**Reflection Essay**

**Communication**

Communication is an essential element to any organization. On that account, an organization has to ensure that there is efficiency in communication. It has to be noted that communication involves several parties hence the flow of information is from different quarters and, on that note, communication can tend to be complex but it is the responsibility of an organization to make sure that it is simple and effective. The soundness of decision is significantly influenced by the quality of information that is present at a given point in time (Thompson, 2018). Therefore, an organization cannot afford to have its communication to have shortcomings as this will have a detrimental impact to its performance. Healthcare facilities have different departments and numerous employees and all these departments need to be integrated so as that information flows seamlessly for sound decisions to be taken. According to (Krautscheid, 2008), the adopted communication channel or strategy by an organization should enhance information flow within the organization and also allows traceability. Based on the importance of communication, this is a reflection paper discussing communication in a nursing working environment where an incident related to the communication challenge happened.

**Description of the situation**

I have been working as a nurse in one of the healthcare facilities in Saudi Arabia. I can recall there was this day when I had an overnight shift and as usual, I checked into the hospital as early before my shift began. The night-shift on that particular day had 15 nurses. Miss Fatima who was the nurse manager assigned each one of us patients whom we were supposed to take care during our shift. I was assigned three patients during my shift two of the patients I was familiar with since they were under my care for the past four days. The other patient had been admitted two days ago in a critical condition and had been diagnosed with pneumonia and malaria. On that particular day, he was much better as most of his vitals had stabilized. As usual, a nurse taking care of a patient needs to hand over the patient by providing briefs to the nursing to be in-charge. The nurse that was taking care of the three patients briefed me about the patient and signed-off her shift. I made it my norm to greet my patients and let them know I am in charge. Based on the brief and report of my colleague I was to inject one of the patients two times. One injection was to be done at 8 pm and the other 2 pm as I had the previous day. The other patient who had been diagnosed with malaria and pneumonia was also supposed to be injected with Ertapenem (Invanz Vial).

At 8 pm I was ready with my medication to give to one of my patients. Upon finishing giving medication to the patient, I walked around the other wards and see how my patients were doing. I noticed that the patient who was diagnosed with pneumonia and malaria had rashes on his skin and was experiencing nausea. In addition, he was experiencing abdominal pain. I did help the patient with water. Based on my nursing experience, I knew these were symptoms of side-effects of a drug administered to the patient. Since his medication was coming up in the next 2 hours, I took his file and check the medication that I was supposed to administer to the patient. Based on the nurse that had handed over the patient to me, I was supposed to inject the patient with 1g of Ertapenem. However, based on how I had seen the state of the patient, it was within my wisdom that I seek assistance as it looked that the patient was reacting severely to the drug being administered. The doctor who checked the patient during the day was called and after a lengthy conversation, it dawned on me that the doctor had ordered the nurse to change the drug and administer the patient with Cefepime. The conversation took long as the doctor was not well conversant with both English and Arabic since he was a Latino and spoke Spanish. I, therefore, changed the drug and administered it to the patient at exactly 11:30 pm. At 2 pm I went with the medication to the other patient and to my surprise, the patient asked me why a second time. I took the patient file just to confirm and it was clear that the patient was to be administered with injection two times. I decided to inquire about the patient and he told me the doctor had said that the drug will be scaled down and administered only once at night. I believed the patient since he was a foreigner from Spain. However, it was still a hard decision to make since I had to involve the nursing manager and my colleague would suffer a disciplinary action for the negligence.  Lastly, I decided to follow the protocol before making such a critical decision. We had a lengthy discussion with the nurse manager and we decided not to administer it for the night and seek clarification from my colleague tomorrow.

When my colleague showed up for her shift early in the morning, I approached her and informed her about the contradiction in her last briefing. She appeared shocked and admitted that the doctor had indeed told her to scale down the administration of Hydralazine but she forgot to brief me and also to note it. However, with the case of changing drug of the other patient, she said that she cannot recall the doctor saying so. The nurse further informed me that she was facing a domestic problem, her son had been arrested and was being framed for drug trafficking and this has greatly affected her job concentration. At that moment, I realized that my colleague needed help, not a disciplinary action and I considered it prudent to escort her to the nursing manager. After 30 minutes discussion, my colleague was allowed to work for half day and take a rest for one week before resuming her job. In addition, she was to undergo counseling.

