Government of **Western Australia**
Department of **Health**
Clinical Simulation Support Unit

Interprofessional Learning Through Simulation Project

Incident in a waiting room – managing upwards to avoid adverse events

Facilitators' Guide

Acknowledgements

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The filmed scenario has been developed from the experiences of the Interprofessional Learning in Simulation Project Steering Group. All due care has been taken to make the scenarios as realistic as possible. The characters in the filmed scenarios are fictitious and any resemblance to persons living or dead is purely coincidental.

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Contents

How to use this resource

This resource (the Facilitator's Guide) provides the framework to support the development of communication and problem solving, together with problem-based learning scenarios that encompass some challenging (but quite typical) patients that clinicians could expect to encounter as part of their practice. The goal of this interprofessional learning experience is to help prepare all health professionals – be they students or beginning clinicians – for working together.

This resource is intended to develop your understanding of the principles of interprofessional practice and raise your awareness of opportunities for implementing interprofessional practice in your own environment. Throughout the resource are opportunities to consider how notions of interprofessional practice affect your current work practices and activities that enable you to reflect on these.

The goal of this interprofessional learning experience is to help prepare all health professionals – be they students or beginning clinicians – for working together.

Interprofessional learning through simulation

This resource utilises simulation as a means to facilitate a learning experience; one that re-creates events that are closely linked to reality. Gaba[1] defined simulation as a technique, rather than a technology, to replace or amplify real life experiences with guided experiences, often immersive in nature, to evoke or replicate aspects of the real world, in a fully interactive pattern.

Simulation provides a safe learning environment for students to practice, where they are free to make mistakes, correct them and improve the processes of care.[2] Simulation is the bridge between classroom learning and the real life clinical experience, allowing students to put theory into practice.

Interprofessional learning through simulation provides learning opportunities to prepare future health care professionals for the collaborative models of health care being developed internationally[3] and can encompass a range of environments and resources that harness technologies, including multimedia and online applications.[4]

Resource contents

There are four sections within this resource. Information presented in Section One and Section Two is largely focussed on interprofessional learning and Section Two also contains an introductory section on managing upwards.

- Sections One and Two of this resource contain questions that require users to reflect on the content they have covered.
- Scenarios included in Section Three require users to watch the associated audiovisual resource ‘Incident in the waiting room’ and complete the questions that relate to interprofessional learning and managing upwards to avoid adverse events.
- Section Four provides a literature review about managing upwards to avoid adverse events, which can be used as reference material.

Learning objectives

The key interprofessional learning message of this resource is:

Managing upwards to avoid adverse events – how to address incorrect behaviour in an acute situation

The learning objectives of this resource are based on **five competency domains** from the Australian audit of interprofessional education in health:

- Teamwork;
- Understanding roles and respecting other professions;
- Role clarification;
- Understanding of Interprofessional Education (IPE);
- Reflection.[5]

Learning outcomes will be addressed through the consideration and discussion of material presented in Sections One and Two in relation to interprofessional practice generally, and the case study presented in Section Three which is focussed more specifically on managing upwards to avoid adverse events.

Learning outcomes

On completion of this resource, participants should be able to:

- Identify the key elements of interprofessional practice;
- Differentiate between interprofessional practice and current ways of working;
- Understand the importance of 'human factors' and appreciate how non-technical factors impact patient care;
- Develop an awareness of tools to enhance successful communication with patients and carers;
- Describe strategies to develop a deeper understanding of other professions' roles and responsibilities;
- Identify what changes are required to promote interprofessional practice;

- Distinguish between the roles of the health professionals involved in this case study, including areas of possible overlap;
- Identify the potential barriers to interprofessional communication and collaboration in the context of an adverse event;
- Analyse managing upwards in the context of the health care team;
- Assess the impact of team communication and team relationships on patient care; and
- Reflect on own and other health professionals' practice.

Section One: What is 'interprofessional'?

Why the need for interprofessional learning?

In today's health care setting, human service professions are facing problems so complex that no single discipline can possibly respond to them effectively.[6] The World Health Organization (WHO) has stated 'It is no longer enough for health workers to be professional. In the current global climate, health workers also need to be interprofessional'.[7]

What does the term interprofessional mean?

Interprofessional learning (IPL) is defined as:

- Learning arising from interaction between members (or students) of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or education settings.[8]

Encourages professions to learn with, from and about each other

Interprofessional education (IPE) is defined as:

- Occasions where two or more professions learn from, with and about each other to improve collaboration and the quality of care.[8]

Interprofessional practice (IPP) is defined as:

- Two or more professions working together as a team with a common purpose, commitment and mutual respect.[8]

When interprofessional practice is working well it is thought to achieve the following six outcomes:[9]

1. **Works to improve the quality of care:**

   No one profession, working in isolation, has the expertise to respond adequately and effectively to the complexity of many users' needs and to ensure that care is safe, seamless and holistic to the highest possible standard.

2. **Focuses on the needs of service users and carers:**

   IPL puts the interests of service users and carers at the centre of learning and practice.

3. **Encourages professions to learn with, from and about each other:**

IPL is more than common learning, valuable though that is to introduce shared concepts, skills, language and perspectives that establish common ground for interprofessional practice. It is also comparative, collaborative and interactive, a test-bed for interprofessional practice, taking into account respective roles and responsibilities, skills and knowledge, powers and duties, value systems and codes of conduct, opportunities and constraints. This cultivates mutual trust and respect, acknowledging differences, dispelling prejudice and rivalry and confronting misconceptions and stereotypes.

4. **Respects the integrity and contribution of each profession:**

IPL is grounded in mutual respect. Participants, whatever the differences in their status in the workplace, are equal learners. They celebrate and utilise the distinctive experience and expertise that participants bring from their respective professional fields.

5. **Enhances practice within professions:**

Each profession gains a deeper understanding of its own practice and how it can complement and reinforce that of others. This is endorsed where the IPL carries credit towards professional awards and counts towards career profession.

6. **Increases professional satisfaction:**

IPL cultivates collaborative practice where mutual support eases occupational stress, either by setting limits on the demands made on any one profession or by ensuring that support and guidance are provided by other professionals if and when added responsibilities are shouldered.

How is interprofessional practice different to how people currently work?

The Australasian Interprofessional Practice and Education Network (AIPPEN) have identified a number of terms currently that convey a similar but different intent and meaning to the term interprofessional.[10]

Interdisciplinary

- Interdisciplinary has been used by researchers and practitioners when they attempt to analyse, synthesise and harmonise the connections between disciplines, to generate a coordinated and coherent health delivery system.[11] 'Interdisciplinary' is said to lack the inherent depth of collaboration implied by the term 'interprofessional'.

Multidisciplinary

- Health professionals represent a range of health and social care professions that may work closely with one another, but may not necessarily interact, collaborate or communicate effectively.[12]

Multiprofessional

- Work occurs when a range of professional practitioners work in parallel. Each discipline has clear role definitions and specified tasks and there are hierarchical lines of authority and high levels of professional autonomy within the team.
- Multiprofessional, as a term, may not imply optimal levels of collaboration.
- Practitioners consult individually with service users and use their own goals and treatment plans to deliver services.[13]

Collaboration

- Is ‘an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the ways client/patient care and broader community health services are provided’.[14]

Do we need to focus on interprofessional collaborative practice – don't professionals already work interprofessionally?

