

Chapter 2

The Context of Communication in Emergency Departments

2.1 Introduction

The way we use language is always shaped by what we are communicating, and reflects the context in which we are doing so. The communicative challenges and risks in emergency departments arise directly from the unique contextual demands of the emergency department environment. In this chapter, we begin our account of communication demands of the emergency department by describing its characteristic features and seeing how these directly affect the nature of communication.

Patients experience many sites when they present to the emergency department—the waiting room, the ambulance bay, the triage, the acute and subacute sections and the ‘bridge’. The bridge is the colloquial name given to the central communications hub in the emergency department of many hospitals in Australia.

Although it is referred to by other names, the bridge is a fixture in all emergency departments. Clinicians meet, talk, work on computers, often carry out the shift-to-shift handovers and write up the patient medical records in this central area. It is always full of action, with staff standing and sitting, moving into and out of the area. There are many communication and electronic artefacts (computer terminals, equipment), phones are constantly ringing and patient medical records are often scattered over the bench tops. The bridge is the communal centre of activity through which all clinicians move at some time during a shift. The purpose of the (usually) elevated platform that underpins the area and gives it its name is to provide a ‘watchtower’ view of the ambulance bay and resuscitation beds, and a good view of a number of the acute beds. It is also a central point for communication, both written and spoken.

We conducted a total of 1094 hrs of ethnographic observations in the different sections of emergency departments, which included shadowing key clinicians through parts of their shift, audio recording and taking detailed notes. These observations and shadowing yielded a rich graphic account of the activities, people, stories and interactions that take place daily in the triage room, the ambulance bay, the

acute, subacute, emergency medicine unit (EMU), resuscitation areas, bridge and waiting room. Overall, they reveal a picture of busy, overstretched worksites with constant movement, talk and clinical action. This complexity is compounded for patients and carers who arrive as outsiders to the emergency department environment.

To set the scene, we begin our description of the emergency department context by presenting a vignette of a day during which we shadowed a senior nurse manager in one large metropolitan emergency department. We followed the nurse throughout her shift on a Monday following a typically busy weekend. Several patients who had arrived over the weekend were still awaiting admission to a hospital ward. Others were waiting to be seen by specialists from other areas of the hospital, unable to be discharged from the emergency department until they were cleared. The description is based on the observation notes and audio recordings of the nurse's interactions. It clearly demonstrates the high stress and intense demands of working in emergency departments, and the significant challenges faced by clinicians in them.

We then describe the various contextual factors that characterise emergency departments and make them unique, and demonstrate how these contextual factors manifest in specific communication practices in emergency department care.

2.2 Setting the Scene: A Busy Day in an Emergency Department

It was a bad weekend. The director of the emergency department (ED) had been called on Sunday at 2 am and informed that the situation in the ED was critical. Now Monday, 1.45 pm, it is still critical. The primary problems are bed space and acuity. Patients are spilling into the corridors and out of the exits. A senior nurse working in the ED complains that staff cannot even see the patients—there are just too many of them, piled up and out of view. At around 1:50 pm 'another' level 3 page goes out, notifying the hospital that the ED is in a situation of overcrowding and in need of the wider hospital's support. Already over the ambulance threshold (with seven patients waiting in the bay), ambulance officers have begun to queue around the entry to the department.

A bed manager comes down to allocate beds among the waiting patients but gets nowhere. The access to beds is not there, creating further queues. The queue for beds at 2 pm is nine people long. A senior doctor suggests that they start doing the rounds to find people who are better and 'to see who we can get rid of'. The senior nurse on duty replies that there is no-one who can be moved. A young girl has been in an ED bed since the night before. The orthopaedic ward refuses to take her until her neck is formally cleared and documented. The orthopaedic registrar had been on his way down to do this but has been called away to do something else.

Two staff specialists are 'trapped' in the ambulance bay. Although this is a non-treatment area they have started treating patients anyway, taking patient

bloods, getting ECGs. With every patient there is an ambulance officer—sitting around, waiting to handover his or her patient when a bed becomes available. They monitor their patients, although regulations prevent them from administering any care. Mostly, they just have to ‘sit there’ and wait. Another ambulance turns up making the queue ten patients long.

A senior nurse goes to call the hospital bed managers but is informed that all bed managers are unable to come down as ‘they’re in meetings’. She calls them anyway, informing them that it ‘is critically unsafe down here’. The researchers are told that those words ‘critically unsafe’ get a response. The senior doctor and nurse try to work out whether they can send any of the patients down to EMU to free up a bed. They agree that five can go; however, in the end they only manage to free up one bed. Another ambulance arrives. There are now 11 patients in the ambulance bay and the ED now ‘does not have resusc capacity’¹. Non-resusc patients are occupying the beds dedicated to this level of care. The senior nurse, still having received no response from the bed managers, writes to the program executive, pleading for managerial staff to support them.

