



Interprofessional communication in an emergency care unit: a case study*

Comunicação interprofissional em unidade de emergência: estudo de caso

Comunicación interprofesional en Unidad de Urgencias Hospitalarias: estudio de caso

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ABSTRACT

Objective: To map internal and external factors in an emergency care unit that interfere with interprofessional communicative practice. **Method:** This is a single case study carried out in the emergency care unit of a general hospital. Data were collected through participant observation, document analysis, and semi-structured interviews, and were triangulated and subjected to thematic analysis, out of categories defined *a priori*, based on the SWOT matrix. **Results:** Twenty-two health care professionals participated in the study. As for the strengths and opportunities, it was found that professionals understand the importance of communication as a safety measure, and they use the shift change and written communication to share information. However, overcrowding, work overload, the lack of behaviors standardization, the inexperience of professionals, and the deficit in the interprofessional relationship are factors that hinder effective communication. **Conclusion:** The fragile interprofessional communicative process hampers interaction and information sharing for shared decisions that allow the safe continuity of care.

DESCRIPTORS

Communication; Emergency Service, Hospital; Patient Care Team; Interprofessional Relations; Patient Safety.

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INTRODUCTION

In the Brazilian Public Health System, organized through the establishment of Health Care Networks, the Emergency Hospital Service is one of the main components of the urgency and emergency network and it is the gateway to high complexity cases⁽¹⁾. Factors that are internal and external to this unit, such as an alternative of care and the possibility of the population having access to assistance with greater resolution, overcrowding, difficulty of team integrated performance in an environment of uncertainty, high turnover, patients' severity, multiplicity of tasks leading to the worker's overload, among others⁽²⁻³⁾, are difficulties that can cause distortions in the communication established among professionals, interfering with its effectiveness, as well as causing health care fragmentation.

Interprofessional communication (IPC) can be understood as the ability for effective communication among people, especially from different professions, in a collaborative way⁽⁴⁾. Improving communication among health care professionals is the second international patient safety goal, established by the Joint Commission International, in partnership with the World Health Organization⁽⁵⁾.

The construction of dialogue in an interprofessional environment allows the creation of a relationship with integration among those involved, which allows the recognition of the work of the other and its specificities, being a primary determinant for the achievement of effective communication among professionals, favoring a safer and more humanized care environment⁽⁶⁻⁷⁾.

Of note, IPC is an important tool that shall be used since the patient's arrival at the emergency care unit (EU) through the Reception System with Risk Classification¹ (*Acolhimento com Classificação de Risco – ACCR*). This system allows patient horizontal care using recommended appropriate flowcharts and protocols⁽⁸⁾. Patients, when received and classified as red risk, require immediate referral to the red room. In the path from one space to the other, communication among professionals shall allow continuity of care in a safe manner, minimizing errors and improving the quality of care.

The national and international scientific production on IPC highlights aspects that address the limits in this communication, such as the absence of regular and planned communication routines among professionals from different categories and the use of standardized tools, fragile interaction and use of dialogue to favor team work, unfavorable environment, among others^(2-3,6,9). However, no studies were identified that map the internal and external factors interfering with communication. Therefore, the proposed study shows relevance and innovation, considering

¹ Ordinance 2,048 of the Brazilian Ministry of Health proposes the implementation of embracement and the "classification of risk classification" in the emergency care units. According to this Ordinance, this process "shall be carried out by a health professional, with a higher level, through specific training and the use of pre-established protocols and aims to assess the degree of urgency of patients' complaints, placing them in order of priority for service".

the theme from the perspective of interprofessionality in an emergency hospital setting.

In collaborative interprofessional practice, the different professional categories shall work together to obtain positive results in health care provision⁽¹⁰⁾. It is believed that an effective IPC favors teamwork and continuous patient care, minimizes risks and adverse effects, and contributes to patient safety^(6-7,10-11). In this regard, this study is justified because it contributes to discussions that help in the comprehension of factors interfering with the effectiveness of the communication process among professionals from different categories, in a critical environment such as that of the emergency unit, allowing triggering of actions that contribute to communication planning.

Considering that communication is among the six competencies required for an effective collaborative interprofessional practice⁽¹¹⁾, the following research question was raised: How do internal and external factors in an emergency care unit interfere with interprofessional communicative practice?

Thus, this study aims to map internal and external factors in an emergency care unit that interfere with interprofessional communicative practice.

