

Chapter 33 Professional Communication and Team Collaboration

Michelle O'Daniel; Alan H. Rosenstein.

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Background

In today's health care system, delivery processes involve numerous interfaces and patient handoffs among multiple health care practitioners with varying levels of educational and occupational training. During the course of a 4-day hospital stay, a patient may interact with 50 different employees, including physicians, nurses, technicians, and others. Effective clinical practice thus involves many instances where critical information must be accurately communicated. Team collaboration is essential. When health care professionals are not communicating effectively, patient safety is at risk for several reasons: lack of critical information, misinterpretation of information, unclear orders over the telephone, and overlooked changes in status.¹

Lack of communication creates situations where medical errors can occur. These errors have the potential to cause severe injury or unexpected patient death. Medical errors, especially those caused by a failure to communicate, are a pervasive problem in today's health care organizations. According to the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations, JCAHO), if medical errors appeared on the National Center for Health Statistics's list of the top 10 causes of death in the United States, they would rank number 5— ahead of accidents, diabetes, and Alzheimer's disease, as well as AIDS, breast cancer, and gunshot wounds.² The 1999 Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, revealed that between 44,000 and 98,000 people die every year in U.S. hospitals because of medical errors.² Even more disturbing, communication failures are the leading root cause of the sentinel events reported to the Joint Commission from 1995 to 2004. More specifically, the Joint Commission cites communication failures as the leading root cause for medication errors, delays in treatment, and wrong-site surgeries, as well as the second most frequently cited root cause for operative and postoperative events and fatal falls.³

Traditional medical education emphasizes the importance of error-free practice, utilizing intense peer pressure to achieve perfection during both diagnosis and treatment. Errors are therefore perceived normatively as an expression of failure. This atmosphere creates an environment that precludes the fair, open discussion of mistakes required if organizational learning is to take place. In the early 1990s, Donald Berwick wrote about patients needing an open communication system instead of experiencing adverse events stemming from communication failures.³ More than a decade later, this concept still has profound implications on our method of health care delivery. As such, this chapter will review the literature on the important role of communication and team collaboration in helping to reduce medical errors and increase patient safety.

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Research Evidence

What Are Communication and Team Collaboration?

Webster's Dictionary defines communication as "the imparting or interchange of thoughts, opinions, or information by speech, writing, or signs." It is important to consider that communication is not just verbal in form. One study states that 93 percent of communication is more affected by body language, attitude, and tone, leaving only 7

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Table of Contents Chapter 33 Professional Communication And Team Collaboration

1. Understanding the eBook Chapter 33 Professional Communication And Team Collaboration
 - The Rise of Digital Reading Chapter 33 Professional Communication And Team Collaboration
 - Advantages of eBooks Over Traditional Books
2. Identifying Chapter 33 Professional Communication And Team Collaboration
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Chapter 33 Professional Communication And Team Collaboration
 - User-Friendly Interface
4. Exploring eBook Recommendations from Chapter 33 Professional Communication And Team Collaboration
 - Personalized Recommendations
 - Chapter 33 Professional Communication And Team Collaboration User Reviews and Ratings
 - Chapter 33 Professional Communication And Team Collaboration and Bestseller Lists

5. Accessing Chapter 33 Professional Communication And Team Collaboration Free and Paid eBooks
 - Chapter 33 Professional Communication And Team Collaboration Public Domain eBooks
 - Chapter 33 Professional Communication And Team Collaboration eBook Subscription Services
 - Chapter 33 Professional Communication And Team Collaboration Budget-Friendly Options
6. Navigating Chapter 33 Professional Communication And Team Collaboration eBook Formats
 - ePub, PDF, MOBI, and More
 - Chapter 33 Professional Communication And Team Collaboration Compatibility with Devices
 - Chapter 33 Professional Communication And Team Collaboration Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Chapter 33 Professional Communication And Team Collaboration
 - Highlighting and Note-Taking Chapter 33 Professional Communication And Team Collaboration
 - Interactive Elements Chapter 33 Professional Communication And Team Collaboration
8. Staying Engaged with Chapter 33 Professional Communication And Team Collaboration
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Chapter 33 Professional Communication And Team Collaboration
9. Balancing eBooks and Physical Books Chapter 33 Professional Communication And Team Collaboration
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Chapter 33 Professional Communication And Team Collaboration
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Chapter 33 Professional Communication And Team Collaboration
 - Setting Reading Goals Chapter 33 Professional Communication And Team Collaboration
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Chapter 33 Professional Communication And Team Collaboration
 - Fact-Checking eBook Content of Chapter 33 Professional Communication And Team Collaboration
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning

- Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
- Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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