

The importance of effective communication

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Communication is basically the process of sending and receiving information among people. It can be written, spoken, or done with our bodies. How effective it is depends on how well we try to put over what we want to say and how well we interpret what is being communicated to us.

For any organization, effective communication is important to smooth functioning and for us as a hospital it is even more so. Unclear or misinterpreted protocols in patient care could lead to complications or even death, and in manager/employee interactions, it often results in hiccups in the execution of duties and even disciplinary action.

In my observations, it would be advantageous for us to have clearly worded protocols for frequently occurring situations and more so for the uncommon ones as they are time sensitive and cannot wait for us to then decide what needs to be done. What is the first step? To whom should be report?

Laura Hutton, writing for the Australian Institute of Business, gives six reasons why effective communication should be a focus in organizations. They are: builds and maintains relationships, facilitates motivation, builds effective teams, managing employees, contributes to organizational growth and ensures transparency. I have adapted the reasons to suit our situation here at the hospital.

- Builds and maintains relationships- relationships are built and can be maintained by positive encounters with others. Without effective communication skills, it will be difficult to properly construct and foster productive relationships.
- Facilitates motivation- when employees feel comfortable in openly communicating new ideas cooperation and innovation will be at an all-time high. They are the ones on the frontline and might be better able to give ideas of how to improve processes.
- Builds effective teams- encouraging open communication results in the emergence of effective and cohesive teams. When employees feel that they are well informed of the hospital's direction and vision, they will feel more secure in their role. Regular internal communication can also lead to an improved work ethic if employees are reminded of achievements and feel that they are working towards a common goal.
- Managing employees- when managers are effective communicators, they are more able to inform staff adequately of their responsibilities and what is expected from them. Good communication skills also help managers to provide constructive feedback to their staff, build better relationships, and understand personal goals that staff may wish to accomplish.
- Contributes to organizational growth- it can lead to increased productivity and help to avoid unnecessary delays in the implementation of policies and processes.
- Ensures transparency- communication with clients helps us to build and maintain trust in the hospital and our services. Woodlands Hospital has the privilege of being a well-established and long standing medical facility with trustworthy doctors. The onus is on us to maintain this position. From admission, where clients are greeted and treated well, to the nurses attending them on the ward to physicians pausing for a few moments to answer questions and/or address any concerns the clients or their relatives might have to discharge and final bill payment- each step plays an integral role in allaying any fears of discrepancies and/or malpractice. This is the procedure that is being done, this is the doctor doing it, these are the associated risks, these are the estimated costs, this is the aftercare- these seem easy enough to communicate, but sometimes lines become crossed and patients are unclear either because they do not read the written information given to them or we fall short in our explanations. It is a collaborative effort and each employee who interfaces with a client and/or his/her relatives has an integral part to play.

Equally important, is the need for colleagues to communicate with each other in a respectful manner. Sending memos is a good way to document processes, help in acknowledgement, and maintain accountability. We should strive to speak how we would like to be spoken to. It might not be a good thing to sugarcoat, but we should employ tact. Avoid condescending language and tones and certainly there should be no rolling of the eyes or dismissive hand waves. The cliché 'it's not what is said, but how it's said' holds true in this regard. Speak TO each other, not AT each other.

Until next time, stay well.