METHOD

DESIGN OF STUDY

This is a descriptive, qualitative, single case study⁽¹²⁾ that follows the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ)⁽¹³⁾.

PARTICIPANTS

Twenty-two professionals from the health team participated: 7 physicians, 10 nurses, and 5 nursing technicians. The interest was to analyze the phenomenon among the professionals working in the ACCR and in the red room, spaces used by the patient in an emergent situation, either due to spontaneous or regulated demand.

SCENARIO

Emergency care unit of a large, public, high-complexity, tertiary care general hospital in the State of Bahia. The emergency care unit uses the Risk Classification according to the Manchester triage system to prioritize care according to severity levels⁽⁸⁾.

SELECTION CRITERIA

The following inclusion criteria were adopted: being a professional of the unit's permanent health care team, working in patient direct care in the emergency care unit, during the period of data collection. There was no exclusion criterion.

SAMPLE DEFINITION

Selection was carried out by means of intentional non-probability snowball sampling⁽¹⁴⁾. The first participant

was suggested by the hospital board of directors, a nurse attending in ACCR and in the red room. This one, in her turn, indicated other people to be interviewed, and so on, with no refusals. The study proceeded with the collection, continuing until less and less information was obtained at each interview.

DATA COLLECTION

The use of multiple sources of evidence allows the development of convergent lines of investigation in a case study⁽¹²⁾. The sources of evidence used in this study were participant observation, semi-structured interview, and document analysis. Data collection took place in three distinct and complementary steps and the information collected was triangulated, allowing the convergence of evidence that helped reinforce the construct's validity⁽¹²⁾.

In a first step, participant observation, carried out freely, for 30 non-consecutive days, totaling 50 hours, in different shifts and times, allowed the researcher to be inserted in the daily routine of the emergency care unit. As a starting point for this step, the following question was asked: how does the flow of communication about the patient take place among professionals working in the ACCR and between them and those who work in the red room? The observation was maintained until signs of saturation were identified, that is, when less and less new information was obtained at each session. The data observed were recorded in the fieldnotes and later fully transcribed.

In the second step, the semi-structured interview was held, in a reserved place in the institution, following a script, containing characterization data and guiding questions related to the importance of communication: how it occurs, factors that interfere with communication, and suggestions for its improvement. The data of the interview, which lasted between 15 and 60 minutes, were recorded and fully transcribed.

In the third step, secondary data were obtained from the written instruments used by the ACCR (patient evaluation form) and red room (medical record) workers, where there was information related to the patients, and from the reports produced by the institution's Department of Health Quality and Surveillance. Based on the initial reading of the selected documents, a screening of the materials was carried out and, subsequently, a detailed reading was carried out that allowed to know how the information was recorded, and whether the communication among the health team through these documents allowed the continuity of the care provided to the patient.

Data triangulation allowed apprehending information about the object of study in different types of knowledge and levels of comprehensiveness. Thus, the data obtained from the fieldnotes, in the interviews with the research participants, and in the documents, allowed to know the flow of communication, how this occurs, what its importance is

for physicians, nurses and nursing technicians; which factors interfere with it, and whether the information recorded was complementary and contributed to the coordinated conduction of patient care.

DATA ANALYSIS AND TREATMENT

Information was analyzed using Bardin's thematic analysis method⁽¹⁵⁾. First, in the pre-analysis step, data were organized, generating the research corpus. Then, the exploration of the material was started through a thorough and detailed reading of the transcriptions, with central ideas and structures of relevance of the study being apprehended, allowing coding and categorization of the material, based on the research question and the results treatment phase.

The internal and external factors interfering with the communicative practice in the study unit were mapped with the use of Swot Matrix⁽¹⁶⁾ based on the data produced. The analysis management matrix tool SWOT is an acronym related to four components: Strengths, Weaknesses, Opportunities and Threats. It allows analyzing the internal and external factors linked to an organization, and mapping information and general situations, to assist in strategic planning and in the decision making process⁽¹⁶⁾.

Data were organized based on categories defined *a priori*, based on the fundamentals of the SWOT matrix: strengths and weaknesses, opportunities and threats in the emergency care unit, as well as on analytical inferences related to each of these points, according to the thematic analysis organization.

ETHICAL ASPECTS

The research followed the ethical principles of Resolution No. 466/2012 of the National Health Council and was approved by the Human Research Ethics Committee of Hospital Geral, in 2019, under opinion no. 3.159.649. To preserve the participants anonymity, a nominal coding was used, with names being represented by letters according to the professional category and a numerical coding to indicate the corresponding interview number.