Interprofessional practice is a way of practicing that is based on collaboration. Nurses, doctors and other health professionals have for a long time worked closely together and have developed successful long-term partnerships. However, as has been stated:

> We cannot assume that health professionals have either the skills or attributes required for interprofessional practice. They may need to learn how to collaborate. Developing interprofessional practice requires a commitment to engage in shared learning and dialogue. Dialogue has the potential to encourage collegial learning, change thinking, support new working relationships, and improve client care.[15]

Although health professionals receive extensive professional development, most training emphasises specific disease processes, technology and treatment and has largely undervalued human factors. Human factors training is necessary to help individuals learn how to improve working relationships with colleagues and those from other disciplines.[15]

The end goal of interprofessional education is to create a health workforce with improved levels of teamwork, collaboration, knowledge-sharing and problem-solving, eventually leading to better patient and client outcomes in health settings.[16] The WHO has recognised the importance of interprofessional education and collaborative practice in developing a health workforce that is able to meet the complex health challenges facing the world and assist in the achievement of the health-related Millennium Development Goals.[7]

ACTIVITY ONE

What would you expect to notice as indicators of interprofessional practice?

What range of factors might be different in an interprofessional practice environment?

ACTIVITY ONE: ANSWER AID

Anecdotes from clinicians with an increasing awareness of interprofessional thinking and behaviour in the clinical environment:

“I went to a placement and something clicked. It gelled and I suddenly got it…it’s more than an awareness of others – you realise you are not an island and it’s up to others as well. You can recognise opportunities for clients and refer them to other disciplines”.

“I used to get frustrated at them not seeing through my discipline lens but then I saw how difficult it was for me to learn about their discipline”.

“You begin to realise you are part of a bigger picture and because of that you need to be able to communicate with people in a way they understand… I was listening to nurses with all the jargon they use and it made me become more aware of the amount of jargon I use – I thought I was practising interprofessionally but didn’t realise I was using so much jargon”.

Section Two: Competency framework for interprofessional education

Although a range of competencies have been identified, there is no one overarching framework that provides a definitive set of interprofessional competencies. Initial findings from an Australian national audit of pre-registration interprofessional education in health identified five IPE domains to support the development of a national curriculum framework. The identified domains were:

- Teamwork;
- Understanding roles and respecting other professions;
- Role clarification;
- Understanding of IPE; and
- Reflection.[5]

Patients will increasingly demand physicians, nurses and other health professionals to communicate and work together effectively

Teamwork

The identified domain 'teamwork' included the elements: communication, leadership, attitudes, team relationships and conflict resolution. We know that effective teamwork plays a key role in improving quality and safety in health care, and the need for increased collaboration and teamwork across the health professions is necessary in order to care for an aging population with multiple chronic illnesses.[17] Patients will increasingly demand physicians, nurses and other health professionals to communicate and work together effectively. Teams bring their collective knowledge and experience to provide a more robust foundation for decision making than any single clinician can offer.[17]

Team functioning and collaboration is thought to be enhanced when individuals:

- Participate in team activities;
- Foster positive team relationships;
- Appreciate differing personalities within teams; and
- Demonstrate respect.[17]

Lack of focus on human factors

The elements that make up teamwork are regarded as 'human factors' and are the non-technical factors that impact on patient care. Human factors can be defined as the interaction of equipment and individuals and the variables that can affect the outcome.[18,19] Bromiley and Reid quote Catchpole in their article,[20] stating that more broadly the term clinical human factors can also encompass interactions with the environment that include an 'understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities, and the application of that knowledge in clinical settings'.

The contemporary focus of human factors in health care reportedly had its genesis in the work of James Reason in 1995 when he stated that, 'human rather than technical failures now represent the greatest threat to complex and potentially hazardous systems'.[21] More recent research highlights that rather than poor technical skill, human factors such as suboptimal communication and organisational system and culture inadequacies were implicated in up to 87% of the errors, adverse events and near misses that occur.[22-25]

Historically, health care has regarded technical skills and competence as key to patient safety. Technical excellence in, for example, nursing and medicine is important because health care professionals need to know what they are doing to maintain high standards of care and quality outcomes for patients. However, other safety-critical industries (such as defence and aviation) have learnt that even the most technically qualified and expert individuals can encounter difficulties when under stress. Such non-technical abilities – sometimes referred to as 'soft skills' – need to be valued equally.[26] Humans, when under pressure, have a capacity to become overly focused or fixated on technical problems.[27] Focus on human factors to improve the way teams work is important because:

- Opportunities to optimise the way teams work is becoming progressively more difficult with an increasing number of part-time workers, increasing patient loads and decreased staffing;
- The attitudes and behaviours of those who make up `teams' can be problematic at times and a lack of congruence in how teamwork itself is interpreted exacerbates underlying resentments, undermines professional esteem, and in some cases, creates outright conflict; and
- Working in teams, at times, can be fraught with difficulties and the `ideal' of effective team – working as defined in the prescriptive literature, is apparently rarely realised.[28]

ACTIVITY TWO

Think about your team (past or present) and how your team functions…what are the issues that make it challenging to focus on improving team performance?

What strategies have you found to be effective in improving team performance?

What do you feel could be done to improve team performance?

Communication

Appropriate interprofessional communication:

- Maintains patient confidentiality;
- Provides and delivers feedback;
- Promotes the role of other disciplines to patient/carers;
- Communicates in a clear and concise manner;
- Acknowledges the knowledge and skills of other disciplines; and
- Minimises discipline specific terminology.

Interprofessional practice also places an increased focus on the needs of service users and carers. Although communication among and between professionals is critical, to ensure the interests of service users and carers remains at the centre of learning and practice, strategies to enhance communication practices with service users and carers are essential. Patient-centred care:

- Places the service users and carers at the centre of practice;
- Establishes patient-centred goals;
- Facilitates decision making with patient/family; and
- Recognises and responds to the patient's changing needs.[29]

The mnemonic LIPSERVICE will help ensure that you consider the many aspects of successful communication with clients and patients and will be utilised later in the resource.

L is for Language	• Does your patient speak English? • How well do they speak it? • Do you need to consider getting an interpreter to assist? • What is the person's education level and understanding – will you need to modify the language you use in order to help them understand what you are asking or telling them?
I is for Introduction	• Make sure you introduce yourself to the person, and give them your role – especially if what you do is something that is not commonly known. While most patients will understand the role of a 'doctor', they may not be familiar with what an 'occupational therapist' does. If in doubt, you should explain your role.
P is for Privacy, Dignity and Cultural issues	• Is this a person who is going to be embarrassed by being examined by someone of the opposite gender? • Should you ask before you address them by their first name. Many more elderly patients are of a generation who value the respect that being called 'Mr' or 'Mrs' gives them. Be aware of different cultural expectations that you may encounter.

S is for Subjective Questioning	• This is where you take the person's history. • A thorough history will be invaluable in helping to make a diagnosis. • Be aware of the power of 'leading questions' though. • Ask open-ended rather than closed questions to obtain your answers.
E is for Examination	• Some considerations here include talking the person through what it is that you are doing, especially if this is an invasive or unusual procedure for them. • Knowing what is happening and why, as well as what to expect, can help alleviate the person's concern about what it is you are doing to them.
R is for Review	• Talk through what you have done as part of the examination – and what it added to your knowledge of their condition. • For example, 'You were talking about how you get short of breath, and I could hear from listening to your chest that your lungs are quite congested.'
V is for Verdict	• The diagnosis. • What their history and your examination have led you to think is causing their symptoms and signs.
I is for Information	• What does the diagnosis mean for the person? • Having a diagnosis of a lump in the breast can mean many things. • The person needs to know about these.
C is to remind you to Check Understanding	• This is where you determine if what you have said has made sense to the person. • People may only hear the diagnosis and then go into a state of shock – which means they don't process what you tell them next.
E is for End or Exit	• What's going to happen next for the person? • What about follow up? • Referrals to other professionals?