**Feelings**

It was quite unfortunate that my colleague (nurse) was going through a lot that greatly affected her nursing care. A nurse just like any other human will be psychologically affected by social or personal issues hence affecting their service delivery (Zydziunaite, 2012), and, therefore, this is not different from my friend. However, I must applaud my colleague for deciding to open up to me about what she was going through. As a result of this, the nursing manager made the right decision. If this information was not availed to the nursing manager, she would have been too harsh to my colleague and this would have furthered her predicaments. On that note, I felt glad and relieved by the decision the nursing manager took. However, I felt that as the nursing department we should always look at how a colleague and inquire if there is any challenge as this would show a sign of concern and Allcorn, & Stein, (2015), advocate for such act in order to foster teamwork. If this was the case, then the issue of my colleague would have been noted early enough. I also felt great when I took into consideration the query of the patient who I was about to administer the second injection. Also my assessment of the patient’s which lead to a change of drug hence preventing further complications.

**Evaluation**

Based on this incident, it dawned on me how communication is vital in an organization as it influences the decision to be made. There is a need for an organization to develop a communication platform that will ensure that information flows smoothly so as to enhance service delivery to the patient. On that account, I would like to evaluate the source of information and reception of information. It has to be noted that a source of information is as important as the person receiving the information. A communication is considered to be successful if the involved parties have the same interpretation of the information being shared (Blackman, & Walkerdine, 2001; Jandt, 2001). On that line of thought, there was no communication between the nurse and the doctor with regards to the changing of the patient’s drug. The doctor being of Cuban origin hence not conversant with both English and Arabic could not relay a message clearly to my colleague hence whatever message that was shared between the two was not well interpreted and no communication took place. Language is vital in communication and language barrier will stall communication and other vital operations at an organization (Slade, et. al, n.d). This is evidenced by how long it took for the nursing manager and the doctor had to agree with regards to the change of drug.

Effective communication between human requires concentration as this will allow one to dissect the information so as to understand as well to seek clarifications (Zydziunaite, 2012). Mental stability significantly influences the concentration of an individual in a discussion and, on that note; my colleague was psychologically unstable due to the fact that her son had been arrested. Therefore, her concentration level at work was not good for an effective communication. In that regard, she forgot to note the changes that the doctor had ordered her to make on medication. Based on this incident, I am delighted that I have enhanced my communication skills and management have developed confidence in my action.

**Analysis**

The fact that there are different personnel involved in the delivery of care to patients in a healthcare facility there is a need for coordination in communication. According to Bach, Grant, & Bach, (2015), the hand-over of nurses should include the exchange of vital information for the betterment of the patient’s health. On that note, Dawson, Taylor-Whilde, & Torkington, (2001), suggested that there is a need for a well-structured hand-over exercise that will ensure all paramount information is shared during handover.

Medication errors are the worse errors that should not occur at a healthcare facility as this is a setback towards a patient recovery process. As it can be noted that in my incident medication error was about to occur but fortunately enough the issue was tackled before matters got complicated. A breakdown in communication is the cause of medication errors in hospitals. Records are important in communication as they provide a reference to an incident in an organization (Edwards, 2008). On that note, all the files that were handed over to me by my colleagues are vital when tracing any errors and verification purposes.

**Conclusion**

The incident has actually served a fundamental role in shaping and enhancing my communication capability not only in the nursing field but also in my social life. I have taken into account, the importance of having total concentration while at work as this will greatly influence the quality of care patients receive from me or my colleagues. It is also important that the services of an interpreter are considered if the language barrier has been experienced as it is in this incident. Medication errors may not be the wish of a healthcare provider but through effective communication practices, such errors can be avoided. Although, as a nurse one undergoes numerous pressures, the safety of patient should be the guiding rule for all medical personnel.

**Action plan**

Based on this incident, I have made up my mind that when I am on shift I will ensure that I have my concentration to everything at work. This will ensure that I deliver quality services to patients. In addition, communication involves non-verbal acts. Therefore, if I have a good concentration I will be able to decode non-verbal acts. Lastly, in case I have pressing issues that will affect my concentration level I will inform the nursing manager and request for a break. This will ensure that I do not make medication errors as my colleague hence putting the lives of patients at risk.

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