RESULTS

Of the 22 professionals participating in the study, there was a predominance of females (12), age ranged from 27 to 54 years, with an average of 30.7 years. Time of profession ranged from 1 to 25 years and time working at the emergency unit ranged from 1 month to 8 years.

The identification of the strengths, weaknesses, opportunities, and threats of communication in the emergency unit (Chart 1) with the SWOT Analysis matrix allowed to know internal and external factors interfering with the communicative practices produced in the interactions among health care professionals.

Chart 1 - SWOT matrix of internal and external factors interfering with interprofessional communication in the EU - Salvador, Bahia, 2019.

STRENGTHS	OPPORTUNITIES
-The team understands communication as a safety measure; -Internal safety center; -Communication consultancy.	-Public sector investments for renovation in the Emergency Unit with expansion of the number of beds, as well as investments for renovation in the Surgical Center and wards beds.
WEAKNESSES	THREATS
-Overcrowding; -Service on a first-come, first-served basis in situation of overcrowding; -Overload; -Lack of standardization of care behaviors; -Professionals with no experience; -Deficit in interprofessional relationship; -Failures in oral and written communication.	-Interruption of operation of the Emergency Care Unit located in front of the locus hospital. -Lack of training in the use of the Manchester Triage System.

Emergency unit strengths: Internal factors positively interfering with the communication among professionals

Communication is recognized by professionals as a safety measure, and the communication tools used, such as oral communication on shift change, and written communication with the use of the patient's evaluation form in the ACCR and the medical record, used when referral to the red room is required, to be safe shall be objective, with uniform language, being able to share the established behaviors, giving continuity to them.

When you receive all the information with consistency, you offer the patient better assistance, in a safe way and without putting our lives and the lives of others at risk (NT10).

Proper communication allows continuity of care. You notice the difference between a patient who comes straight from the door to the red room and the one who goes through the ACCR. We are able to have better information when they come from the ACCR (N6).

[...] our objective is to leave the medical record well written, so that the colleague understands what we thought, what was done, and what is expected to be found, to continue (P11).

To support safety actions, the hospital has an Internal Safety Center, which, in partnership with its communication consultancy, carries out specific campaigns to raise the professionals' awareness about the safety measures to be instituted daily, highlighting the importance of interprofessional communication for conducting actions for the patients' benefit.

Emergency care unit weaknesses: Internal factors negatively interfering with communication among professionals

Internal factors weaken the interprofessional communicative process, with the overcrowding of the unit being emphasized, which led to consultations on a first-come, first-served basis, rather than on a priority basis, with a high demand for non-urgent care, causing work overload for professionals, and weakening the communication among them.

[...] the demand and flow are great, everything is very fast and makes people not stop to listen to the information transmitted (N15).

You deal daily with naturally stressful situations, and the lack of infrastructure, overcrowding, the lack of adequate human resources interfere with communication among professionals (P16).

Communication in the red room is deficient, as it is always full of patients and professionals. Often, the ACCR patient comes in and we are not informed. When you least expect it, they're in here, we don't know the name or why they came (NT18).

Lack of care behaviors standardization, failures in the shift changes, and inexperienced professionals fragmented information sharing among professionals, leading to occasional communication, making it difficult to ensure continuity of actions to promote safe care.

The lack of standardization in the transmission of information due to the lack of unit organization means that information is transmitted incomplete (P11).

The shift change is fragile and with a lot of lost information, leading to time loss. If information was adequate, I would be able to streamline and optimize patient care (N5).

The inexperience of many professionals and the lack of behavior standardization make the decisions for care undergo constant changes. This creates conflict among the teams, as the professionals don't trust the information conveyed (N15).

Oral verbal communication took place without a standardized protocol, contributing to lack of uniformity, with little interprofessional interaction, and among people of the same professional category. In addition, it underwent constant interference due to noise from devices and monitors, parallel conversations, interruptions by other professionals who were not part of the team, breaking the train of thought of the people involved and making it difficult to share information about care.

When analyzing the user's attendance form filled out by physicians and nurses at the ACCR, it was observed that not all professionals filled it out completely. Despite the existence of computerized forms, medical and nursing records were filled out manually, compromising legibility. Moreover, repetition rather than complementarity of the information recorded by physicians, nurses and nursing technicians was identified.

