CHAPTER 3

KEY ATTRIBUTES OF PATIENT-SAFE COMMUNICATION

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LEARNING OUTCOMES

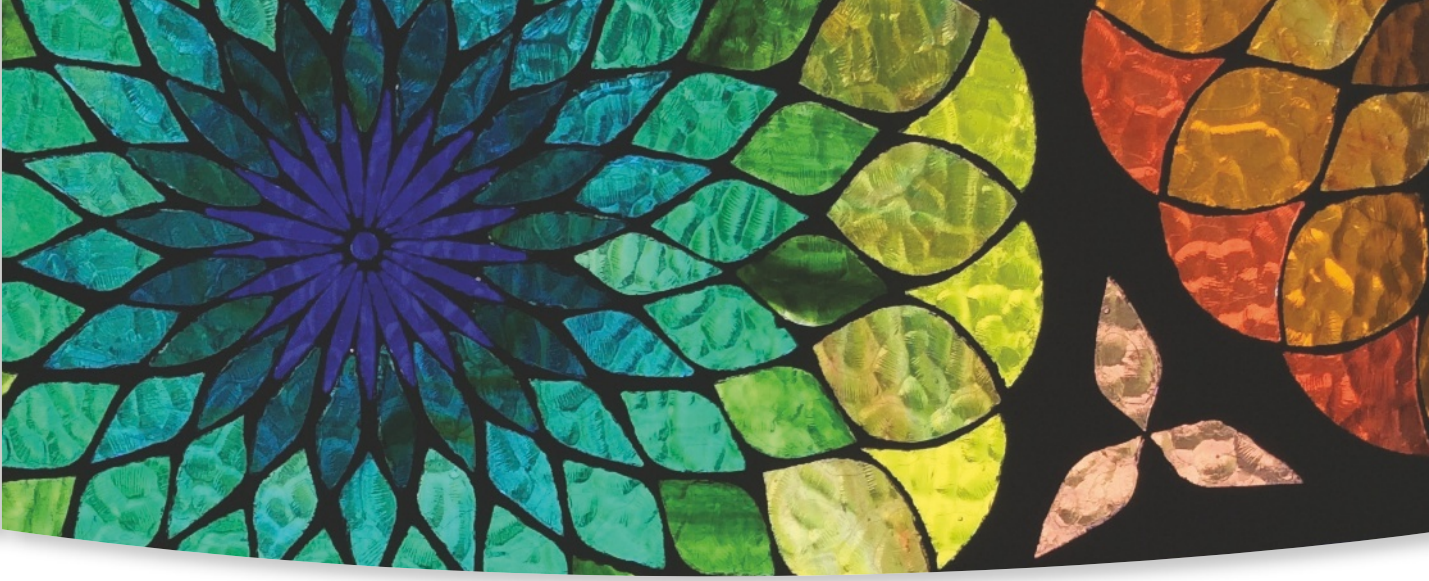
Chapter 3 will enable you to:

- describe the principles, practices and outcomes of person-centred care[1]
- explore the relationship between person-centred care and patient-safe communication
- describe the attributes and attitudes that promote patient-safe communication
- discuss the impact of interprofessional and team-based communication on patient safety
- reflect on your personal attributes and consider how they have the potential to enhance or detract from your ability to be person-centred and clinically safe.

KEY CONCEPTS

Patient-safe communication | person-centred care | interprofessional communication | teamwork

1 The terms 'person-centred' and 'patient-centred' care are often used interchangeably. In this book we use the term 'person-centred care' as this is the term commonly used in healthcare literature. We acknowledge that for some disciplines the term patient-centred care is preferred. Both terms are conceptually similar, and emphasise the central roles of patients, families and carers in aspects of care, as well as in the broader approach to improving health service planning and delivery.