A further admission is declared by one of the doctors in the ambulance bay. A senior nurse does a round of the ambulance bay getting briefed on the waiting list—several patients have been sitting in this area since 10 am. It is now almost 2 pm. No-one has been treated. Meanwhile, the ambulances have begun to queue behind the doors at the entry to the ED. The doctors have ‘no visual line’ to those patients. One of these patients is diagnosed as critically unwell with a pericardial effusion. It needs to be tapped urgently. Another patient has a severe allergic reaction. Another has had a severe epileptic seizure. A ‘psych’ patient occupying one of the beds is asked to move into a seat to make space for the patient with the allergic reaction. Another mental health patient, who has been in the ED for an inordinate number of hours without a bed, is moved into the corridor. Meanwhile, the patient with the allergic reaction still goes untreated—it is predicted that she will lose an airway if she is not addressed shortly.

The senior nurse walks to the EMU and finds there are five beds there. She decides to override the department’s own policies and assigns five non-urgent patients’ beds down there. Instantly, the ED beds that were freed up are filled again. It is now 2.20 pm and there are still six people waiting in the ambulance bay. The girl waiting for the orthopaedic registrar has still not been moved and there has been no sign of the bed managers. A nurse explains to the researchers that three beds in the ED are being blocked because the patients cannot be transferred into wards. One of these patients is a 98-year-old woman who has been in the ED since 2 pm the day before—she cannot be moved because there is simply no bed for her to go to. Staff attempt to clear

¹ ‘Resusc’ refers to a reserved bed where patients who need resuscitation can be put.

the beds in 'resusc' so that they can regain resusc capacity. Every patient they approach is waiting for a bed to be freed in a ward. None can be moved. There are no clinical beds and no mental health beds in the hospital. Further, despite three mental health admissions, only one 'special' nurse has been provided—they have been given one-third of what is required for safety.

Two beds become free in EMU and resusc capacity is temporarily regained. The acting director of nursing comes down to sort out the ward blocks. Just as the staff begin to regain control, the computer board refreshes itself and sends out the message that the ED can take two more patients. This is anything but the case. A new patient who has arrived is suspected of having *Legionella* and needs to be isolated. Seconds later a mental health patient arrives without a 'special' nurse in attendance. Staff attempt contact with the Mental Health Unit to clarify whether they have beds. At 3 pm, the second bed manager comes down. Moments later the orthopaedic registrar arrives to make a decision about the girl's neck. He clears the spine immediately and the girl is moved. Doctors remain in the ambulance bay, attempting to provide whatever care possible to those patients not yet able to be placed in a clinical area in the ED. A nurse comments to the researchers: 'This is where it gets unsafe. Doctors in the ambulance bay with trolleys and with needles. All you need is a psychotic patient in there to go off and all hell will break loose.'

The senior nurse does another round of the bay and finds a 'potential SBE'² in need of urgent antibiotic treatment. She also meets a man with myocardial infarction who has had his ECG delayed. He needs to go on a bed immediately. Meanwhile, the patient suspected of having *Legionella* has still not been isolated. As predicted by ED staff, the man with infarction has an abnormal reading on his ECG and is an admission. Behind him, staff frantically make phone calls trying to free up beds and create movement for patient flow. The ambulance bay is still spilling with patients and trolleys and it is virtually impossible to walk freely around the department. A senior nurse asks the ambulance officers to attempt to make a clear way. Finally a man with hypoglycaemia who arrived at 11.30 am is offloaded from the ambulance bay onto a bed at 3.15 pm.

There is a woman in the corridor waiting on a trolley and obstructing the path to resusc. One staff member, on seeing her, groans: 'If they have a cardiac now, how do they run through there?' She is moved onto a seat in the main area so that she can be watched by staff. Minutes later the radio announces that a cardiac arrest is on its way in. There is no bed empty in the resuscitation rooms but staff manage to clear an empty space in one by putting all occupied beds in the one resuscitation room. One of the patients in Resuscitation 2 has been there all day. Around six minutes after being announced, the cardiac arrest arrives and is rushed into resusc. Her heart stops beating; they 'call it'—

² SBE: Shortness of breath on exertion.

they are not able to bring her back. The senior doctor and the social worker go to see the family of the cardiac patient, who have been waiting in a nearby room, to explain that the patient has died.