Understanding roles and respecting other professions / role clarification

The need to address complex health and illness problems, in the context of complex care delivery systems and community factors, calls for recognising the limits of professional expertise and the need for cooperation, coordination and collaboration across the professions in order to promote health and treat illness. However, effective coordination and collaboration can occur only when each profession knows and uses the other's expertise and capabilities in a patient-centred way.[30]

The WHO report in 2005 argued that health care providers must work interdependently, demonstrating mutual respect, trust, support and appreciation of each discipline's unique contribution. Although it is changing, the traditional way in which health professional students are educated is uni-professional; and occurs within discipline- and profession-specific groups.[31] Within uni-professional environments students develop a solid grounding in the specific knowledge of their own profession, although many, if not most, students leave educational environments with a cursory understanding of other disciplines' roles and responsibilities.

Interprofessional practice is about developing professionals who are confident in their own core skills and expertise and who are also fully aware and confident in the skills and expertise of fellow health and care professionals.

One educational approach which is thought to assist professionals to develop greater `team awareness' is to understand other professional perspectives through 'shared learning'.[28] Shared learning has the potential to deepen understanding of how professional roles and responsibilities complement each other[30] and engender a greater appreciation of 'common' or overlapping competencies.[32] An enhanced understanding of other professional's roles and responsibilities possible through shared learning can alleviate some of the potential tensions that exist in relation to overlapping competencies between health practitioners.

Interprofessional practice is about developing professionals who are confident in their own core skills and expertise and who are also fully aware and confident in the skills and expertise of fellow health and care professionals.[33]

ACTIVITY THREE

Within your own discipline, how easy/difficult would it be to verbalise your concerns about a colleague's knowledge, skills or competencies?

Thinking outside your own discipline, how would you know what knowledge, skills and competencies other disciplines need/should have? Pick a discipline you have contact with and explain what it is they do, as if you were explaining it to a patient.

Would it be more or less difficult to flag concerns about a colleague from another discipline than your own discipline, and why?

ACTIVITY THREE (continued)

Over your career, how have you learnt about other professional's roles?

Given that optimal interprofessional practice requires you to have a deeper understanding of other professions' roles and responsibilites, identify two professions you would like (or need) to know more about and list strategies you could implement to attain a greater in-depth understanding of that profession's roles and responsibilities.

ACTIVITY THREE: ANSWER AID

Each profession's roles and responsibilities vary within legal boundaries; actual roles and responsibilities change depending on the specific care situation. Professionals may find it challenging to communicate their own role and responsibilities to others. For example, Lamb et al.[34] discovered that staff nurses had no language to describe the key care coordination activities they performed in hospitals. Being able to explain what other professionals' roles and responsibilities are and how they complement one's own is more difficult when individual roles cannot be clearly articulated. Safe and effective care demands crisply defined roles and responsibilities.

Specific Roles/Responsibilities Competencies:

RR1. Communicate one's roles and responsibilities clearly to patients, families, and other professionals.

RR2. Recognise one's limitations in skills, knowledge, and abilities.

RR3. Engage diverse health care professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.

RR4. Explain the roles and responsibilities of other care providers and how the team works together to provide care.

RR5. Use the full scope of knowledge, skills, and abilities of available health professionals and health care workers to provide care that is safe, timely, efficient, effective, and equitable.

ACTIVITY THREE: ANSWER AID (continued)

RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.

RR7. Forge interdependent relationships with other professions to improve care and advance learning.

RR8. Engage in continuous professional and interprofessional development to enhance team performance.

RR9. Use unique and complementary abilities of all members of the team to optimize patient care.

(Interprofessional Education Collaborative, 2011)

Reflection

The importance of personal reflection in interprofessional practice was highlighted in a national study designed to inform the further development of IPL in Australian health professional education and workforce development. The report identified the importance of reflection as interprofessional education centred on:

> …the relational aspects of practice or practising, with a learning and reflective focus on the team, as well as the individual, and is responsive to a body of knowledge and ethical orientation that engages with teams and team functioning as well as individuals and individual functioning.[5]

Processes that facilitate both individual and team reflection are critical to increase awareness and understanding of intra and inter personal relationships. One such tool to assist in the process of personal or team-based reflection to generate well-considered steps to problem solving with team members, patients and clients, is the mnemonic ASPIRIN.

A	Acknowledge the problem	Basically, is there something that needs to be addressed?
S	Situational analysis	What is the cause of the situation? How did it come about and who is involved? What is likely to happen if you don't act? What are the risks if you do act?
P	Provide some solutions.	There is almost always more than one approach that could be used to try and solve this situation. Decide on which is the most suitable.
I	Implement	Your preferred solution.
R	Review the outcome	How did it help? Do you need to try something else?
I	Inform stakeholders	Let people know – communication is very important.
N	Next steps	Is this a temporary fix? Do you need to look at a different long term solution? Will the problem occur again and again unless steps are taken to resolve it in the longer term?

ACTIVITY FOUR

Consider a problem (past or present) and utilise ASPIRIN to assist you to generate new ways of thinking about that situation.

Reflect on how you consider interprofessional practice has the potential to impact upon patient outcomes.

Reflect on what you have covered in this resource thus far and consider what changes you need to make to ensure your own practice is interprofessionally-focussed.

Managing upwards to avoid adverse events

Adverse events

- International research has now shown that between 4% and 17.7% of patients suffer from some kind of harm (including permanent disability and death) as a result of adverse events while in hospital.[34]
- Injuries resulting in harm to a patient and caused by medical management rather than the underlying condition or disease of the patient are identified as *adverse events*.
- These adverse events are considered preventable and may be the result of a single or multiple accumulating errors occurring in practice.
- Some adverse events do not result in a patient injury or harm and are referred to as *near misses.*
- Research and investigation into adverse events and near misses has seen an increased emphasis on what is termed *human factors*.
- There are two elements that contribute to human errors: latent and active factors.
- Active factors are more common and are the actions or inactions of individuals.
- Latent factors are present in all organisations and are reflected through poor communication, policies, heavy workload, poor management skills and overall organisational culture.
- Research into adverse medical events highlights that rather than poor technical skills, human factors such as suboptimal communication and organisational systems and culture inadequacies are implicated in the majority of errors, adverse events and near misses that occur.

Managing upwards

- Management is getting things done through people, and upward management can be defined as getting things done through those who supervise us.
- The team approach to management results in more cooperation, togetherness and commitment.
- Four key points in maximising the effectiveness of managing upwards:
    1. Clear communication;
    2. In praise of the boss – let your manager know they are appreciated;
    3. Know what's important – ensure you are aware of your manager's priorities; and
    4. Know when to fold 'em – choose your battles carefully.

- There are several factors that may hinder effective upwards communication, including: fear of penalisation if an employee discloses their real opinion; avoiding risk of penalty if uncertain how their manager may respond; fear of punishment; and fear the employee may be perceived as lacking independence if they take a work-related problem to their manager.
- The key to promoting upwards communication lies, therefore, in the creation of secure relationships with employees and the modelling of desirable communication behaviours by managers.