Deficit in the interprofessional relationship was another weakness identified and was influenced by the established hierarchy. It was observed that the relationship among professionals involved in the care of patients who were admitted to the ACCR and were referred to the red room took place only among professionals from the same professional category. The relationship established by the ACCR nurse

with the physician in the red room was almost inexistent, and few physicians and nurses considered interacting with nursing technicians, limiting communication to the request of procedures.

ACCR physicians enter the red room and address the doctors. The nurse passes the information to the nurse, and she tells us what to do for the patient (NT13).

The physician's communication with the nursing team is more written than verbal. Verbal communication depends on the relationship the doctor has with us. If he knows us, he seeks us to clarify any doubts, or discuss something related to the patient (N3).

Failure in the transmission of information among the nurse, the nursing technician, and the physician interferes with care. The doctor should pass on the information clearly, discuss what he is planning, so that everyone can know (P7).

Opportunities: Factors of the external environment interfering with the communication of professionals.

Public sector investments for reform in the EU of the HG, with an increase in the number of beds, and reform in the Operating Room and wards beds, are important opportunities for the improvement of work and, consequently, of interprofessional communication. However, these reforms had not yet started at the institution, and it is necessary to check the conditions and feasibility of use of these opportunities.

Threats: Factors of the external environment that hinder effective organizational development, interfering with interprofessional communication.

Periodic interruptions in the operation of the Emergency Department, close to the HG, due to overcrowding, also caused overcrowding in the EU, becoming a threat to the establishment of IPC.

It was pointed out that ACCR professionals' lack of training, for risk classification, contributes to failures in IPC about the patient in these spaces, and among them. Although training is offered by the Municipal Health Department of the city, this has not occurred for more than three years, according to information from the managers.

[...] Lack of training leads ACCR team to fail. If the critically ill patient arrives and the correct information is not given in the red room, there is risk of death (N1).

[...] The lack of training impacts the moment that the nurse will provide information about the patient to the red room. He/she does not get the correct complaint, and fills the flowchart without being consistent, conveying inappropriate information (N15).

DISCUSSION

The information produced related to the health status and needs of the people assisted in the emergency unit has to be made available through an effective network of interprofessional sharing, contributing to the work process and the provision of care. For the participants, IPC in patient information sharing is an important safety measure, and shall be objective for the planning and execution of continuous actions.

However, fragile communication was identified among the professionals at the locus emergency unit, as a result of factors such as overcrowding, work overload, lack of material and human resources, professionals' inexperience, and lack of behaviors standardization. Such factors are reflected in a work process that fragments care, with repercussions on communication and, as a consequence, disarticulation of care and dissatisfaction of professionals and patients⁽¹⁷⁾. Overcrowding, for instance, is considered a worldwide phenomenon, which interferes with the quality of service provision, the dynamics of work, and the safety of care⁽¹⁷⁻¹⁸⁾.

In this context, verbal information sharing about the patient, carried out by professionals from different categories, with constant interference, associated with the absence of a standardized communication tool, promotes loss of information uniformity. Written communication, consisting of incomplete, repetitive, and poorly readable information, makes it difficult to understand care and the therapeutic plan.

Communication failures with an excessive or reduced amount of information, and inconsistent information, are factors that interfere with the IPC⁽⁹⁾ and the continuity of safe care. It is challenging to identify methods and adopt strategies that reduce the deterioration of information, with the loss of important clinical data during communication in critical sectors⁽³⁾. Therefore, organizational protocols and procedures shall be instituted to ensure that all team members are present and all information available⁽¹⁹⁾.

A prospective pre- and post-intervention study aimed at determining the impact of an improvement program on verbal communication among nurses in an intensive care unit showed a positive impact on communication, including assessment of the severity of the disease (37% pre-intervention versus 67% post-intervention), decrease in the frequency of interruptions, and absence of negative impact on the nursing workflow. Therefore, it revealed the importance of standardized training programs, with a focus on improving IPC to reduce errors⁽⁹⁾.

The improvement program of the above-mentioned study was carried out through educational training on the best practices of verbal communication, mnemonic implementation of verbal transfer, and visual materials. Nurses were instructed on important elements to be shared, the use of a standardized format that starts with general information and follows with specific information, and on the importance of providing up-to-date and relevant information.