Meanwhile, outside, the patient who had an epileptic seizure still sits in the ambulance bay waiting for treatment. The staff believe he will have another seizure soon. Nine more patients are about to arrive at the ED by ambulance. There is still nowhere to offload them. Waiting to be seen are a young man with a dislocated shoulder with pain at 8/10 and 'a febrile old lady'. A nurse re-categorises them as Category 2 'so someone can just start seeing them'. It is decided that at least two patients who have been in the department all day will be held overnight—there are no beds to accommodate them ...

This scene clearly demonstrates that when presentations are relentless the situation reaches a critical point. Comments made by staff highlighted the lack of resources and inadequate staffing in the emergency departments, presenting a work environment that is cumulatively and increasingly challenging.

2.3 The Context of the Emergency Department

Emergency departments are sites of significant and increasing contextual complexity. This complexity stems from a number of factors, including operational hours and uncapped patient loads; the increased demand for emergency department care; the short term and an episodic nature of emergency department care and the impact it has on clinician–patient relationships; the multidisciplinary nature of emergency department healthcare teams; the tertiary function of emergency departments as a practical training facilities for student and junior doctors and nurses; their linguistic and cultural diversity; and, finally, their reliance on spoken language as the main medium of communication between clinicians, and between clinicians and patients.

2.3.1 Operational Hours and Uncapped Patient Loads

Emergency departments operate 24 hrs a day, 7 days a week. At any time, patients suffering a range of acute illnesses and injuries can arrive at the emergency department door. As such, while emergency medicine may be described as a specialty in its own right, the range of patient injuries and illnesses that emergency department clinicians must diagnose and treat means that it can also be described as 'encompassing every specialty that exists in the world of medicine' (registrar, hospital B).

There are no limits to the number of patient presentations—rather, emergency departments have uncapped patient loads. As one senior doctor we interviewed explained, unlike 'a ward [in which I can say] we've got 30 beds and that's it, we can't take anymore ... it doesn't matter whether we're prepared or not, we have to be pre-

pared and we have to provide that service. We're a service that has excess demands all the time for the resources available' (medical specialist, hospital A).

One flow-on effect of the combination of the operational hours and uncapped demand is that emergency departments must be staffed by changing shifts of clinicians. As a result, patients are likely to be cared for by many different doctors and nurses during their time in the emergency department. In turn, emergency clinicians will care for patients simultaneously (Redfern et al. 2009, p. 653) as they balance the organisational and policy requirements of providing care to all patients who arrive at the emergency department, within specified time frames.

2.3.2 Increased Presentations and Overcrowding in Emergency Departments

The demand for emergency care is on the rise around the world (see, e.g. Committee on the Future of Emergency Care in the United States Health System 2006, pp. 38–39; Lowthian et al. 2012). In Australia, emergency department presentations have risen on a steady incline for the last 5 years. Between 2008 and 2013, presentations increased by an average of 2.9% per year (Australian Institute of Health and Welfare 2013, p. 7). The peak times for patient arrival tend to be during the weekends and on Mondays, between the hours of 10 am and 12 noon (Australian Institute of Health and Welfare 2013, p. 12).

Emergency departments around the world need to have a process for determining the priority of patient treatments based on the severity of the patient's condition. This process, referred to as 'triage', is essential if resources are such that not everyone can be treated as soon as they arrive. The triage categories vary from country to country—in Australia, the triage categories are on a scale of 1–5 (referred to as the Australasian Triage Scale (ATS). The scale has been in use since 1994. The scale consists of 5 levels, with 1 being the most critical (resuscitation), and 5 being the least critical (nonurgent). In order of urgency and priority, these categories are resuscitation, emergency, urgent, semi-urgent and nonurgent (Table 2.1).

Nationally, most patient presentations fall into the latter three categories (Australian Institute of Health and Welfare 2013, p. 17). The increasing use of emergency departments by nonurgent patients is a worldwide phenomenon, and reflects many

Table 2.1 Australasian Triage Scale

Triage level	Description	Should be seen by provider within (min)
1	Resuscitation	0
2	Emergency	10
3	Urgent	30
4	Semi-urgent	60
5	Nonurgent	120

factors, including the 24 hrs accessibility and availability of emergency department care, patient's desire to avoid prolonged waiting times for appointments in primary healthcare contexts, perceptions of emergency departments as one-stop healthcare sites for multiple tests and access to a range of specialisations and rising costs of healthcare in private settings (Durand et al. 2012; Committee on the Future of Emergency Care in the United States Health System 2006, pp. 38–39).