Customer Service Manager Ms. Carolann Marcus

<p style="text-align: center;">NEWS IN BRIEF</p> <p style="text-align: center;">SOME STATISTICS For SEPTEMBER 2017</p>	<p><u>DOCTORS MEETING:-</u> Was held on , 27 September,2017 at 17:00 hrs.....Chairperson—Dr. N. Gobin Topic: Diabetic Retinopathy Screen by Dr. Sugrim</p>
<p><u>Emergency Room</u> Patients Seen— 2295 Admissions— 22</p> <p><u>Maternity</u> Total Deliveries— 58 Males— 29 Females— 30 Caesarean Sections- 27 Neonatal Death— 0 Twins— 1 Premature— 0 Breech— 0 Still Births— 0</p> <p><u>Male ward</u> Admission— 108 Deaths—0</p> <p><u>Female ward</u> Admission - 175 Deaths—0</p> <p><u>ICU</u> Admissions— 33 Deaths- 5</p> <p><u>Radiology</u> X-ray— 1176 CT— 134 Ultrasound— 2448 ECHO— 133 Holter—7 Stress— 14</p> <p><u>Theatre</u> Surgeries— 158 Ophthalmology — 42</p> <p><u>Pharmacy</u> Prescriptions— 3877</p> <p><u>Laboratory</u> Patients attended-3058</p>	<p><u>NURSES MEETING:-</u> R/N R/M 14th September 2017 Topic : Prevention of Hospital Acquired Infection by N Sinclair N/A/LPN 15th September 2017 Topic : Prevention of Hospital Acquired Infection by N Sinclair</p> <div style="border: 1px solid red; padding: 5px; text-align: center;"> <p><u>Theory vs. Practice: Pathology Laboratory</u></p> </div> <p>Working in a laboratory requires both theory and practice. While training students one would notice that with practice alone, these students will not understand the ‘whys’ behind what they are doing, whereas with theory alone the students will not receive a hands on experience needed in their day to day activities of the working world.</p> <p>Steve Klabnik, (2012) describe theory and practice like a strained relationship between two persons or group of persons, but when put together they work best. They are two separate fields connected by the fact that theory deals with ideas and practice is applying these ideas. Where practice is successful in application, theory is also successful.</p> <p>Take for instance working in a Pathology Laboratory;</p> <ul style="list-style-type: none"> • Staining of the tissue sections is essential for visualisation of what would otherwise be transparent. Various procedures and the purpose for which particular stains are used would be discussed theoretically, however that knowledge is applied to practice and with that combination a successfully stained slide is produced. Without theory there is no knowledge behind the process and it would be following a protocol with no understanding of how to interrupt the results or why various components adhere to certain dyes while other components did not. Yet, in order to validate the various staining techniques, experiments (practical analysis) would have been conducted. • Sectioning on the other hand is an acquired skill. Theory can greatly assist in trouble shooting e.g the reasons for split ribbons or lengthwise scratches, holes or thick or thin portions, dry torn or incomplete sections. But in order to troubleshoot any problem one must first develop the art of sectioning. Again it’s a combination of theory and practice. Experiencing the problems identified would have led to investigating the theory why it has occurred, thus recognising solutions. • Even as it relates to the quality management system, theory is needed to know how to create SOPs but practice allows application of the theory. An individual can be taught the outline and requirements for a SOP, but if that person has the practical experience it then become easier to apply the knowledge and make the SOPs relevant to the laboratory. Preparing a management system based on theory alone may not always be appropriate to the laboratory, hence it become tedious to implement and maintain. <p>The Economic Time, (2010) states, “Two words that describe a person's competence are knowledge and skills. Knowledge refers to learning concepts, principles and information regarding a particular subject(s) by a person through books, media, encyclopedias, academic institutions and other sources. A skill refers to the ability of using that information and applying it in a context”.</p> <p>When attending a job interview as a medical technologist/laboratory scientist, the employer seeks both practice and theory. It may seem possible to argue that an employer may choose a candidate with a distinction and no experience over one who has graduated with minimal grade but has a few years of experience. However, before a person can actually qualify to work, laboratories have policies govern by their quality management system where employees must be deem competent prior to working independently. That is, they must acquire the relevant skills by improving their knowledge with practical experience.</p> <p>In conclusion, it can be stated that theory and practice are co-dependent. With years of experience and competency, a medical technologist/laboratory scientist can easily habitually relay on practice alone, however laboratory science keeps evolving and with new techniques comes new theory, leading to new practice.</p> <p>References: Steve Klabnik, 2012. <i>Theory and Practice</i>. [Online] Available at: http://words.steveklabnik.com/theory-and-practice [Accessed 04th, October. 2017] The Economic Times 2010, <i>Theoretical knowledge vs practical skills</i>. [Online] Available at: http://economictimes.indiatimes.com/theoretical-knowledge-vs-practical skills/slideshow/5922135.cms [Accessed 04th, October. 2017]</p>

Patient selection

Risk prediction can help in making the decision whether to adopt an operative or non operative management strategy. In many different fields, there has been an increasing involvement of the so-called multidisciplinary team (MDT). This allows several specialists with different areas of expertise to input management plans, with the ultimate aim of providing the best form of treatment to the patient. This has been most commonly seen in cancer management. Despite the obvious benefits of such an approach, however, there are potential pitfalls. It is not surprising that there can be difficulties in harmonizing alternative views to result in an agreed plan. Most MDTs are led by surgeons, as surgery still remains the best chance of a relative cure for most solid cancers, and this perhaps encourages oncological resection despite the risks. However, it should be remembered that a decision not to operate is generally agreed to be more difficult than the one to proceed with surgery.

In addition to the fear of cancer spread, debilitating symptoms may influence what degree of risk is acceptable to patient and surgeon. It is likely that these difficult decisions are going to become increasingly frequent with the advancing age of a population that may have more-than-realistic expectations of modern-day surgery. In an increasingly elderly population, the calculation of actuarial life expectancy can be useful when assessing whether the surgical intervention is going to prolong life. Ultimately the patient should decide whether or not to undergo surgery, but some patients are more capable of making these complex decisions than others.³ Though it is important, patient choice should not make the surgeon commit to futile surgery where the operative risks of procedures clearly outweigh those associated with the natural disease progression. The majority of patients are guided by their surgeon, but an objective assessment of risk may help all concerned, especially when the decision is in doubt.

Informed consent

There has undoubtedly been an increased level of litigation surrounding the management of medical conditions in recent years. This may be partly attributed to the increased expectations of patients. These may be tempered by objective prediction, which also offers protection to the surgeon. The ability to predict perioperative morbidity and mortality is thus important in surgical management, as it allows individual patients to give informed consent.