An effective tool for use in the emergency unit is the SBAR technique. Formed by the acronym situation, background, assessment, and recommendation, it is a structured method to standardize the exchange of information and the sequence of actions of health professionals, contributing to patient safety⁽²⁰⁻²¹⁾. It allows, in an easy and focused way, to set expectations for what will be communicated among the team members, allowing the development of interprofessional work. A study of mixed methods consisting of assessing the impact of the use of SBAR on the quality of transfers on admission to an emergency department revealed an improvement in the quality of verbal communication among

professionals, contributing to delineate responsibility for care and to streamline the flow⁽²²⁾.

Written communication in the study unit occurred, predominantly, through the medical record. This is a legal document used for the daily recording of information in the hospital, and shall convey information capable of promoting improvements in the care provided to the patient⁽²³⁾. However, due to illegibility, computerization of medical records is required, something that is still incipient in the unit studied. Written communication shall be aligned with the computerized system, allowing data to be recorded in a consistent and clear manner, with crucial information highlighted and easy to view⁽¹⁹⁾. "Effectiveness in the distribution of written and oral information, to the various professionals, provides autonomy for decisions and more involvement of the assistance levels with actions to improve quality of assistance⁽²⁴⁾".

For this, the relational aspect is important. However, it was evidenced in the study that this was a weak point in the unit, associated with hierarchical issues, lack of bond among professionals, especially among different professional categories. A study that sought to understand the view of nursing professionals in an emergency room on the transfer of patient care revealed lack of dialogue, omission of information and inequality in the valuation of the different works as hindering the construction of horizontal interprofessional relationships that are able to contribute to the establishment of effective communication, and teamwork⁽³⁾.

One aspect that was highlighted, both in the speeches and in the observation, was the fragility of the communication between the nursing professionals and physicians with the nursing technicians. Information sharing usually took place among physicians and nurses, and the nursing technician remained silent beside these professionals, performing delegated tasks. This finding is similar to that found in another study that highlighted the lack of appreciation and the feeling of inferiority as factors that hindered the communication of this professional with the rest of the team. There were also difficulties in teamwork involving nursing professionals, who work focused on the execution of tasks and procedures, and lack of cooperation and distancing from the team of physicians⁽³⁾.

The persistence of hierarchical and unequal practices among the different professional categories in the health area, the silos (groups of professionals who work in isolation), power, conflicts at work, and the difficulty in understanding the role of the other favor the professionals' parallel performance, to the detriment of teamwork, influencing the way in which interprofessional communication is established, which can lead to communication failures, with risk for the patients^(19,24).

Difficulty in establishing team work in daily health care practices is influenced by the hegemony of the traditional biomedical and fragmented model, one of the great challenges of the Brazilian health system today⁽²⁵⁾. This reality is opposed to the understanding of a team of professionals who should integrate the different knowledges through interprofessional collaboration, recognizing their interdependence

"based on intersubjective communicative practice among team workers, and among the latter and users and families"⁽⁷⁾, with a view to providing more qualified care, centered on the users and on their health needs⁽⁶⁻⁷⁾.

The development of teamwork in the emergent situation shall consider the application of technical and scientific knowledge, which has an instrumental nature, along with the establishment of communication among professionals from different categories who work together, allowing information sharing about the user's health condition and setting of priorities for care. From this perspective, the practice shared with professionals from other areas, centered on attention to the user's health needs, through the construction of symmetrical and linear relationships, contributes to the development of IPC⁽⁷⁾, improvement of health care quality, allowing transversalization of actions beyond the assistance in the acute situation faced by the patient.

The use of educational, psychological, and organizational strategies allows overcoming the communication barriers of the interprofessional team, through the application of structured learning methods; training of the interprofessional team; communication skills training through simulation; redefinition of the "team" of professionals, with the creation of democratic teams, favoring the feeling of belonging in each member, strengthening the feeling of appreciation and trust; as well as organizational protocols and procedures⁽¹⁹⁾.

A study aiming to analyze strategies adopted for improvement of internal communication in a general hospital highlighted a project whose focus was the continuity of qualified professional practice for 24 hours, through the standardization of communication. For the authors, effective communication, along with the professionals' engagement and involvement in their actions, allowed the construction of a unique culture focused on the quality and effectiveness of strategic information, promoting autonomy for the workers' decision-making⁽²⁴⁾.

Regarding threats, the participants in the project at issue highlighted the deficiency of the loco-regional network, which interfered with the planning of the unit, contributing to overcrowding and the consequent IPC deficiency. Evidence points out that services disarticulation in the emergency care network weakens qualified access, and causes problems in patient safety and privacy⁽²⁶⁾, corroborating this study findings.

