

MODULE 4

Communicating with Colleagues and Promoting Teamwork

General Acute/Maternity/Paediatric



Elaine Bromley (Slide 58)

Background

Elaine Bromley was a fit and healthy young woman who was admitted to hospital for routine sinus surgery. During the anaesthetic she experienced breathing problems and the anaesthetist was unable to insert a device to secure her airway. After 10-minutes it was a situation of ‘can’t intubate, can’t ventilate’; a recognised anaesthetic emergency for which guidelines exist. For a further 15-minutes, three highly experienced consultants made numerous unsuccessful attempts to secure Elaine’s airway and she suffered prolonged periods with dangerously low levels of oxygen in her bloodstream. Early on nurses informed the team that they had brought emergency equipment to the room and booked a bed in intensive care but neither were utilised. 35-minutes after the start of the anaesthetic it was decided that Elaine should be allowed to wake up naturally and was transferred to the recovery unit. When she failed to wake up she was then transferred to the intensive care unit. Elaine never regained consciousness and after 13-days the decision was made to withdraw the ventilation support that was sustaining her life.

Say something like

“Now we are going to watch a video of a real time construction of the Elaine Bromley case in which the timing of various interventions, vital signs and so on match the known timeline and details of the case. Please focus on the teamwork issues under the following headings:

- Safety and trust
- Shared goals
- Clear roles
- Effective communication
- Leadership”

Issues

Safety and trust

- Lack of assertiveness (Nursing staff recognise need for emergency equipment to be used but do not speak up)
- Nursing staff not empowered to speak up
- Knew what needed to happen. Didn't know how to assert themselves

Shared goals

- Help called late
- Delayed recognition of crisis
- Insidious onset, assumption that next intervention would work
- Task overload
- Impaired situational awareness
- Task fixation. Repeated interventions that had already failed
- Nursing staff not empowered to speak up
- Impaired decision making
- Breakdown in decision making process
- Distorted time perception
- Cognitive overload
- Absence of structured approach
- No shared mental model of situation/plan

Clear roles

- Failed to use help effectively
- Help rapidly drawn into fixation error of primary team
- No coordinator
- No structured approach to using help

Effective communication

- Inadequate handover to help
- No declaration of what options/optimisations attempted and what remained
- Communication processes dried up
- Nurse not listened to/poor listening skills
- No structured approach to communication

Leadership

- Breakdown in leadership
- No clear leader
- Culture
- Self-consciousness
- Assumed to be primary anaesthetist