

# Patient-clinician communication in hospitals

## Communicating for safety at transitions of care

▶ An information sheet for senior executives and clinical leaders

### Why is this important?

Communication errors are a major contributing factor in hospital sentinel events,<sup>1</sup> and are the most commonly cited underlying cause of complaints about the Australian health care system.

At transitions of care, the risk of communication errors is increased, which can lead to poor health outcomes, patient distress or inappropriate patient care.<sup>2-5</sup> Effective patient-clinician communication and engagement with patients at transitions of care can:

- positively influence a person's health outcomes
- prevent adverse events during care
- reduce readmission to hospitals following discharge.<sup>6, 7</sup>

This information sheet outlines guiding principles and examples of tools and strategies to improve patient-clinician communication at transitions of care.

### ! KEY POINTS

**The importance of effective patient-clinician communication is reflected across all of the National Safety and Quality Health Service (NSQHS) Standards.<sup>8</sup>**

The NSQHS Standards require health services to partner and communicate with patients, families and carers about care, and to provide information that supports patients with decision making.

Effective communication is also a key element of ensuring person-centred care, which is a well-recognised dimension of safety and quality.



### DEFINITIONS

**Effective patient-clinician communication:** is the exchange of information between a patient and their healthcare provider, and includes communications with the family and carer.

It involves two-way communication (spoken, written and non-verbal) that engages patients in decision making and care planning. It is tailored, open, honest and respectful and there is an opportunity for clarification and feedback.

**Transitions of care:** is when all or part of a patient's care is transferred between healthcare providers, locations or different levels of care within the same location, as the patient's conditions and care needs change.

## What is my role?

You have a critical role in ensuring that the care provided in your organisation is safe.

Implementing systems and processes to support effective patient-clinician communication at transitions of care is a key element of ensuring safety and quality. This includes:

- supporting and encouraging patient-clinician communication across your organisation
- fostering a culture of engagement and teamwork, where the patient is recognised as part of the team
- leading and managing change to improve patient-clinician communication
- supporting your healthcare providers by providing resources and tools for engaging patients, families and carers in transition communications
- acknowledging best practice
- implementing improvements, when necessary.

“ It takes the team, the nursing team, the allied health team, the medical team and the family and patient. Everybody’s on board. We’re here for the patient. ”

Nurse Manager<sup>7</sup>

## How can I improve patient-clinician communication in my organisation?

In collaboration with healthcare providers and consumers, organisations should take a systems approach.

This requires the implementation and integration of systems and processes that support effective patient-clinician communication across the organisation – from the highest level of governance to the point where care is delivered.

“ Excellence here... it looks at aligning our goals, aligning our behaviours and guiding our processes to get a consistent outcome. ”

Nurse Manager<sup>7</sup>

## Three key principles to help guide improvements within your organisation are:

1

### Strong organisational leadership and commitment to person-centred care and patient participation at all levels of the health service and across disciplines

- Executive leadership and leadership in nursing, allied health and medicine at all levels of the organisation are necessary to ensure a culture that supports and engages patients, their families and carers in communication at transitions of care.
- Implementing organisation-wide structures and resources that promote and facilitate patient engagement in communication is key.
- The NSQHS Standards can be an important driver for cementing person-centred care and patient-clinician communication within organisations.<sup>7</sup>

2

### Early engagement and support for patients, families, carers and healthcare providers to communicate and participate in transition communications

- Put in place strategies for early engagement with patients, families and carers to identify the patient's values and goals for their care.
- Support and respect a patient's preferences and choices.
- Give careful consideration to the health literacy, language barriers and culture of the people accessing your service.<sup>7</sup>

3

### Support the implementation of standardised tools and strategies to engage patients, families and carers in transition communications

- Tools and strategies are appropriate and useful for the specific clinical setting.
- Tools and strategies have some level of standardisation to ensure consistent implementation across the organisation, but allow for some flexibility to take into consideration individual patients' conditions and preferences.
- Support patients, families, carers and healthcare providers to understand and actively participate and use the various communication tools and strategies available to them.<sup>7</sup>

# CASE SUMMARY

## Multidisciplinary leadership and commitment to engaging patients in transition communications is key

One large Australian hospital has taken active steps to engage patients in communication at transitions of care. The hospital has demonstrated leadership and commitment to person-centred care at an organisational, service and individual staff level. Leaders in this service articulate their goals as being to:

- develop trust-based discussion and collaboration to achieve continuity of care
- pause long enough to give patients the opportunity to enter discussions
- create spaces for patients to get into the conversation.

The hospital has unit-level multidisciplinary collaborative practice teams, designed to ensure inclusiveness of staff, patients and families and consistency of how and what information is communicated.



## STRATEGY

**Multidisciplinary collaborative practice teams** are formal groups that include doctors, nurses, allied health professionals and a patient advocate. The group reviews processes, identifies areas for improvement and can assist in maintaining a patient centred focus.

## Implement standardised strategies and tools to support effective patient-clinician communication; recognising the barriers to, and potential enablers of, communication

Staff use a number of tools that are part of the TeamSTEPPS approach, including:

- the mnemonic ISBAR (Introduction, Situation, Background, Assessment, Recommendations) for handovers, which incorporate steps to engage the patient, and their family or carer, in communications
- formal discharge planning processes that keep patients aware of their expected date of discharge
- structured multidisciplinary team handovers that occur every day at a set time
- checklists and protocols to ensure communication and patient information is provided for all care transitions. Often these involve prompts to involve patients and families.