This increased demand for nonurgent care in the emergency department setting results in many patients experiencing extensive waiting time before being admitted. They are often unaware of the rationale behind triage, and are subsequently frustrated by the delay between their initial arrival at the emergency department and receiving treatment. The often unmanageable demand also increases the risks to patient safety inherent in the triage system. For example, many clinicians reported the limitations of this practice, citing lack of clinical expertise by the clinicians responsible for triage which can result in under-triaging (so underestimating critical nature of presenting condition), not considering differences in injury severities and survival probabilities between types of trauma, and not taking age into account (see Navin and Sacco 2010).

The increased number of presentations are associated with overcrowding, with widespread reports of overcrowding in emergency departments around the world raising doubts about the capacity of emergency services to provide safe care (Lowthian et al. 2012). There is increasing evidence that overcrowding affects patient safety. Bernstein et al. 2009, p. 1 state that:

A growing body of data suggests that ED crowding is associated both with objective clinical endpoints, such as mortality, as well as clinically important processes of care, such as time to treatment for patients with time-sensitive conditions such as pneumonia. At least two domains of quality of care, safety and timeliness, are compromised by ED crowding.

On 31 August 2014, hospital D's emergency department clinical director said on the online edition of the daily *ABC news* that he was very concerned about the increased patient presentation numbers to the emergency department and that 'current patient numbers are unsafe and unsustainable'.

He said that the presentations to the emergency department have increased by 7%, and that overcrowding not only affects the patient experience but more critically their safety:

Once you've been seen and you have a diagnosis, how long you stay in emergency and how crowded emergency is has impacts on health. It increases time in hospital, it increases costs, it increases complications and in fact it increases mortality. (Dr Michael Hall, emergency department clinical director, online Australian Broadcast Commission news, 31 August 2014)

The continuing rise in patient presentations presents significant challenges to both the quality and safety of the patient experience, with significant evidence from around the world that the risk of adverse events is increasing due to overcrowding (Schull et al. 2002).

2.3.3 Short-term, Episodic Patient Care: The Lack of Familiarity Between Emergency Department Patients and Clinicians

Emergency departments are set up to provide short-term, episodic, urgent and life-saving care. The primary objectives of emergency department care are to determine as efficiently as possible a patient's diagnosis, and to decide whether the patient can be treated within the emergency department and discharged, or whether they need to be admitted to the wider hospital or referred elsewhere for ongoing care and supervision. The challenge for emergency department clinicians is to make these determinations in the absence of any readily accessible medical records, known medical histories or established relationships with patients. In the words of one staff specialist we interviewed 'Our patients are unknown, they're new, so they don't come in with the diagnosis tattooed on their forehead and that is often very difficult for people who don't work in emergency to understand' (staff specialist, hospital A). Although some patients may return to the emergency department for follow-up care, for most, their relationships with their emergency department clinicians will cease following their discharge from the emergency department. As a result, it is imperative for patient safety that patients leave the emergency department with a clear understanding of their diagnosis and their clinician's recommended treatment regimen postdischarge. Without this, as Perez-Carceles et al. (2010, p. 456) note, compliance with discharge instructions will be unlikely, as there will be no subsequent contact between clinicians and patients, and therefore no further opportunity for patients to clarify their understanding, or clinicians to ensure patient comprehension.

2.3.4 The Physical Environment: Noise Levels, Privacy and Comfort

A flow-on effect of the short-term, functional nature of emergency department care is that they are not designed for prolonged patient stays. As one clinician commented, the emergency department is 'a terrible environment for people to sit in for 24 hrs, there's no doubt about that. Our beds aren't designed for people to stay, we don't have enough showers, we don't—we're not meant to be that' (senior staff specialist). Researcher observations of the physical environment of each emergency department we studied paint the picture of crowded, cold, sterile and clinical spaces, summarised in Table 2.2.

Emergency departments are also notoriously noisy clinical environments, filled with the constant sounds of medical equipment, patient monitors, computers, overhead announcements, phone calls and conversations between patients and clinicians and amongst clinicians themselves. As Short et al. (2011, pp. 28–29) found, the highest noise levels tend to be in the resuscitation areas and acute sections of the emergency department, often exceeding established recommendations of sound levels for patient areas and wards. Exposure to high levels of constant noise in clinical settings has been correlated with increased agitation and psychological distress, patient confusion, staff exhaustion and medical and nursing errors (Short et al. 2011).

