Summary of the report:
"Engaging patients in communication at transitions of care"

Introduction

Effective communication between the patient and the clinical team and within clinical teams is essential to providing safe patient care.[1-3] This is reflected in the National Safety and Quality Health Service (NSQHS) Standards,[4] which requires health services to engage with patients in care planning, provide patients with information and support patients with decision-making.

Patient-clinician communication is also identified as an essential aspect of clinical handover, and more broadly at transitions of care within and between services. In recognition of this, the Australian Commission on Safety and Quality in Health Care (the Commission) is advancing work under its Clinical Communication program on patient-clinician communication, with a focus on engaging patients in communication when their care is transferred.

To inform this work, the Commission contracted a consortium from Deakin and Griffith Universities to conduct a research project focusing on engaging patients in communication at transitions of care. A summary of the report findings is discussed below.

Summary of the report

This project consisted of a literature review and interviews with 62 key stakeholders across seven hospitals. Stakeholders included nurses, allied health, doctors, patients, health advocates, volunteers and family members.

The purpose of the project was to:
- identify enablers for, barriers to, and myths about engaging patients in communication at transitions of care
- determine the current evidence and knowledge gaps in this area
- identify examples of best practice
- identify strategies, tools and resources to promote and enable patient engagement in communication at transitions of care.

The final report[5] was completed in January 2015 and is available on the Commission's web site at:

[Engaging patients in communication at transitions of care](#)

A summary of the key themes and guiding principles to support effective patient-clinician communication at transitions of care in acute services is outlined below.

Key themes

The literature review focused specifically on the engagement of patients in communication with health professionals at transitions of care into, within and from acute care facilities. The majority of studies included in the review focused on handovers at different transition points, with bedside shift to shift handovers by nurses being examined in more than half of the studies. Four main themes were identified relating to:

- the roles for patients, families and health professionals
- outcomes of communication at transitions
- barriers to engaging patients in communication at transitions
- facilitating factors that enable communication at transitions

Overall, the review found that effective transition communications require there to be interactions between multiple health professionals (across disciplines) and the patient and family member/s, with each person playing an important role. A number of expected outcomes from communication at transitions were described, including a better experience and better recovery for patients/families, promoting health professional accountability, developing authentic partnerships with patients/families and improved patient safety. However, the perceptions about the roles each stakeholder played and expectations regarding communication outcomes varied across the research studies.

Barriers

A synthesis of the literature review and stakeholder interviews revealed common barriers relating to patients engaging in communications at transitions of care. Key barriers include:

- *Patient/family barriers:* the physical and/or mental condition of an individual patient may act as a barrier, as well as social and cultural issues, such as language issues, health literacy and stigma associated with age and diagnosis.

- *Health professional barriers:* the sheer number of health professionals often involved in patient care can act as a barrier, with patients and families being unsure of who to talk to, and what they are able to talk about.

- *Interpersonal barriers:* the relationship between patients, families and health professionals can influence the communication that occurs. In particular, it can be difficult for patients to build rapport and establish a trusting relationship with their health professional when a patient's care provider continually changes (e.g. as a result of shift work). Patients in these situations may feel uncomfortable about participating and speaking up about their care.

- *Organisational barriers:* the characteristics of a ward and work processes can act as barriers as they may result in high workload for staff or multiple transfers within the hospital, which can expose patients and families to numerous services and different local ward routines. A lack of standardised processes to ensure that general practitioners receive a summary of the patient's admission on discharge from hospital was also seen as a key issue.

Facilitating factors

The report found that consistent structures and processes facilitated patient engagement in communication at transitions of care in acute care services. These were evident at all levels of a health service. The table below provides a few examples of how health services in Australia have implemented structures and processes to support patient-clinician communication at transitions of care. These were drawn from the key stakeholder interviews that were conducted as part of the research project.

Level	Case study examples of how health services are enabling patient-clinician communication at transitions of care
Health service organisation	**Leader rounds:** Leaders at various levels of the organisation walk around the wards asking patients/families and nursing staff about their day, their plans for care, preferences, needs and issues.
	Patient/family feedback: Various processes are used to seek feedback including patient stories, formal surveys and follow-up phone calls after hospital discharge. There are clear processes to evaluate the feedback received, and acted on when required.
	Organisation-wide ward management principles: The aim of the principles is timely, active progression of patient care from the time the patient arrives at a hospital. The six principles are:

Level	Case study examples of how health services are enabling patient-clinician communication at transitions of care
	1. All patients are reviewed within two hours after being referred for admission 2. Decision-making by senior members of the multidisciplinary team. 3. Multidisciplinary rounds for every patient, every day. Rounds should provide the opportunity for patient engagement and participation. 4. Each team has a home ward and patient allocation on availability and equality of distribution. 5. Patients are actively managed to ensure they are only in hospital for as long as clinical necessary. 6. There is appropriate transfer of care.
Unit/ward	**Multidisciplinary rounds:** One model is the Structured Interdisciplinary Bedside Rounds, where the multidisciplinary team comes together before the round to identify the specific issues to be dealt with, determine who is the 'round manager' and any information about families who want to be included in the rounds. Specific formats are used to include patients/families in the rounds, such as pausing and requesting their input and letting them know the team will follow-up on complex questions and any concerns after the round. **Bedside handover:** A communication tool used by staff to share information about which patients are being discharged or transferred, expected admissions and patients who are expected to stay in the unit. Information that is handed over can include the names of the care team, goals for the day, expected date of discharge, discharge plans and any requests made by the patient. The process helps everyone know the plan, and it is reviewed daily. **Patient care boards:** Whiteboards, located around the patient bedside, record key information about the plan of care such as upcoming tests and patient goals. Patients/families are able to write comments on the board for staff.

Tools and Case Summaries

A full list of the tools, processes and strategies identified in the review is provided at pages 50-56 of the report. Case summaries, including tools, tips and lessons learned can be found at Appendix F.

Guiding principles

As a result of the analysis on the enablers and barriers that health services consistently face in this area, the report proposes three guiding principles for improving patient-clinician communication at transitions of care in acute services. These principles are:

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

2. Early engagement and support for patients, families and health professionals to participation in transition discussions.

> To enable participation (or not) depends on knowing patient preferences and respecting patient choices. Communication should occur with careful consideration to health literacy, language barriers and culture. Patient engagement must begin early. With the assistance of health professionals, preferences may be tempered by discussion about what is realistic and possible. Health professionals also need to recognise and reflect on the timing, location, privacy and appropriateness of information sharing and the difference between dispatching information and engaging in two-way communication.

3. Standardised tools and strategies to engage patients in transition of care communications are in place.

> These must be appropriate and useful for specific clinical settings and have some flexibility to allow for consideration of individual patients' conditions and preferences.

These guiding principles reflect the knowledge (i.e. benefits of patient input), skills (in using tools) and attitude (in a commitment to patient-centred care) that will promote patient engagement in communication about their care transitions. These principles will inform the Commission's work under the Clinical Communications program.

Essential elements for effective patient-clinician communication

Recommended strategies and processes to support effective patient-clinician communication at transitions of care are described for each level of the health system at pages 58-61 of the report. This includes recommendations for patients and families, health professionals, units/wards, health services, education, policy, and research.

To access the full report click here

More information
For more information about the Clinical Communication program at the commission, please visit http://www.safetyandquality.gov.au/our-work/clinical-communications/

References
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4. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney: Australian Commission on Safety and Quality in Health Care, 2011.
5. Australian Commission on Safety and Quality in Health Care. Engaging patients in communication at transitions of care. *Prepared by a consortium from Deakin and Griffith Universities*. Sydney: ACSQHC, 2015.