Assertive communication

- Poor communication and communication overload are shown to have a direct correlation with patient outcomes, adverse events and stressors among health care professionals.
- There are two vital communication skills, **active listening** and **assertion**, which provide the foundation of effective communication.
- Active listening describes communication behaviours focused on overcoming barriers to shared understanding.
- Assertiveness is a term used to describe behaviours that a person can use to deliver clear messages and stand up for him/herself in difficult situations without violating the rights of others.
- Assertive body language means developing an awareness of our bodily expression of meaning and assuring a ‘good fit’ in the verbal and non-verbal messages we are sending. Assertive, congruent body language is especially helpful in stressful situations.

The abilities to manage upwards and communicate assertively within the health care team are essential skills in the provision of optimal patient care and the minimisation of adverse events.

A more complete literature review about managing upwards to avoid adverse events is available in Section Four.

Resource activities in relation to managing upwards to avoid adverse events follow in Section Three.

The scenario in Section Three highlights the importance of managing upwards to avoid adverse events and its implications for interprofessional collaborative practice.

Section Three: Scenario – Incident in a waiting room

Scenario

A young resident doctor has recently started work in a regional hospital. In the waiting room of this hospital a man collapses. An experienced nurse takes charge of the care for this patient, but is not using current evidence-based practice. The young resident doctor wants to intervene, but does not know how to address his experienced colleague.

List of characters

- Young resident doctor
- Registered nurse
- Alex Martin (patient)
- Receptionist
- Exercise physiology student
- Registrar (by telephone)

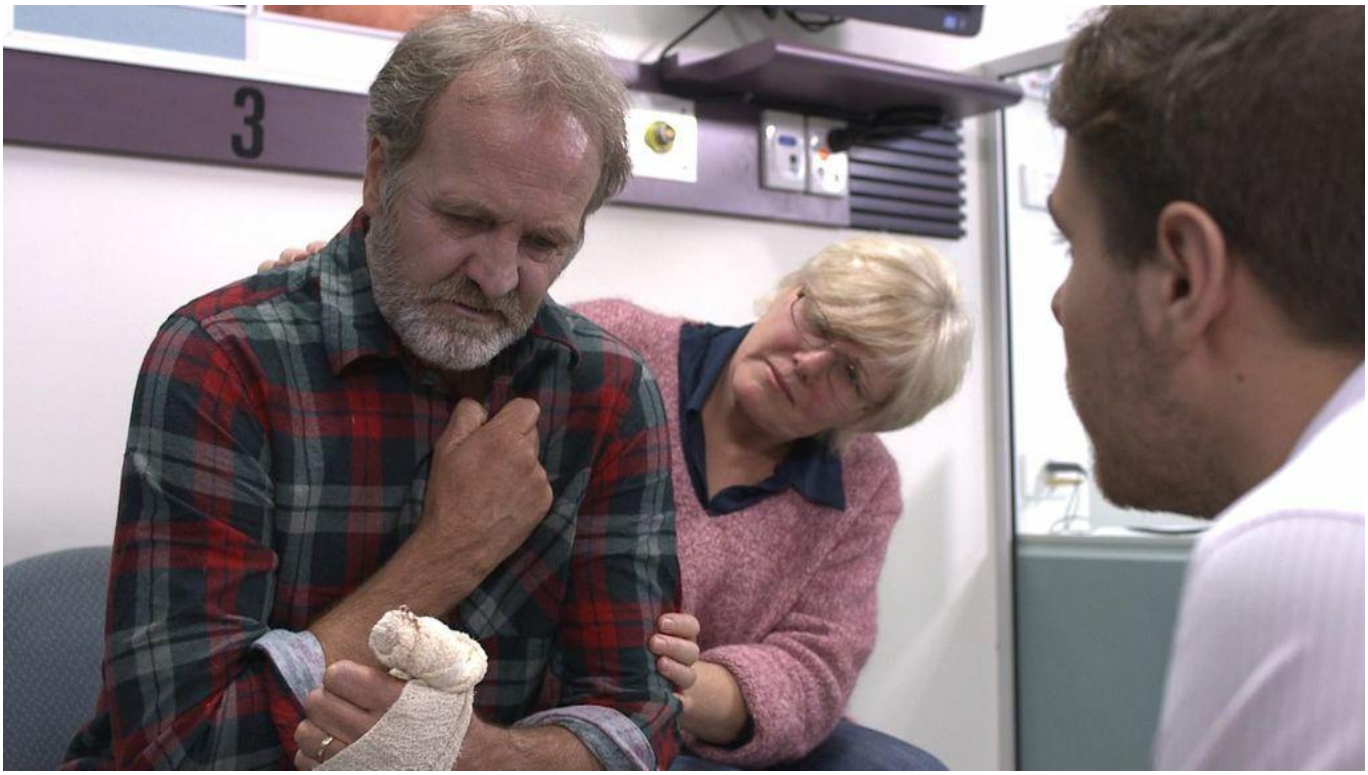
What to do next

Section Three of the resource requires that you:

1. Watch each scene of the associated resource ‘Incident in a waiting room’.
    - Scene One – Waiting room of a regional hospital
    - Scene Two – Improved practice
2. After you have watched a scene, complete the activity questions relevant to that scene.
3. If necessary, refer to the ‘answer aid’ text box positioned after the activity questions for hints relating to managing upwards to avoid adverse events.

Scene One: Waiting room of a regional hospital

Please watch ‘Incident in a waiting room’: Scene One



Notes:

ACTIVITY FIVE

What four factors would you change in this scene to improve teamwork?

How might a team member know their interpersonal skills are lacking?

What factors might contribute to the suboptimal communication between team members in this scenario?

ACTIVITY FIVE (continued)

Describe how role perception has influenced this scenario's outcomes (for all players).

What factors might prevent a team member from voicing their opinion?

If you were in this situation and assumed a leadership role, how would you allocate and manage the team to achieve a good outcome for the patient?

ACTIVITY FIVE: ANSWER AID

What factors might prevent a team member from voicing their opinion?

There are several factors that may hinder effective upwards communication, including: fear of penalisation if an employee discloses their real opinion; avoiding risk of penalty if uncertain how their manager may respond; fear of punishment; and fear the employee may be perceived as lacking independence if they take a work-related problem to their manager. In this scenario, the nurse has 20 years experience so a junior medical colleague may be reluctant to speak up for fear of reprisal from nursing staff.

One of the five domains identified in an Australian national audit of pre-registration interprofessional education in health, is teamwork. Interprofessional practice includes the elements: communication; leadership; attitudes; team relationships; and conflict resolution. Facilitation of this resource should include identifying if and where these behaviours occur in the interaction between the nurse and doctor.

Effective communication

Curtis[35] identified the following as a guide to effective communication:

- Personal considerations – learn to recognise your own emotional state and attempt to understand the other person's perspective;
- Preparation – a few moments of preparation (when possible) aids delivery of your message, both in terms of structure and content;
- Structure – a structured approach to communication ensures important details are not missed and minimises the risk of a communication error; and

ACTIVITY FIVE: ANSWER AID (continued)

- Graded assertiveness – staff may be afraid to be assertive in communicating with senior staff even when aware something is not right. This technique aims to assist the staff member to escalate their concern through a stepped process. See ‘Assertive Communication’ in ‘Section Four: Literature Review – Managing upwards to avoid adverse events’ for more information.

As it is a routine process, clinical handover can be improved by the use of tools and techniques that standardise the process, while leaving room for situational variance. Within the Western Australia Department of Health, the standardised structure for all clinical handovers is iSoBAR:[36]

Identify

Situation

Observations

Background

Agree to plan

Readback

Scene Two: Improved practice

Please watch ‘Incident in a waiting room’: Scene Two

Notes:

ACTIVITY SIX

Describe the communication and teamwork factors in this scenario that contributed to the changed outcomes.