> We are guests in our patients' lives; and we are their hosts when they come to us. Why should they, or we, expect anything less than the graciousness expected by guests and from hosts at their very best. Service is quality.
>
> (Berwick, 1999, p. 9)

INTRODUCTION

In Chapter 1, patient-safe communication was defined as a goal-oriented activity focused on preventing clinical errors and helping patients attain optimal health outcomes. Patient-safe communication was described as an essential foundation for working collaboratively with both patients and other healthcare professionals to ensure safe care (Schuster & Nykolyn, 2010). Person-centred care is the most important attribute of patient-safe communication, and we begin Chapter 3 by discussing the benefits of this approach to patients, healthcare professionals and healthcare organisations. We then outline the importance of interprofessional communication and teamwork to patient safety. In the chapters that follow, these issues are discussed in greater depth with specific clinical examples provided.

MRS GRUZENSKI'S STORY

Professor Donald Berwick, an internationally recognised leading authority on quality and safety in healthcare, gave a graduation address at Yale Medical School on 24 May 2010. The following story is an excerpt from that address, and it begins by recounting an email that Professor Berwick received from Mrs Jocelyn Gruzenski in 2009:

> *'My husband was Dr William Gruzenski, a psychiatrist for 39 years. He was admitted to hospital after developing a cerebral bleed with a hypertensive crisis. I was denied access to my husband except for very strict visiting, four times a day for 30 minutes; my husband was hospitalised behind a locked door. He wanted me present in the ICU, and he challenged the ICU nurses and doctors saying, "She is not a visitor, she is my wife". But, it made no difference. My husband was in the ICU for eight days out of his last 16 days alive, and there were a lot of missed opportunities for us. His care was not individualised to meet his needs; he wanted me there more than I was allowed. I feel it was a very cruel thing that was done to us. My husband and I loved each other very deeply and we wanted to share our last days and moments together. We both knew the gravity of his illness, and my husband wanted quality of life, not quantity.'*

'What might a husband and wife, aware of the short time left together, wish to talk about in their last days? Someone stole all of that from Dr and Mrs Gruzenski. A nameless someone. I suspect an unknowing someone with "rational" words such as "It's our policy", "It's against the rules", "It's in your own best interest". This is the voice of power; and power can be, to borrow Mrs Gruzenski's word, "cruel".'

Donald Berwick continued his address to the graduating students:

'Today you take a big step into power. With your anatomy lessons and your stethoscope, you enter today a life of new and vast privilege. You will not always feel powerful or privileged—not when you are filling out endless forms and struggling through hard days of too many tasks. But this will be true: In return for your years of learning and your dedication, society will allow you to hear secrets from frightened human beings that they are too scared to tell anyone else. Society will permit you to use drugs and instruments that can do great harm as well as great good. Society will let you make rules. And in that role, with that power, you will meet Dr and Mrs Gruzenski over and over again. You will meet them every day—every hour. They will be disguised as a new mother afraid to touch her premature baby. Disguised as a construction worker too embarrassed to admit that he didn't understand a word you said after "It might be cancer". Disguised as the alcoholic who was the handsome champion of his soccer team and dreamed of being an architect someday. Disguised as the child or the 90-year-old grandmother over whom you tower. Disguised as the professor in the MRI machine who has been told to lie still, but who desperately needs to urinate and is ashamed. Disguised as the man who wants you to call him "Bill", and as the man who prefers to be called "Dr Gruzenski". Mrs Gruzenski wrote, "My husband was a very caring physician and administrator for many years, but during his hospitalisation, he was not even afforded the respect of being called 'Doctor'." Dr Gruzenski wanted to be called, "Dr Gruzenski". But, they did not do so. You can. That choice is not in the hands of nameless power. It is your choice; your power.

'What is at stake here may seem a small thing in the face of the enormous healthcare world you have joined. But that small thing is what matters. I will tell you: it is ***all*** that matters. All that matters is the person. The person. The individual. The patient. The poet. The lover. The adventurer. The frightened soul. The wondering mind. The learned mind. The Husband. The Wife. The Son. The Daughter. It is all about choice. You have a magical opportunity. Yes, you can hide behind the protocols and policies. You can lock the door and say, "Sorry, Mrs Gruzenski, your 30 minutes are up." But, you can also ***unlock*** the door. You can ask, "Shall I call you 'Dr Gruzenski'?" "Would you like to be alone?" "Is this a convenient time?" "Is there something else I can do for you?"'