Another threat to be highlighted is the lack of training of professionals working in the ACCR regarding the use of the Manchester Triage System. The lack of periodic training for the professionals updating contradicts what is recommended on the risk classification protocols⁽²⁶⁾. It is important to note that ACCR is an area that aims to offer immediate assistance. The lack or scarcity of information resulting from professional inexperience becomes an impediment to directed, fast, and uniform behavior.

The study, although carried out in a single EU, reflects strengths, weaknesses, threats and opportunities common to many national and international emergency units, especially with regard to overcrowding⁽¹⁷⁻¹⁸⁾, relationship among the team⁽²⁻³⁾, and investment in the public sector. However, it

has some limitations, since the scenario mentioned refers to a public health unit, which has its particularities. Therefore, the results shall be compared in new studies, to broaden the understanding of the problem in question.

This study will contribute to the discussion of communication in the emergency service, giving visibility to complex problems within the health team in hospital organizations. The results can support the construction of effective IPC strategies so that it becomes part of the internal organizational culture.

CONCLUSION

Factors that are internal and external to the emergency care unit interfere both positively and negatively with the communication among professionals. They understand the importance of communication as a safety measure, and use the shift change and written records to share information.

However, overcrowding, work overload, lack of behavior standardization, inexperienced professionals, and a deficit in the relationship between those who work in different categories contribute to the interaction and the interprofessional communicative process becoming fragile, and make information sharing for shared decision-making difficult.

Thus, aspects interfering with it shall be overcome, with a change in the care paradigm from the biomedical to the interprofessional view, allowing patient-centered care strengthening rather than a professional-centered approach. The professionals shall recognize the importance of teamwork, establish more dialogical working relationships with integrated care actions, change their behaviors related to interprofessional communicative practice and, in partnership with the institution management, plan and implement actions that contribute to effective communication, improving tools already used.

RESUMO

Objetivo: Mapear fatores internos e externos em uma unidade de emergência que interferem na prática comunicativa interprofissional. **Método:** Estudo de caso único realizado na unidade de emergência de um hospital geral. Os dados foram coletados por meio de observação participante, análise documental e entrevista semiestruturada, triangulados e submetidos à análise temática, a partir de categorias definidas *a priori*, baseadas na matriz SWOT. **Resultados:** Participaram 22 profissionais de saúde. Quanto aos pontos fortes e oportunidades, constatou-se que os profissionais compreendem a importância da comunicação como medida de segurança, utilizam a passagem de plantão e a comunicação escrita para compartilhar informações. Porém, a superlotação, a sobrecarga de trabalho, a ausência de padronização de condutas, a inexperiência de profissionais e o déficit no relacionamento interprofissional são fatores dificultadores de uma comunicação efetiva. **Conclusão:** O processo comunicativo interprofissional fragilizado dificulta a interação e o compartilhamento de informações para a tomada de decisões compartilhadas que possibilite a continuidade do cuidado de maneira segura.

DESCRITORES

Comunicação; Serviço Hospitalar de Emergência; Equipe de Assistência ao Paciente; Relações Interprofissionais; Segurança do Paciente.

RESUMEN

Objetivo: Mapear factores internos y externos en una unidad de urgencias que interfieren en la práctica comunicativa interprofesional. **Método:** Estudio de un único caso realizado en la unidad de urgencias de un hospital. Los datos fueron colectados por observación participante, análisis documental y entrevista semi estructurada, triangulados y sometidos al análisis temático, a partir de categorías definidas *a priori*, basadas en la matriz SWOT. **Resultados:** Participaron 22 profesionales de salud. Se constató que los profesionales comprenden la importancia de la comunicación como medida de seguridad, utilizan la entrega de turno y la comunicación escrita para compartir informaciones. Pero, los hospitales muy concurridos, el exceso de trabajo, la ausencia de una estandarización de conductas, la inexperiencia profesional y el déficit en las relaciones interprofesionales son obstáculos para que la comunicación sea efectiva. **Conclusión:** el proceso comunicativo interprofesional debilitado dificulta la interacción y la división de informaciones para la toma de decisiones compartidas que permita la continuación del cuidado de manera segura.

DESCRIPTORES

Comunicación; Servicio de Urgencia en Hospital; Grupo de Atención al Paciente; Relaciones Interprofesionales; Seguridad del Paciente.

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