Do these changes align with your answers in Activity Five? If not, what is different and has your opinion changed?

How is the safety of current and future patients improved, in comparison with Scene One?

ACTIVITY SIX (continued)

Debriefing is a semi-structured conversation with an individual who has just experienced a stressful or traumatic event. In most cases, the purpose of debriefing is to reduce any possibility of psychological harm by informing people about their experience or allowing them to talk about it.[37]

Discuss the importance of debriefing after an incident.

What changes will you make in your personal future practice as a result of what you have learnt in this scenario?

ACTIVITY SIX: ANSWER AID

Between Scene One and Scene Two the difference in three of the four aspects which enhance team functioning and collaboration is made visible:

- Foster positive team relationships;
- Appreciate differing personalities within teams; and
- Demonstrate respect.

Discuss the importance of debriefing after an incident.

Debriefing can serve as an opportunity to reflect on an experience and make it meaningful by identifying what we learned about ourselves and others. Processes that facilitate both individual and team reflection are critical to increase awareness and understanding of intra/ interpersonal relationships.

Anecdotes of managing upwards in clinical practice.

Anecdote 1

“The patient in question was a lady that had multiple co-morbidities, one being chronic renal failure, for which she attended dialysis three times a week. Fluids prescribed were three litres of normal saline with potassium over 24 hours. Having recently qualified and spending time on the Renal Unit as a student, I thought fluids containing potassium would be detrimental to my patient. I questioned this with the senior staff nurse, who said if the doctor has prescribed it, put it up. I still wasn’t happy, but felt unsupported and not sure where to turn. So I went behind her back and phoned the Renal Unit. They advised me in no uncertain terms I shouldn’t put the fluids up and to call the doctor back to prescribe something more appropriate. This instance made me feel more confident about my own judgement but also not to be intimidated by seniority and question things if I was unsure.”

ACTIVITY SIX: ANSWER AID (continued)

Anecdote 2

“I have worked in a high acuity area for over 13 years and I consider myself an experienced, competent clinician. On one occasion when working with a student, I was commencing and discussing a routine, policy-based, naso-gastric feeding regime. The student however disagreed with my practice and informed me that recent evidence-based literature supported a different regime of feeding and quoted the rationale to support the changes. This challenge to my knowledge and practice made me feel defensive but I had to concede that I had become caught up in the routine of my daily practice and was not as informed as the student. On reflection, this experience demonstrated effective upward management from the student and highlighted the mutual benefits of student supervision.”

Anecdote 3

“I was working as a new graduate midwife with only six months experience and was rostered for the day with a registered midwife who had over 20 years experience. We were caring for a woman in labour on the labour and birth suite. The woman was getting to the second stage of labour, when the midwife began applying pressure and ‘sweeping’ the perineum. I was immediately concerned as we had been taught at university that this practice was now outdated and not evidence-based, yet the midwife had over 20 years experience and had said this was the best way to reduce perineal trauma and tears. Following the delivery, I attempted to discuss this with the midwife and she was surprised by what we had been taught and asked that I bring in some relevant and evidence-based proof to support this. I did and together we provided an education session to all labour ward staff regarding this practice.”

ACTIVITY SIX: ANSWER AID (continued)

Anecdote 3 (continued)

“I learnt that newly trained staff have knowledge despite their lack of experience and that we should always be looking to provide the most evidence-based practice in order to provide the highest standard of care to our patients.”

ACTIVITY SEVEN

Watch scenes One and Two again and complete LIPSERVICE (below) to determine how focused the individual characters were on the needs of service users and carers.

First letter	LIPSERVICE Questions	Your notes
L is for Language	• Does your patient speak English? • How well do they speak it? • Do you need to consider getting an interpreter to assist? • What is the person's education level and understanding – will you need to modify the language you use in order to help them understand what you are asking or telling them?	
I is for Introduction	• Make sure you introduce yourself to the person, and give them your role – especially if what you do is something that is not commonly known. While most patients will understand the role of a 'doctor', they may not be familiar with what an 'occupational therapist' does. If in doubt, you should explain your role.	
P is for Privacy, Dignity and Cultural issues	• Is this a person who is going to be embarrassed by being examined by someone of the opposite gender? • Should you ask before you address them by their first name (many more elderly patients are of a generation who value the respect that being called 'Mr' or 'Mrs' gives them). • Be aware of different cultural expectations that you may encounter.	
S is for Subjective Questioning	• This is where you take the person's history. • A thorough history will be invaluable in helping to make a diagnosis. • Be aware of the power of 'leading questions' though. • Ask open-ended rather than closed questions to obtain your answers.	

E is for Examination	• Some considerations here include talking the person through what it is that you are doing, especially if this is an invasive or unusual procedure for them. • Knowing what is happening and why, as well as what to expect, can help alleviate the person's concern about what it is you are doing to them.
R is for Review	• Talk through what you have done as part of the examination – and what it added to your knowledge of their condition. • For example, 'You were talking about how you get short of breath, and I could hear from listening to your chest that your lungs are quite congested.'
V is for Verdict	• The diagnosis. • What their history and your examination have led you to think is causing their symptoms and signs.
I is for Information	• What does the diagnosis mean for the person? • Having a diagnosis of a lump in the breast can mean many things. • The person needs to know about these.
C is to remind you to Check Understanding	• This is where you determine if what you have said has made sense to the person. • People may only hear the diagnosis and then go into a state of shock – which means they don't process what you tell them next.
E is for End or Exit	• What's going to happen next for the person? • What about follow up? • Referrals to other professionals?

Section Four: Literature review – Managing upwards to avoid adverse events

Adverse events

The issues of patient safety and the financial costs of harm in health care were little understood until the relatively recent past. International research has now shown that between 4% and 17.7% of patients suffer from some kind of harm (including permanent disability and death) as a result of adverse events while in hospital.[34] In one of the first studies to undertake a review of medical histories for adverse events, it was found that approximately 70% of adverse events were preventable.[38,39]

In the USA it is estimated that over 98,000 patients die each year because of human error. Although this statistic is alarming, it is also important to highlight the fact that adverse events also lead to poor outcomes. Those poor outcomes correlate to longer recovery and hospital stays.[18] The most commonly used definition of medical error is one developed by Reason and described in the seminal report To Err is Human.[40,41] It defines medical error as 'the failure of a planned action to be completed as intended (i.e. error of execution) or the use of the wrong plan to achieve an aim (i.e. error of planning)'.

Generally, medical errors have been described as failed processes which may not necessarily result in harm to a patient.[39,42] Sometimes these medical errors may be classified as resulting in an adverse event and at other times a near miss. Injuries resulting in harm to a patient and caused by medical management rather than the underlying condition or disease of the patient are identified as *adverse events*. These adverse events are considered preventable and may be the result of a single or multiple accumulating errors occurring in practice.[39] Some adverse events do not result in a patient injury or harm and are referred to as *near misses*.[39,43]

Research and investigation into adverse events and near misses has seen an increased emphasis on what is termed *human factors*. Human factors have been studied more frequently in areas outside health care, e.g. aviation and the military. Reason[18,19] notes that the analysis of human factors is the study of the interaction of equipment and individuals and the variables that can affect the outcome.