One of the major challenges faced by this hospital was maintaining a culture of person-centred care, which was affected by:

- dealing with the time pressures of high workloads
- bed block and lack of space
- the need to integrate staff goals (especially for those who may be only intermittently employed in the unit)
- accommodating numerous, often rapid patient transitions across services.

There was also the challenge of encouraging participation among patients and families with cultural and linguistic diversity, Aboriginal and Torres Strait Islander patients, children, and those with mental health issues or who were distressed.

Engaged and supported nurses who are good listeners can act as enablers of person-centred care by including patients in conversations about pain relief, access to care, comfort, nutrition, and social support.

“ I think the high turnover of health care professionals and the need for continuity of patient care and collaboration about how they contribute to their care planning are very difficult because relationships are much harder to form in the hospital setting. Clear organisational processes that support transitions...that cause everybody to pause and give patients an opportunity to enter the discussion...and a structured, multidisciplinary bedside handover with families at the bedside...helps involve patients in transitions. ”

Physician<sup>7</sup>



## TOOLS

**TeamSTEPPS** is an evidence-based teamwork system developed by the Agency for Healthcare Research and Quality in the United States. It is aimed at optimising patient care by improving communication and teamwork skills among health care professionals, including frontline staff. More information can be found at <http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html>

**Multidisciplinary rounds:** are where the multidisciplinary team comes together at a specified time to determine care priorities, coordinate care, establish daily goals and plan for potential transfer or discharge. Specific formats are used to include patients, families and carers in the rounds, such as pausing and asking for input and letting patients know the team with follow-up complex questions and any concerns after the round.

The Institute of Healthcare Improvement's *How-to-Guide: Multidisciplinary Rounds* is a useful resource. <http://www.ihl.org/resources/pages/tools/howtoguidemultidisciplinaryrounds.aspx>

The NSW Clinical Excellence Commission In Safe Hands program uses structured interdisciplinary bedside rounds. Encouraging patients to participate and communicate during rounds is part of the program. <http://www.cec.health.nsw.gov.au/programs/insafehands>

# CASE SUMMARY

## Volunteers and consumer advocates can play an important role in engaging patients, families and carers in transition communications

Another major feature in this hospital is the role of the consumer advocate who collects patient stories. These stories validate the importance to patients of their experience throughout the hospital journey, decoding medical information to patients and families, and feeding back authentic information to staff. The consumer advocate role is endorsed by the hospital executive, who are committed to maintaining the centrality of the patient's authentic voice.

The consumer advocate and other volunteers also communicate feedback and information to patients and families in an information pack that they receive in the pre-admission clinic. The information pack includes:

- a business card for ongoing contact
- information on visiting hours
- maps and bus routes
- information on social work issues, treatments and procedures
- tell us what you think survey with patients stories
- a patients' rights and responsibilities handbook.



### STRATEGY

**Collect and share patient stories:** Sharing patient stories is a powerful way to help health professionals understand the patient experience. It can highlight effective communication or where there may be service gaps. A patient advocate can take responsibility for this activity.



It's about engaging their relatives or their carers so they can fill in the gaps, and engaging the consumer at the coal face, ensuring their experience is [as] positive as possible...providing them with information at the right time [this] is carefully done through the volunteer service, also through our nursing and medical staff. I think people are given a load of information, and we give them one information brochure with clear succinct information. ”

Volunteer<sup>7</sup>



### LESSONS LEARNED

Effective patient engagement in communications at transitions of care requires multidisciplinary leadership, commitment and engagement.

In environments with multiple patient transitions and staff pressures a major key to engaging patients in transition communications lies in valuing the important role of volunteers and consumer advocates.

This case study is adapted from research on 'Engaging Patients in Communications at Transitions of Care (2015).<sup>7</sup>

## Examples of other strategies and tools

### Leader rounds

Leaders at various levels of the health service organisation walk around the wards asking patients, families and healthcare providers about their day, their plans for care, preferences, needs and any issues they may have.

### Patient care boards

Patient care boards can be placed around the patient's bedside and used as a communication tool to record key information about the care plan, upcoming tests, who the clinical contact is and the patient's preferences and goals. All members of the clinical team can write a comment on the board, including the patient and their families and carers.

### Patient passports

A small document held by the patient. It includes a section for personal information of who the patient is as a person (may include photos). Other sections focus on the illness history, symptoms and experiences.

Examples of patient passports can be found on:

The Primary Health Tasmania website as part of the Shared Transfer of Care program

<http://www.primaryhealthtas.com.au/templates/passport-better-health>

The Virtual Hospice, an initiative by The Maitland Hospital

<http://www.virtualhospice.com.au/the-patient/>

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## References

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8. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service (NSQHS) Standards - September 2012. Sydney: ACSQHC, 2012.

## More information

The Australian Commission on Safety and Quality in Health Care recognises the importance of effective communication between healthcare providers and their patients (including, carers, families and consumer advocates). Programs that support this work include:

- Clinical Communications
- Health Literacy
- Patient and Consumer Centred Care
- Shared Decision Making
- Open Disclosure.

More information about these programs is available at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)

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## Other publications in this series

- Patient-clinician communication in hospitals: Communicating for safety at transitions of care - An information sheet for healthcare providers
  - Communicating with your healthcare provider when you are in hospital - An information sheet for consumers
  - Consumer posters: Communicating with your healthcare provider - Why it is important and what actions can I take?
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