes with the maintenance of safe operations by obscuring the effect and importance of individual and collective action. Safety is more appropriately conceptualized as a social construct of *collective agency* that is essential to understanding and managing evolving, and frequently unpredictable, threats. Knox (2003) and Henneman and Gawlinski (2004) conceptualized safety as a *dynamic process* in which the role of health care providers is to *create safety* by actively seeking potential sources of harm and deflecting them from the patient.

> Health care providers must promote safety by actively seeking potential sources of harm and deflecting them from the patient.

In the inpatient obstetric setting, this active role of identifying and deflecting the slips, trips, lapses, organizational problems, and latent system failures that will inevitably place the patient in harm's way (Gaba, 2000; West, 2000), falls disproportionately on the nurse as the primary gatekeeper of observations, interventions, treatments, and often the management of labor (IOM, 2004; James, Simpson, & Knox, 2003). However, in their review of patient safety, human factors, and adverse obstetric events, Simpson and Knox (2003) identified the following repetitive themes in near misses and injuries: "Concern was expressed, but not directly. The problem was stated, often not clearly. A proposed action didn't happen. A decision was not reached or acted upon." (p. 243) and identified assertive communication as "the key to maintaining safe operations," (p.234) in the high-risk domain of inpatient maternity care.

Several recent studies have documented what Gaba, Singer, Sinaiko, Bowen, and Ciavarelli (2003) described as "problematic" attitudes toward safety practices and teamwork in health care environments. Sexton, Thomas, and Helmreich (2000) noted that research is needed to better understand health care provider attitudes that may be amenable to intervention, as work in aviation psychology has demonstrated that attitudes regarding stress, hierarchy, teamwork, and error are not only predictive of safe performance in high-risk conditions but also sensitive to intervention via targeted training. The purpose of this review is to identify knowledge gaps, what is known, and opportunities for research regarding the role of assertion and teamwork and the application of aviation training techniques to improving patient safety in inpatient obstetric care.

The Problem: What is Known About the Presence and Effects of Assertiveness in Teams?

Theories of organizational safety have been applied to health care environments (Gaba, 2000). Normal accident theory (NAT) focuses on the complexity and "tight coupling" of system components as sources of accidents. From a NAT perspective, accidents are inevitable because the root causes of accidents can be traced to latent properties of the organizational system which, when triggered, result in a cascade of events which is not always caught by the system's technical or procedural defenses; and in fact, the addition of new defenses into the system may increase risk by increasing system complexity (Gaba). Application of human factors theory has demonstrated that communication patterns, team function, workload, and coping mechanisms affect both individual and group ability to identify evolving problems and make appropriate management decisions in complex decision-making situations (Carthey, de Leval, & Reason, 2001; Helmreich, Foushee, Benson, & Russini, 1986; Schaefer, Helmreich, & Scheidegger, 1995).

Highly reliable organizations manage the tendency toward accidents through collective agency for identifying and managing continuously evolving threats. That is, all operators are charged with scanning continuously for threats, and for speaking up when they identify potential threats, regardless of their status in the hierarchy or their defined role on the work team. This collective sense of agency is generated by the intensity of operations, identification and elimination of underperformance, and disciplined practice in managing, planning, anticipation, communication, and teamwork (Gaba, 2000; Rochlin, 1999; Weick, 2002).

When high reliability, normal accident, and human factors theories were applied to practical experience in aviation and other high-risk domains, assertiveness was identified as a key skill for creating patient safety and effective teamwork in the obstetric environment (Knox, 2003; Leonard, Graham, & Bonacum, 2004; Simpson & Knox, 2003). However, importing concepts and methods from other fields without understanding the experiences of nurses in the context of health care teams is not likely to overcome long-standing interprofessional conflict. Understanding nurses' perceptions of their own use of assertiveness and the factors that facilitate or constrain their effectiveness or their sense of agency is therefore a critical component of building and maintaining safe patient care systems.

Assertiveness occurs when "an individual provider asserts their opinion [through questions or statements of opinion] during critical times" (Thomas, Sexton, & Helmreich, 2004), or "individuals speak up and state their information with appropriate persistence until there is a clear resolution" (Preston, 2003).

Download English Version:

https://daneshyari.com/en/article/2633977

Download Persian Version:

https://daneshyari.com/article/2633977

Daneshyari.com