Health care, for the most part, was slow to respond to how human factors influenced errors. The old focus was reactive and focused on placing blame. Errors are based on unintentional actions,

not planned actions and in any system involving human interactions, human factors are present.[18]

Reason[19] and Drew[18,44] state that there are two elements that contribute to human errors: latent and active factors. Active factors are more common and are the actions or inactions of individuals. Active factors appear to lead to the error happening and are typically unique to the situation, having immediate effects. Active factors include:

- A lapse, such as not using a checklist;
- A slip, which refers to doing an action incorrectly;
- Mistakes, in which individuals choose the wrong action; and
- Not following procedures.

Active factors are the easiest to identify because they tend to be the final product of a series of events culminating in the error.[18]

The latent factors are harder to detect. Latent factors are present in all organisations and are reflected through poor communication, policies, heavy workload, poor management skills and overall organisational culture. Often, latent factors are not evident until an active failure occurs that leads to an adverse event, and one latent factor can lead to multiple active factors and injuries.[18,19,44]

Vincent[45] extended and adapted Reason's model for use in health care by developing a broad framework of contributory factors that can affect clinical practice and that includes both error-producing conditions and latent failures (Table 1). The framework essentially summarizes the major influences on clinicians in their daily work and the systemic contributions to adverse outcomes, or indeed to good outcomes. Vincent maintains that the analysis of adverse incidents should not focus on the ‘root cause’, but on a ‘systems analysis’ whereby the purpose is to reveal gaps and inadequacies in the health care system rather than a single cause.

Table 1. Framework of factors influencing clinical practice and contributing to adverse events

Framework	Contributory Factors	Examples of Problems That Contribute to Errors
Institutional	Regulatory context Medicolegal environment	Insufficient priority given by regulators to safety issues; legal pressured against open discussion, preventing the opportunity to learn from adverse events
Organisation and management	Financial resources and constraints Policy standards and goals Safety culture and priorities	Lack of awareness of safety issues on the part of senior management; policies leading to inadequate staffing levels
Work environment	Staffing levels and mix of skills Patterns in workload and shift Design, availability, and maintenance of equipment Administrative and managerial support	Heavy workloads, leading to fatigue; limited access to essential equipment; inadequate administrative support, leading to reduced time with patients
Team	Verbal communication Written communication Supervision and willingness to seek help Team leadership	Poor supervision of junior staff; poor communication among different professions; unwillingness of junior staff to seek assistance
Individual staff member	Knowledge and skills Motivation and attitude Physical and mental health	Lack of knowledge or experience; long term fatigue and stress
Task	Availability and use of protocols Availability and accuracy of test results	Unavailability of test results or delay obtaining them; lack of clear protocols and guidelines
Patient	Complexity and seriousness of condition Language and communication Personality and social factors	Distress; language barriers between patients and care-givers

Source: Vincent, 2003[45]

Once the sequence of events in an adverse incident is clear, there are three main considerations:

- The care-management problems identified among the events;
- The clinical context of each of these problems; and
- The factors contributing to their occurrence.

Any combination of these factors can contribute to the occurrence of a single care-management problem.[45]

Wachter, Pronovost, and Shekelle[46] believe that:

> A decade ago, our early enthusiasm for patient safety was accompanied by a hope, and some magical thinking, that finding solutions to medical errors would be relatively straightforward. It was believed that by simply adopting some techniques drawn from aviation and other "safe industries", building strong information technology systems and improving safety culture, patients would immediately be safer in hospitals and clinics everywhere. We now appreciate the naivety of this point of view. Making patients safe requires ongoing efforts to improve practices, training, information technology, and culture. It requires that senior leaders supply resources and leadership while simultaneously promoting engagement and innovation by frontline clinicians...We need competent, well-trained providers equipped with high-quality evidence and working with talented, strong leaders using well designed and integrated technologies and sound policies.

Research into adverse medical events highlights that rather than poor technical skills, human factors such as suboptimal communication and organisational systems and culture inadequacies are implicated in the majority of errors, adverse events and near misses that occur.[22-25] Described as the systems, behaviours or actions that modify human performance,[47] human factors in health care operate on two levels:

- Level 1 relates to how human factors work in a specified system or environment (including ergonomics — how people interact with systems); and
- Level 2 refers to non-technical skills, which are cognitive, social and personal. Specific aspects included within this level are cognition and error, situational awareness, leadership and teamwork, personality and behaviour, communication and assertiveness, decision making, and the effects of tiredness and fatigue on human behaviour.

There are many elements included within the broad term human factors and they encompass areas such as working in teams; communication; knowing when your ability to work is compromised; reactions due to toxic workplace culture; situational awareness; and rule violations. The following sections will discuss managing upwards and assertive communication, as elements of avoiding adverse events.

Managing upwards

Management is getting things done through people, and upward management can be defined as getting things done through those who supervise us.[48] Hegarty and Goldberg[49] described two different approaches to management: the **adversary approach** of 'us against them', and the team approach of participative management. The **team approach** results in more cooperation, togetherness and commitment.

Hegarty and Goldberg[49] defined four denominations of leadership. No one leader has all the characteristics of one leader type, but may have a combination of characteristics:

1. The **Drive** leader is demanding. He or she threatens and punishes and may be driven by fear or low self-esteem. This style of leadership is task focussed and stifles creativity, inevitably resulting in an adversarial relationship with staff;
2. The **Default** leader plays numbers and politics and is often more concerned with finances than individuals. The default leader is generally not an expert in the field they manage and has tremendous problems with communication. This type of leadership results in low motivation, low energy, low morale, and, ultimately, the adversarial approach;
3. The **Draw** leader has skills in dealing with people. He or she seeks to draw out the best in people and has an understanding of each person's strengths, weaknesses, values and skills, as well as their likes and dislikes. This manager relates to each as an individual. They seek to improve the work environment and encourage staff to evaluate their own work. This type of leadership results in employee support and institutional success; and
4. The **Develop** leader recognises and develops people. He or she knows the organisational goals and communicates them. Their self-confidence and job commitment are evident to staff and result in a basic trust. This type of leadership results in happy staff and high performance.

Both the draw leader and develop leader are communicative and emphasise the employee. In order to build a relationship with a manager or supervisor, an employee must identify their manager's particular leadership style(s).

Steps in managing upward

Boegli[48] identified eight steps in developing the skills of upwards management:

1. Know, accept, build, assert and control oneself. Control of anything must be preceded by a thorough understanding of what one wishes to control;
2. Understand and promote your manager. Listen to what is said and what is not said, what was meant to be said and what was said to others. Look for their good qualities and forget their weaknesses. Look for strengths and reinforce them. An employee's own strengths and weaknesses can complement those of their manager;
3. Support your institution and understand its philosophy, purpose and goals. Loyalty is important. To manage upwards, an employee must demonstrate an interest in the larger management issues;
4. Create and maintain effective working relations. Some ways to enhance working relationships are:
    - Stay away from what is not your business;
    - Keep personalities out of conversation;
    - Keep departmental concerns within the department;
    - Avoid gossip or small talk;
    - Accentuate the positive;
    - Demonstrate professionalism; and
    - Set your manager up to win.
5. Listen to, not against. There are several things to consider here:
    - Begin with clear and positive intentions;
    - Match tempo with tone;
    - Combine content with feeling;
    - Relate without repeating;
    - Beware of double-talk;
    - Hear it out;
    - Evaluate, don't judge; and

- Learn to say no.

6. ‘Do’ versus ‘done to’. There are two kinds of people – those who do and those who are done unto. Becoming part of the solution and not part of the problem results in participative management and a team approach to problem solving;
7. Use your power. There is power in knowledge and expertise, and effective communication and persuasive reasoning are especially powerful; and
8. Managing the ‘write’ way. When appropriate, it may be more effective to express your ideas in writing. Written communication can provide greater clarity, as well as a guide to action.

