Standards of communication with patients

The importance of communication in clinical practice: a medical student's view

Modern medicine is just as much about communication as it is about science.

My experience of clinical medicine is a patchwork of different experiences, different doctors and different specialities. I have worked with GPs, surgeons, hospital doctors and a whole range of healthcare professionals including nurses and therapists. The one thing they all have in common is communication.

The draconian medical school experience of old is an intense education that championed scientific knowledge, examined rigorously and applied subsequently in the real world. Communication training took a back seat to scientific excellence. Today's medical education is very much different. Although a robust scientific expertise is still required, patient - i.e. real world - interaction is at the forefront of our education from the first year.

The application of our new scientific knowledge is no more important than the tools needed to communicate it. The same way as a doctor's knowledge is no more useful to a patient than what the patient can understand. From witnessing GP and patient interaction, the main focus of the consultation was open communication of the implications of a diagnosis, not the diagnosis itself. My experience of medicine so far is that a patient does not come to their clinic to just be told a diagnosis, but to be told how it will affect their lives, whether they will have any lifestyle limitations and, most importantly, whether they will be okay.

Answering these questions requires scientific knowledge, but the communication of this knowledge is an important facet in the training of the new doctor. The simple relation of information must be re-invented to take into context a patient's expectations, as well as establishing a rapport and, more than anything else, breaking down the old paternalistic barrier portrayed by the doctor behind the desk.

Communication can change a patient's experience of a disease drastically. If their questions are not answered, uncertainty can lead to years of unjustified fear. If the doctor appears apathetic, the faith can be lost in the doctor or even in the healthcare system as a whole. A friendly doctor who takes the time to explain a disease in the context of a person's lifestyle establishes a relationship that goes far deeper than one that does not. A relationship breeds trust and it is trust that breeds security in the mind of the patient. My best experiences of

being a medical student so far have been sitting opposite a patient, and taking the time to discuss their condition, their experience of it and their plans to live with it.

So it seems to me that communication is a cornerstone of modern medicine, where understanding and context-driven consultation lead the way in improved patient experience.

THE FIFTH Principle of Nursing Practice

'Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.' Communication is central to human interaction. Without it, people cannot relate to those around them, make their needs and concerns known or make sense of what is happening to them. One of the most basic goals for nursing staff is that their patients and clients and those who care for them experience effective communication (Department of Health (DH) 2010a).

National benchmarks for communication require that communication needs are assessed and appropriate methods are used to enable patients and carers to communicate effectively. Information that is accessible, acceptable and accurate, and that meets patients' and clients' needs, should be shared actively and consistently. Staff should communicate effectively with each other to ensure continuity, safety and quality of health care for all (DH 2010a). Documentation, communication during handover, information sharing, managing complaints, and reporting incidents and concerns are the more formal aspects of communication, and the main focus of principle E. The importance of Principle E is demonstrated when things go wrong. The National Patient Safety Agency (2007) identified communication difficulties as a major factor affecting patient outcomes. Particular concerns included unclear documentation and nurses not being clear and confident in their reporting. The Scottish Public Services Ombudsman (2010) reported that communication and confidentiality were 'once again' near the top of the list of complaints about the NHS. The ombudsman's monthly commentaries repeatedly recommend that organisations improve documentation, communication and reporting processes, and apologise for poor handling of complaints. In England, the ombudsman reported that poor explanations or an incomplete response were the most common reasons for dissatisfaction with complaint handling (Parliamentary and Health Service Ombudsman 2010). Breaches in confidentiality are not so well reported, but they occur regularly in all settings, as researchers observed in GP practice reception and waiting areas (Scott ET al2007). Frequent instances occurred where patient identifiable information was overheard, including names, conditions and test results. Simple measures can be taken to improve such inappropriate disclosures, for example placing signs

in hospital lifts reminding staff that they are in a public place and must not discuss patients. The documents Confidentiality: NHS Code of Practice (DH 2003) and NHS Code of Practice on Protecting Patient Confidentiality (NHS Scotland 2003) are part of the guidance on information governance, which helps to ensure patient information is kept confidential and secure. The NHS Care Record Guarantee (National Information Governance Board for Health and Social Care 2010) is an important reminder of how the NHS should use patient records 'in ways that respect individual's rights and promote health and wellbeing'.

Documentation

Nurses are required to maintain up-to-date and accurate records of assessments, risks and problems, care, arrangements for ongoing care and any information provided (Nursing and Midwifery Council (NMC) 2010a). The primary purpose of these records is to support patient care and improve communication. Audits of record-keeping should consider whether the content of the records is supporting safe, effective care and communication. Record-keeping by nurses is supposed to be an integral part of practice, not 'an optional extra to be fitted in if circumstances allow' (NMC 2010a). Attitudes need to change so that records are valued and well used, rather than being viewed as a necessary evil in case of litigation. However, for attitudes to change, records have to become useful communication tools. An example of how this can be achieved is the 'reading handover' described by Tucker et al (2009). Using documentation as the main method of communication at shift handover resulted in improvements in the quality of nursing records. To help ensure the records were accurate, nurses were encouraged to 'Do it. Document it' rather than write notes at the end of a shift (Tucker et al 2009). Electronic records have the potential to support improvements in documentation because they can eliminate repetitive recording and provide more structure.

