A NOVEL BEDSIDE COMMUNICATION TOOL

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SUMMARY

Effective communication between patients, their families, their carers and health care professionals is paramount to the delivery of high quality care. Addressing the ideas, concerns and expectations of these groups may improve their healthcare experience.

We propose that opening a new channel of communication between patients, families, carers and healthcare professionals on the wards would improve the delivery of healthcare. We present a novel written communication aid- the Care Communication Aid (CCA), with preliminary data from secondary and tertiary healthcare trials demonstrating its efficacy and shortcomings, and the reaction of both recipients and providers of healthcare to this novel approach.

Key words: *communication – patients – carers – families - healthcare professionals*

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Improved patient-doctor communication results in improved biomedical outcomes (Kaplan 1989, Stewart 1995, Ward 2003). There is also evidence to suggest that patients who participate in their own care are more satisfied with that care, and are more likely to follow an agreed treatment plan (Lerman, Wetzels 2007, Edwards 2004, Orth 1987, Heszen-Klemens 1982). These advantages compliment the ethical impetus for us, as medical practitioners, to include our patients in decisions that involve their own persons (Légaré 2010).

Given the importance of bedside communication, how much do our inpatients (or their relatives) participate in shared clinical decision making or discharge planning? Not as much as they would like (Delbanco 1995, O'Leary 2010, Flacker 2007, Jangland 2009). Poor communication is a common cause of complaints to secondary care (Jangland 2009), and frequently patients are unaware of discharge dates, planned procedures and even who is looking after them (O'Leary 2010).

Patient participation includes expressing their concerns, expectations of care and asking questions, as well as simply detailing their symptoms (Street 2005). This process takes time, which studies suggest we may not be uniformly providing. Two German observational studies concluded that on average, 4 minutes per day was spent with each inpatient, and 20 seconds to 1 minute per relative in communicative tasks (Becker 2010, Häuser 1999). A Swiss study reported an average time of 7.5 minutes (range 3-16 minutes) spent with each patient during ward-rounds (Weber 2007). Particularly noticeable in one German study (involving 34 ward doctors over 374 working hours) is that physicians spent 11% of their time discussing medical information with patients, 0.3% discussing their psychosocial issues with them, yet 18% was spent on breaks and activities unrelated to their job, such as walking between wards (Becker 2010). This suggests that more time for communication, or more efficient

communication strategies may be useful in secondary care settings, given the relatively small amounts of communication time currently spent with each patient.

Involvement of relatives in the care of patients is also important. This is particularly the case in psychiatric, paediatric or elderly care medicine where the patient's communication with medical practitioners may be limited. Several questionnaire-based studies suggest that communication pathways for relatives could be improved. Studies in Sweden concluded that relatives wanted more involvement in decision-making in a care of the elderly setting (Lindhardt 2008, Ekeström 1997). Similarly, the relatives of psychiatric patients in both Sweden (Ostman 2004) and Canada (Perreault 2005) reported a desire for increased participation in their care (Ostman 2004). Relatives, as carers, can be helpful sources of information, and better collaboration may improve satisfaction (Perreault 2005) and reduce perceived powerlessness or guilt (Lindhardt 2008). Thus a greater involvement of relatives in at least some healthcare settings would be advantageous.

Currently, the vast majority of communication with inpatients and their relatives is verbal. A written communication tool could eliminate feelings of time pressure (Jacobowski 2010), and prevent the short term amnesia that patients or relatives can suffer during a ward round, under the gaze of the health care team. This written tool would encourage active patient participation. A study of American patients found that most (84%) active participation behaviours (such as offering opinions, asking questions or expressing concern) were patient-initiated rather than prompted by doctors (Street 2005). This suggests that if patients are given an open means to communicate with their healthcare team, they may pro-actively use it.

Providing patients and relatives with a written means to communicate in a secondary or tertiary care setting is not a new concept. However, studies involving written communication tools are limited. In Germany, a small

4-week study used confidential mailboxes on the wards for relatives to ask questions of the healthcare team (Harych 1989). The mailboxes remained unused, as the relatives preferred to communicate directly with the healthcare workers, and thus felt that the mailboxes did not achieve this (Harych 1989). Another approach has been the use of check-list tools, developed to ensure patient-doctor interaction has explored particular areas of importance. In an outpatient psychiatric setting, a communication check-list tool increased the number of patients whose treatment was changed during their first visit (Number needed to treat=8) (VAN OS 2004), whilst a British study suggested that a ward round check-list improved patient-doctor communication (Herring 2011). Thus communication tools that prompt information gathering or provision have shown promise.

Interestingly, whiteboards have recently been trialled as a means to improve patient communication with the medical team. Whiteboards are well-integrated into the hospital wards of the United kingdom. This is primarily because they have been found to be a useful form of communication between staff, aiding patient flow and discharge planning (Herring 2011, Chaboyer 2009). In the recent study, whiteboards were placed in each patient room of a sample of American medical and surgical wards (Sehgal 2010). Nurses and doctors were asked to use them to improve communication with inpatients (Sehgal 2010). Patient satisfaction-with-communication scores (recorded on a 0-100 scale) improved significantly (nurse communication (+6.4, P<0.001) and physician communication (+4.0, P=0.04) on medical wards (Sehgal 2010). No significant effect was found on surgical wards (Singh 2011). This suggests that a written bedside communication tool may be a useful accompaniment to traditional verbal pathways, at least in some settings.

Considering the previous work we have discussed, we propose opening a new channel of communication between patients, relatives and healthcare professionals. We have developed a novel written communication tool: the Care Communication Tool (CCT). This bedside folder provides structured writing space that a patient or relatives can use when healthcare professionals are absent or otherwise occupied. The folder can be used to ask questions, or provide information for the staff. The folder is marked as confidential either for the patient alone, or jointly for the patient and relatives. This record is then routinely checked alongside the observation charts during a ward round. When answers to questions are written in the same folder, then patient or relative retention of medical information (average 20 facts per ward round (Weber 2007)) may improve.

We have begun a pilot study of the CCT in Addenbrooke's Hospital, Cambridge, England. After analysis of how often the tool is used, and the content recorded, we hope to gain a better insight into the information needs of patients and relatives, as well as the quantity of clinically-relevant information recorded.

Given that the efficacy of this tool is likely to be culture and situation dependant, there is future scope for trial outside the United kingdom, to allow for comparisons to be drawn between varied patient cohorts.

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APPENDIX – Care communication tool 2011

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CARE COMMUNICATION TOOL 2011

EXAMPLE: MESSAGE OR QUESTIONS FOR HEALTHCARE TEAM	PATIENT/ VISITOR NAME +/- ROLE	DAY MONTH	HEALTHCARE WORKER SIGNIATURE

FEEDBACK FOR THE CCT: PLEASE TAKE A MOMENT TO TELL US ABOUT YOUR EXPERIENCE WITH THE CCT: **10= completely agree. 0= completely disagree.**	RATING	**SUGGESTED IMPROVEMENTS**
This form helped me communicate with the healthcare team.		
This form would help other patients.		
This form helped me communicate with my patient.		
This form had a positive impact on my patient's care.		

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