Similarly, Lewis[50] identified four key points in maximising the effectiveness of managing upwards:

1. Clear communication;
2. In praise of the boss – let your manager know they are appreciated;
3. Know what’s important – ensure you are aware of your manager’s priorities; and
4. Know when to fold ‘em – choose your battles carefully.

Gemmill[51] states that:

> Managing upward communication requires the building of a relationship between superior and subordinate which encourages and rewards disclosure. The subordinate must have confidence that when he “speaks his mind” his superior will not take advantage of him.

Gemmill[51] asserts that there are several factors that may hinder effective upwards communication, including: fear of penalisation if an employee discloses their real opinion; avoiding risk of penalty if uncertain how their manager may respond; fear of punishment; and fear the employee may be perceived as lacking independence if they take a work-related problem to their manager. The key to promoting upwards communication lies, therefore, in the creation of secure relationships with employees and the modelling of desirable communication behaviours by managers.

Donovan[52] states:

> Attempts at changing interactive behaviour begin by first considering the underlying belief systems. Given this premise, the need for managing upwards is based on the power holder's concern in becoming isolated from relevant information, as a function of hierarchy. In an apparent paradox, it is believed that by keeping the power-holder fully informed, benefits such as greater autonomy result. However, self-protection and a defensive posture operate as barriers in this process. Their effects can be reduced by arriving at a set of personal beliefs that need to be genuinely held, if managing upwards is to be effective for all parties.

Donovan[52] suggests that managing upwards enables the individual to realistically evaluate the relationship with their manager. Key principles in this process include:

- With regard to the operations of the position, a willingness to provide the right information at the right time in the right manner;
- An understanding that it is in one's own interests to clarify misplaced assumptions and so-called 'differences' and that each party has an equal responsibility to initiate this;
- This should also be seen as an opportunity for the individual to get valid feedback on their performance, though it may not be pleasant at first;
- A readiness to act on that feedback, i.e. self-correction; and
- An understanding of the potential gains to the individual in terms of:
    - Knowing what the boundaries of acceptance are within which they should operate; and
    - Correcting assumptions and/or one's own actions before adverse results occur.

McAlister and Darling[53] suggest that:

> Academic studies on upward influence have examined the intentions, personality and other characteristics of the subordinate, but have paid less attention to the characteristics of the supervisor. Although there are sources that offer guidelines for managing upward influence, very few suggest behavioural styles as cues for working with supervisors... Therefore, individuals often miss opportunities for "managing up" because they are unaware of the behavioural style paradigm.

Rather than focusing on the innermost workings of one's personality, behavioural style focuses on how one acts – that is, on what one says and does. Two dimensions of interpersonal behaviour, including assertiveness and responsiveness, determine one's behavioural style. Assertiveness is the degree to which others see behaviours as being forceful or directive. Responsiveness is the degree to which behaviours are seen as emotionally expressive or emotionally controlled. The determination of behavioural style is based almost exclusively on observable data from human interactions.[53]

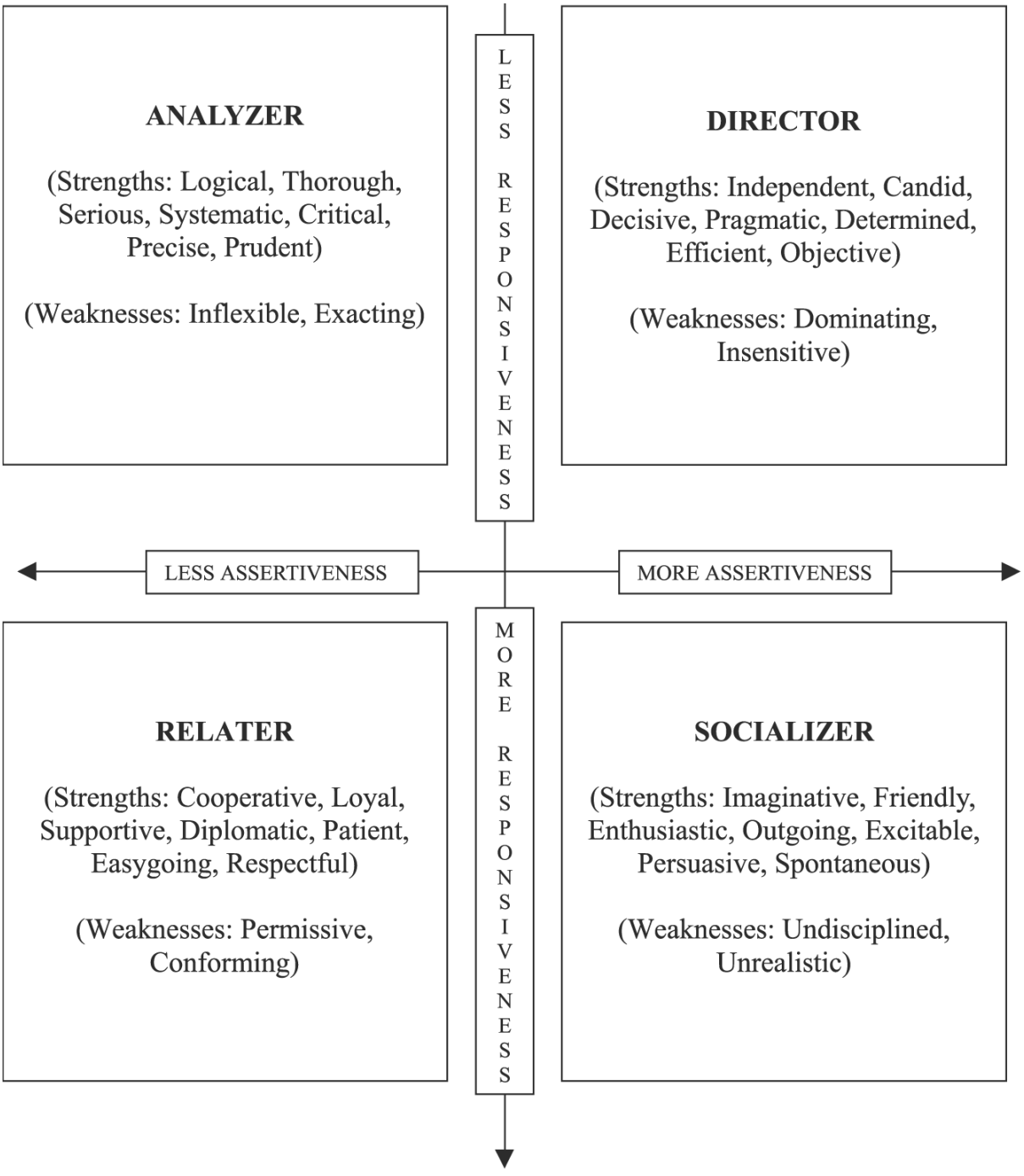
There are four basic behavioural styles:

1. **Analyze**r: low level of assertiveness and low level of responsiveness;
2. **Director**: low level of emotional responsiveness with a relatively high degree of assertiveness;
3. **Socializer**: high levels of both emotional responsiveness and assertiveness; and
4. **Relater**: higher-than-average responsiveness with a comparatively low level of assertiveness.[53]

Figure 1 illustrates the strengths and weaknesses of the four behavioural styles.