Table 2.2 Layout and space in the five emergency departments studied

Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Crowded; cluttered walls; white; bright; few windows; cubicles defined by curtains	Beige; brown; clinical; ordered; windows; clean walls; cubicles defined by curtains	Windowless; ordered; antiseptic; bright yellow; cubicles defined by curtains	Has some windows; bright; antiseptic; cubicles defined by curtains	Windows in one part of acute; none in subacute or EMU; walls are green; cubicles defined by curtains

In our research, we found that the level of noise in the emergency departments frequently affected the audibility of patient–staff interactions, with clinicians and patients regularly needing to repeat themselves in order to hear one another. Further, as patient beds were often only separated from each other by curtains, this provided very little privacy for their occupants. Throughout our research we observed that often patient–clinician conversations were clearly audible from the next-door beds. As one intern (hospital A) said to us:

I often think ... yeah I don't ... I think I would have to be seriously ill to go to an ED (laughter) just because I think it would be such a frustrating experience and particularly late at night because it never closes down ... the lights are always on, there's always noise and there's always people and I think if I felt like that person probably feels, the last thing I would want would be a big noisy room with people running around and no one coming when I press my button and... so that sort of thing. So I think it's a very frustrating and prolonged experience for them. I think once they're on the wards it's a little bit ... far more sane 'cause it's a little bit more settled.

2.3.5 Multidisciplinary Healthcare Teams

Emergency department healthcare teams are made up of doctors, nurses and allied health professionals (although the major disciplinary divisions are between doctors and nurses). All have different roles and priorities in the management and treatment of patients who present to the emergency department. Nurses will typically manage the ongoing care of patients in the emergency department (e.g. administer pain relief, monitor each patient's stability and comfort), while doctors will diagnose, establish a treatment plan and determine whether a patient can be discharged from the emergency department or admitted to a hospital ward for further observation and care. Notably, while the disciplines work side by side, in all but one of the emergency departments we researched, there was very little evidence of interdisciplinary collaboration throughout patient journeys. Rather, we observed clinicians attending patients' bedsides individually and asynchronously, undertaking discipline-specific tasks and care. We also frequently observed tensions between doctors and nurses relating to the performance of tasks that traversed traditional disciplinary boundaries. The lack of interdisciplinary practice also led to a lack of familiarity between staff of different disciplines:

Junior doctor: Do you do lines?

Nurse: Not on him, he's got terrible veins. Technically it's your job doctor.

Junior doctor: I know.

Nurse: I don't do lines, because I'm very good at blowing them.

And in another emergency department:

Junior doctor: Are you looking after the patient in bed 10?

Nurse: I'm a float nurse.

Junior doctor: Is that a 'yes' or a 'no'?

Nurse: That's a 'no'.

In the following sections, we discuss that the multidisciplinary nature of emergency department care will often translate to different communicative roles being undertaken by nurses and doctors in their interactions with patients. It also produces complex networks of care that surround each patient's journey in the emergency department.

2.3.6 Joint Role of Emergency Departments as Training Facilities

In Australia, as elsewhere, emergency departments are training grounds for junior doctors and nurses. As the final report of the Special Commission of Enquiry into Acute Care Services in NSW Public Hospitals pointed out, most of the acute care services for noncritical patients are performed by junior doctors (interns, residents, registrars, career medical officers and locums). In essence the report notes, Australian acute health services are training grounds for junior doctors. (Garling 2008, p. 428).

Junior clinicians with varying levels of experience and expertise learn on the job and predominantly focus on the immediate clinical task in front of them. A central component of the work of senior clinicians is supervising and guiding their junior colleagues. In all emergency departments we researched, however, senior clinicians (both nurses and doctors) were far less in number than their junior counterparts, which stretched the capacity of senior staff to perform their supervisory roles. As a director of one emergency department explained in reference to the medical discipline: 'Junior medical staff ... they're learning so ... they're going to make mistakes ... And we are understaffed with consultants here. So [as a senior doctor] when you're on the floor you've got everybody coming at you all the time for 10 hours looking for direction'. Indeed, across our interviews, nearly all senior clinicians described the key challenge of their work as stemming from the constant interruptions they faced as they multitasked their competing responsibilities of supervising junior colleagues, performing direct clinical care and facilitating patient flow across the department. This was particularly emphasised by senior medical staff members who bear the primary responsibility not only for individual patient diagnosis and disposition decisions, but also for negotiating the transfer of patients from the emergency department to other hospital wards. As one senior staff specialist explained:

Communicating in Hospital Emergency Departments

Slade, D.; Manidis, M.; McGregor, J.; Scheeres, H.;
Chandler, E.; Stein-Parbury, J.; Dunston, R.; Herke, M.;
Matthiessen, C.M.

2015, XIX, 158 p. 20 illus. in color., Hardcover

ISBN: 978-3-662-46020-7