The impact of communication failures

When considering systems it is important to be mindful of the effect that breakdowns in communications within and between teams can have on patient safety. The risk of communication failure is exacerbated by siloed teams and hierarchical structures that prevent the free exchange of information. Co-ordination, communication, and shared responsibilities are more able to be achieved when clinicians respond to one another as partners, not as competitors, and work together collaboratively.

HDC has raised issues with regard to team dynamics over an extended period. In case 12HDC01488 an elderly patient was observed over a period of 90 minutes as having dangerously low blood pressure following surgery. Despite each member of the surgical team having noted this concerning sign, no one in the team recognised that rapid treatment was required. The expert adviser observed:

> "[T]here has been a trend in health care in the last ten years to encourage all members of the medical team to seek the best treatment for the patient, rather than just following orders as they are given. This culture of early warning and pushing concerns by any member of the care team is apparent in all hospitals that I work in, and is to be applauded. It may well have meant a more rapid resuscitation and earlier return to theatre in this case."

In that case the Commissioner said every member of the clinical team had a responsibility to recognise the risk that the patient's prolonged low blood pressure presented, and each had an individual responsibility to step up and advocate for him. It was not sufficient to wait for the surgeon to make the decision to re-operate. The DHB was held responsible for the lack of critical thinking and proactivity of its staff.

In case 14HDC01187 the junior doctor and nurse both said they were concerned by a child's presentation in the ED. However, neither spoke up. Dr C told HDC that "as a junior House Officer it was not easy to challenge a senior doctor". The DHB's Serious Adverse Event (SAE) review made the following comments about the lack of a multidisciplinary approach:

> "The team as a whole was in possession of enough information to indicate that this was a very unwell child, but there was no meeting of minds between the nursing and medical perspectives. This was a result of attitudes and opportunities. Staff were moderately busy with other patients and medical decisions were made while the nurse was out of the room. However an attitude of valuing the nursing perspective would have overcome that and ensured that there was adequate communication of concerns and opinions."

The Commissioner reinforced that any individual in the clinical team should be able to ask questions or challenge decisions at any time, and it is important that employers such as DHBs encourage such a culture. He stated that good support systems (including the safety net of vigilant senior nurses and readily available consultants) are also crucial. He said the fact that both the nurse and the junior doctor said they had concerns but did not raise them demonstrated that more could be done at the DHB to encourage a culture where it is commonplace for questions to be asked, to and from any point in the hierarchy, at any time.

Similar issues arose in a recent decision made by the Deputy Health and Disability Commissioner (16HDC00911).

A woman arrived at the delivery unit at a hospital in established labour at term. At that stage she was cared for by her lead maternity carer (LMC). When the labour failed to progress, and the baby experienced fetal distress in the second stage of labour, a registrar recommended an instrumental delivery. The consultant carried out a ventouse extraction. It took three pulls to deliver the baby's head, and there was moderate shoulder dystocia. The woman had a perineal tear during the delivery.

Immediately following the delivery, the consultant left the room to attend to another patient, and the registrar began to repair the tear. The registrar queried whether it was a fourth degree tear, and discussed the concerns with a senior registrar. The senior registrar examined the woman, and decided that the tear was second degree only, and began repairing it. Part way through the repair, the senior registrar became concerned that the tear possibly involved the anal mucosa, and discussed her concerns with the consultant.

The mother stated that the consultant did not give the team a chance to speak up, and because of a communication issue between the consultant and the registrar, the registrar left the room crying.

The mother told her LMC that she was experiencing faecal leakage. However, the LMC did not examine her. Six days later, the mother again reported faecal discharge. At a further post-natal visit, 16 days post-partum, the woman reported pain and faecal discharge. The LMC examined her, queried an infected perineum, and requested a review by an obstetric registrar. It was found the woman had a fourth degree tear.

In this case, the registrar was concerned that the woman had a fourth degree tear. The senior registrar considered there was a complex second degree tear. Despite the concerns raised by two registrars, the consultant did not identify that the tear was more significant. The consultant was found to have breached Right 4(1) of the Code. The Deputy Commissioner noted that the manner in which the consultant interacted with the registrar was inappropriate.

With regard to the LMC, the Deputy Commissioner was advised that failing to undertake a visual inspection of the perineum prior to 16 days post-partum, in a woman who has undergone a complex repair of the perineum and reported faecal leakage, was a significant departure from accepted practice. The Deputy Commissioner found that the LMC also breached Right 4(1) of the Code.

Healthcare providers generally want to provide a high standard of care resulting in excellent patient outcomes — improved communication creates a safer environment for patients. In addition, compassion and common courtesy are essential, not only when communicating with patients, but also between various members of the clinical team. These issues can also arise in general practice where practice nurses may have an invaluable role in identifying concerns about patients and alerting the doctors to them. If all members of the clinical team work together to accomplish a common goal, patient safety will improve.

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