> When incorporating behavioural style into upwards influence situations, the objective is neither to change one's basic behavioural style nor to imitate the other person. The best and most productive interpersonal relationships and communications occur when two styles become complementary, with each individual's strengths compensating for the weaknesses of the other.[53]

Figure 1: Strengths and weaknesses of the four behavioural styles



Source: McAlister and Darling, 2005[53] adapted from Bolton and Bolton, 1984[54]

Assertive communication

Most health care facilities have policies relating to written communication, but guidelines for verbal communication, which is used most in times of uncertainty and urgency, are generally less regulated. Poor communication and communication overload are shown to have a direct correlation with patient outcomes, adverse events and stressors among health care professionals.[35]

Curtis, Tzannes and Rudge[35] identified several barriers to effective communication:

- Traditional hierarchical relationships – e.g. between doctors and nurses, however higher levels of nurse education have resulted in an increase in assertiveness;
- Increasing workload – increases in patient acuity and complexity of conditions, and an aging population have resulted in an increased workload for health care practitioners and an increase in communications;
- Mobile workforce – staff rotations through different areas and an increasing reliance on casual staff create challenges to effective teamwork and communications;
- Differing perceptions and language – different disciplines within the health care team may have differing patient care priorities; and
- Prior experience – an individual's prior experience may determine their emotional state when interacting with others.

There are two vital communication skills, **active listening** and **assertion**, which provide the foundation of effective communication.

> Active listening describes communication behaviours focused on overcoming barriers to shared understanding. Active listening occurs in a climate which is supportive and includes verbal messages which describe rather than criticize and which assume a problem-solving orientation rather than one which tries to control. Spontaneity and an attitude of empathy and equality in the relationship are equally important.[55]

Table 2. Active listening behaviour

Component	Description	Example
Door-openers	A description of the speaker's body language or an invitation to talk.	'You're beaming today' 'Tell me more' 'Go on...'
Open question	General questions which provide space to answer	'What's on your mind?' 'What are your thoughts on this proposal?'
Paraphrase of message	Concise summary of speaker's feelings	'Seems like you're feeling pretty angry at Jo right now.'
Paraphrase of content message	Concise summary of speaker's words	'You're working on making a decision about this?'
Clarification	Questioning vague or uncertain statements	'I don't understand what you mean by "working on it".'
Confirmation	Questioning the speaker about the accuracy of your paraphrases	'Was I on target?' 'Correct me if I'm wrong about this.'

Source: Cuthbert, Duffield and Hope, 1992[55]

Assertiveness is a term used to describe behaviours that a person can use to deliver clear messages and stand up for him/herself in difficult situations without violating the rights of others.[55,56]

There are three basic steps to assertiveness:

1. Actively listen to what is being said then show the other person that you both hear and understand them;
2. Separate ideas from feelings by saying what you think or what you feel; and
3. Say that you want to happen.[55]

There are additional assertive behaviours that can enhance competence and confidence as an assertive communicator. Using assertive body language is one of these techniques. Assertive body language means developing an awareness of our bodily expression of meaning and assuring a 'good fit' in the verbal and non-verbal messages we are sending. Assertive, congruent body language is especially helpful in stressful situations. Table 3 explores some detectable differences between assertive, aggressive and passive body language.[55]

Table 3. Assertive body language

	Assertive	Aggressive	Passive
Posture	Upright/straight	Leaning forward	Shrinking
Head	Firm not rigid	Chin jutting out	Head down
Eyes	Direct, no staring, good and regular eye contact	Strongly focused staring, often piercing or glaring eye contact	Glancing away Little eye contact
Face	Expression fits the words	Set/firm	Smiling even when upset
Voice	Well modulated to fit content	Loud/emphatic	Hesitant/soft, trailing off at ends of words/sentences
Arms/hands	Relaxed/moving easily	Controlled Extreme/sharp gestures/fingers pointing, jabbing	Aimless/still
Movement/walking	Measured pace suitable to action	Slow and heavy or fast, deliberate, hard	Slow and hesitant or fast and jerky

Source: Morten, Richey and Kellet, 1981[56] cited in Cuthbert, Duffield and Hope, 1992[55]

Curtis, Tzannes and Rudge[35] identified the following as a guide to effective communication:

- Personal considerations – learn to recognise your own emotional state and attempt to understand the other person's perspective;
- Preparation – a few moments of preparation (when possible) aids delivery of your message, both in terms of structure and content;
- Structure – a structured approach to communication ensures important details are not missed and minimises the risk of communication error; and
- Graded assertiveness – staff may be afraid to be assertive in communicating with senior staff even when aware something is not right. This technique aims to assist the staff member to escalate their concern through a stepped process.

Table 4. Levels of graded assertiveness and examples

Level one:	express initial concern with an 'I' statement *I am concerned about...*
Level two:	make an enquiry or offer a solution *Would you like me to...*
Level three:	ask for an explanation *It would help me to understand...*
Level four:	a definitive challenge demanding a response *For the safety of the patient you must listen to me*

Source: Curtis, Tzannes and Rudge, 2011[35]

Conclusion

Errors (in health care) result from physiological and psychological limitations of humans. Causes of error include fatigue, workload, and fear, as well as cognitive overload, poor interpersonal communications, imperfect information processing, and flawed decision making.[57,58]

To provide optimal patient care, all members of the health care team must effectively communicate patient status and the current plan of care. Under the quality and safety competency areas of teamwork and collaboration are two key communication skills to be applied by the health care professional: (a) assert his or her position and perspective in discussions about patient care; and (b) choose communication styles that diminish the risks associated with authority gradients among team members.[59,60]

The abilities to manage upwards and communicate assertively within the health care team are essential skills in the provision of optimal patient care and the minimisation of adverse events.

Acronyms

AHPRA	Australian Health Practitioner Regulation Agency
AIPPEN	Australasian Interprofessional Practice and Education Network
ASPIRIN	Acknowledge the problem; Situational analysis; Provide some solutions; Implement; Review the outcome; Inform stakeholders; Next steps
CPR	Cardiopulmonary resuscitation
IPE	Interprofessional education
IPL	Interprofessional learning
IPP	Interprofessional practice
LIPSERVICE	Language; Introduction; Privacy dignity and cultural issues; Subjective questioning; Examination; Review; Verdict; Information; Check understanding; End or exit
WHO	World Health Organization

Glossary

Active factors	The actions or inactions of individuals that result in medical errors.[18,19,44]
Active listening	Active listening describes communication behaviours focused on overcoming barriers to shared understanding.[55]
Adverse events	Injuries resulting in harm to a patient and caused by medical management rather than the underlying condition or disease of the patient.[39,42]
Assertion	Behaviours that a person can use to deliver clear messages and stand up for him/herself in difficult situations without violating the rights of others.[55,56]
Assertive communication	The straightforward and open expression of your needs, desires, thoughts and feelings. Assertive communication involves advocating for your own needs while still considering and respecting the needs of others.[55,56]
Human factors	The interaction of equipment and individuals and the variables that can affect the outcome.[18,19]
Interprofessional education	Occasions when two or more professions learn from, with and about each other to improve collaboration and the quality of care.[8]
Interprofessional learning	Learning arising from interaction between members (or students) of two professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings.[8]
Interprofessional practice	Two or more professions working together as a team with a common purpose, commitment and mutual respect.[8]
Latent factors	Factors that may lead to human error and are reflected through poor communication, policies, heavy workload, poor management skills and overall organisational culture.[18,19,44]

Mnemonic	Any learning technique that aids information retention, e.g. acronyms and memorable phrases.
Near misses	An adverse event that does not result in a patient injury or harm.[39,43]
Simulated learning environment	A technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion.[1]
Upward management	Getting things done through those who supervise us.[48]

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