Accurate rates of specific complications quoted to patients should ideally come from departmental audit rather than national figures. These, combined with risk-prediction tools, provide objective assessment of likely surgical morbidity and mortality risks that can be directly communicated to patients. And with the patient being at the centre of any decision-making process, surely it should be the clinician's duty to provide the facts rather than dictate treatment. By providing this information to the patient and using the thoughts and concerns of the patient at the time of consultation, patients can be furnished with a more accurate expectation of their surgery and the risks involved.

Level of medical care

Risk prediction may be used to predict the need for monitoring on high-dependency units before or after surgery. An objective scoring system may also allow high-risk patients

relative priority for such a limited resource, as the least-fit patients may be expected to benefit more from the increased intensity of care. As mentioned previously, many of the techniques and strategies used by anaesthetists in elective patients have developed from the critically ill. Such an example is 'goal-directed therapy', a principle by which clear objective goals are targeted in a number of physiological parameters. This aggressive technique has recently been adopted by many intensivists to enhance patients' preoperative status.

By identifying groups of patients who may benefit from this strategy, intensivists have sought to enhance their physiological status, aiming to reduce postoperative complications. This can be further supplemented by nursing patients on high-dependency units immediately after surgery. One study identified patients with the highest POSSUM and ASA scores and admitted them to an intensive care unit both preoperatively for optimization, and postoperatively for care. These patients had significantly lower morbidity and mortality than otherwise predicted using POSSUM.

Surgical outcomes

The publication of league tables of morbidity and mortality may deter surgeons from operating on high-risk cases if case mix is not taken into account. The objective preoperative assessment of risk of mortality may become a vital tool in allowing surgeons to offer high-risk patients the choice of surgery, without the fear of adverse outcomes preventing the surgical option being offered. Measuring outcomes for particular surgical units will allow feedback and adjustment to the accuracy of generic risk-prediction tools validated elsewhere. The audit of personal outcomes may also act to protect the surgeon, who would be able to compare observed mortality figures with those predicted preoperatively.

CONCLUSION

Surgical risk predictors have been developed to objectively estimate complications, though this should not be at the expense of surgical intuition. Though there are increasing numbers of prediction methods available, there seems to be no perfect tool. However, it must be remembered that such tools should not be used in isolation and by no means as the sole means of decision-making. Although predictors can be individualized, they largely pertain to populations rather than an individual, whose mortality rate must be either 0% or 100%. As long as these limitations are understood, they may provide a valuable tool that informs patients as much as protects surgeons. We advocate their use, especially in high-risk surgical patients, as with time they will add science to instinctive decision-making. If used to their potential, scoring systems should impact upon perioperative care planning, informed consent and patient selection for surgery, and allow feedback to surgical outcome measures.

Management and Staff wish to congratulate the following persons on their birth anniversary for October 2017

Haimanda Singh	1st
Alison Mustapha	2nd
Vanessa Drakes	5th
Tishana Gomes	8th
Talfaa Sampson	9th
Dr. Yara Martinez-Diaz	10th
Shinu Thomas	12th
Velencia Langhorn	13th
Godfrey Sukra	15th
Claude Dennis	17th
Amanda Greene	17th
Annesa Madramootoo	17 th
Tamola Phillips	18 th
Xianne Munroe	25 th
Stijo Varghese	25 th
Tofty Mathew	26 th
Jijo Sebastian	27 th
Bertil Noel	28 th



Vacancies

Security Guard: 1 position
 Attendant: 1 position
 Housekeeper: 3 positions
 Kitchen Assistant: 1
 Cook: 1

ALL APPLICANTS WILL BE EXPECTED TO WORK ALL SHIFTS

Quote for the month



CUSTOMER SERVICE SHOULD NOT BE A DEPARTMENT, IT SHOULD BE THE ENTIRE COMPANY

TONY HSIEH, CEO OF ZAPPOS

TAKING A BREAK FROM WOODLANDS HOSPITAL

Crystal Peniston	15 th – 28 th Oct
Deborah Milner	8 th Oct to 4 th Nov
Dr. Vargas	2 nd – 15 th Oct
Estelle Willis	2 nd – 8 th Oct
Gowrie Fraser	1 st – 14 th Oct
Haimanda Singh	16 th – 21 st Oct
Jasmattie Chumandath	2 nd – 15 th Oct
Kayshena Bethel	16 th – 27 th Oct
Maricea Comacho-Chandrabose	20 th Oct – 15 th Nov
Khemwattie Talmakund	2 nd – 29 th Oct
Myrna Patterson	2 nd – 22 nd Oct
Onesia Robertson	1 st – 26 th Oct
Pamela Choo-Shee-Lam	27 th Oct – 14 th Dec
Shanta Paul	8 th – 30 th Oct
Simone Giles	9 th – 29 th Oct
Theona English	1 st – 22 nd Oct
Vanessa Drakes	2 nd – 15 th Oct
Vonetta Rampersaud-Dick	25 th Oct – 7 th Nov

We can now be perused on our Web Site
www.woodlandshospital.com