Reporting

Handing the care of a patient over to another clinician requires good communication and co-ordination. Incomplete or delayed information can compromise safety, quality and the patient's experience of health care (British Medical Association (BMA) 2004). Evidence suggests that communication improves where nursing handover involves the patient and is carried out using a structured reporting format (Mascioliet al 2009, Tucker et al 2009).The World Health Organization (2007) recommends the use of the SBAR (Situation, Background, Assessment and Recommendation) tool to standardise handover communications. A study by Christie and Robinson (2009) demonstrated that the SBAR tool improved the quality of telephone referrals to the critical care outreach team, greatly reduced the time for shift handovers and helped reduce adverse patient outcomes. A single format for patient handover would not suit all settings, but there are elements in common to all, including patient name, diagnosis or problems, plan and tasks to be done (BMA 2004). Nursing teams that do not yet use a standard structure could use these common elements as the basis for agreeing the handover content that is relevant to their patient context. Incident reporting has received increased attention since An Organisation with A Memory (DH 2000) identified an NHS culture in which people are swift to blame or seek retribution. The NPSA (2004) suggests that the more incidents are reported, the more lessons are learnt and action taken

to make health care safer. The document Seven Steps to Patient Safety (NPSA 2004) requires that 'staff know what patient safety incidents to report and how to report them'. The ideal culture is one that is open and fair where reporting is congratulated and individuals are not blamed or penalised if they speak out about safety incidents or other concerns. However, a survey in 2009 of more than 5,000 Royal College of Nursing (RCN) members found that only 43% would be confident to report concerns without thinking twice because of fears about personal reprisals (RCN 2009). Following this survey, the RCN introduced a dedicated telephone line for members to talk in confidence about any concerns that patient safety is being put at risk in their workplace. The Code (NMC 2008) is clear on the nurse's duty to speak out on behalf of patients, stating that: 'doing nothing and failing to report concerns is unacceptable'. The NMC's (2010b) guidance on raising and escalating concerns includes a toolkit to encourage discussion among nursing teams and promote the importance of speaking out on behalf of patients. Further support will soon be available, at least in England, in the form of changes to the NHS Constitution, which is being updated to include a pledge to support all staff in raising concerns about safety, malpractice or wrongdoing at work (DH 2010b).

Handling complaints

In 2009 the NPSA published a safety alert encouraging organisations to promote a culture of openness, honesty and transparency in relation to safety incidents, including apologising and explaining what happened. Being Open (NPSA 2009) is a theme picked up in the Parliamentary and Health Service Ombudsman's (2010) report on complaints handling in the NHS in England. According to this report, providing an apology and a full explanation of what went wrong can help to alleviate distress and reassures complainants that mistakes will not recur. Local policies for handling complaints should be reviewed to see if they align with the Being Open (NPSA 2009) guidance.

Conclusion

Accurate, timely and concise documentation and reporting underpin safe and effective nursing practice. Respecting confidentiality and taking care when sharing information are required by laws but are often overlooked in busy care settings. Regular, practical audit and review of these aspects of communication should be part of nursing staff's daily work. The presence of an open and fair culture is difficult to measure, but is a prerequisite for improving quality and requires that staff feel able to speak out about their concerns.

Good practice

Communicate effectively

You must listen to patients, take account of their views, and respond honestly to their questions.

You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.

You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.

Communicating Effectively with Patients

The significance of effective communication to the quality of patient care is immeasurable. The way in which health care providers communicate with their patients may be as important as the actual information being delivered. Patients who grasp what their caregivers are saying are more likely to understand and follow treatment, modify life choices and everyday behaviours, and adhere to follow-up instructions. Patient surveys have demonstrated that poor communication may lead to negative patient outcomes, an increase in a patient's anxiety levels and feelings of vulnerability and powerlessness.

Where does effective caregiver-patient communication begin? With effective listing.

Caregivers must listen with more than just their ears and brush up on core listening skills. Meeting a patient on his or her level logistically, eliminating physical barriers and maintaining solid eye contact are key. "Being here NOW" is also critical… making sure patients know they have undivided, focused attention will help them feel comfortable enough to express their core concerns and will help to build a solid rapport.

Withholding judgment is also a part of effectual listening. Patients should be encouraged to express themselves and be exempt from interruption or critique. Interest in patients' comments should be encouraged with "interest statements" such as: "Can you tell me more?" or "How often does this event occur?" Caregivers should also reflect back to the patients their understanding of what has been said, and induce elaboration.

When speaking with patients, caregivers should keep these simple approaches in mind.

- Avoid use of medical jargon. It may demonstrate the caregiver's knowledge and expertise, but it won't generate understanding for the patient. Language should be appropriately tailored to fit the audience and situation.
- Cover important information *slowly.* If time is running short, the patient should be scheduled to return for further explanation or to ask questions.
- Be repetitive if needed. Many patients don't remember what they are told verbally. Repeating key points and asking whether the patient understands the information will improve recall and follow-up.
- Include a patient's companion or family member. The old saying "two heads are better than one" can hold true for patient care discussions. Be sure to address questions from the companion with as much attention as if they came directly from the patient.

- Don’t rush through negative information. When speaking about possible side effects or complications, be kind but *candid.* Complications don’t occur often, but if a patient could suffer from one, it is important he or she know what could happen.

Please remember that communication does not just mean vocal

Please note that communication can refer to verbal, nonverbal, electric, written and sometimes displayed through body language for those that cannot express verbally.