Source: Reproduced with permission: Jocelyn Anne Gruzenski and Dr Donald Berwick.

Person-centred care

Recognition that person-centred care is arguably the most important attribute of patient-safe communication is changing the landscape of contemporary healthcare education. The traditional view of patients as passive recipients of care has given way to one where patients are seen as active participants

and integral members of the healthcare team. Patients (and their families) are now seen to have a vested interest and valuable perspective in ensuring safe care.

There are various definitions of the term 'person-centred care', with each underpinned by principles such as *empathy*, *dignity*, *autonomy*, *respect*, *choice*, *transparency*, and a desire to help individuals lead *the life they want*. Person-centred care is built on the understanding that patients bring their own experiences, skills and knowledge about their condition and illness. It is a *holistic* approach to the planning, delivery and evaluation of healthcare that is grounded in *mutually beneficial partnerships* between healthcare professionals, patients and families.

> ***[Person-centredness] is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users [consumers] and others significant to them in their lives. It is underpinned by the values of respect for persons, individual rights to self-determination, mutual respect and understanding.***
>
> **(McCormack & McCance, 2017, p. 60)**

Healthcare professionals who practise person-centred care are *ethical*, *open-minded*, *self-aware* and have a profound sense of *personal responsibility* for actions (*moral agency*). They place the 'person' at the centre of healthcare and consider their needs and wishes as paramount (McCormack & McCance, 2017). Person-centred clinicians:

- appreciate that people have a unique life history that influences their healthcare experience
- seek to understand the patient's perspective
- inform and involve patients in their care
- promote active involvement of family and friends
- elicit patient preferences
- check and confirm information with patients
- share treatment decisions
- respect patients' culture, values and personal beliefs
- provide physical and emotional comfort and support
- maintain patients' dignity
- design care processes to suit patients' needs, not the provider's needs
- ensure coordination and continuity of care
- are transparent and provide access to health information
- are sensitive to non-medical and spiritual dimensions of care
- guide patients to appropriate sources of information on health and healthcare
- educate patients on how to protect their health and prevent occurrence or recurrence of a disease
- provide support for self-care and self-management
- communicate information on risk and probability.

Source: Australian Commission on Safety and Quality in Health Care (ACSQHC), 2011; Institute for Patient- and Family-Centered Care, 2013; Shaller, 2007.

Person-centred care in practice

What we say, how we speak and the words we use have a significant impact on our patients. The right words can calm, comfort and reassure. The wrong words can produce anxiety and create confusion, anger or frustration in situations that are often fraught and stressful. When communicating in a person-centred way, showing respect and gaining trust is essential for enhancing patient cooperation and improving clinical outcomes.

Evidence indicates that exposure to and reflection on authentic patient stories is an effective learning strategy, and one that can cause attitudinal shifts and behavioural change (Shapiro, 2011). Reflect on Mr Teddle's story in Box 3.1 and consider how the use of a person-centred approach may have influenced how the scenario unfolded.

BOX 3.1 **Mr Treddle's story**

Mr Treddle, 82 years old, was being discharged from hospital following admission for a TIA (transient ischaemic attack). His doctor gave him a written referral to his GP (general practitioner) and a prescription for his discharge medications. The pharmacist dispensed the prescribed medications. The dietitian provided a written dietary plan, as Mr Treddle had not been eating a diet appropriate for his type 2 diabetes. The registered nurse gave Mr Treddle a written discharge summary and reminded him to make an appointment to see his GP later that week. The ward clerk organised for him to go home in one of the hospital cars driven by a volunteer. While driving him home, the volunteer discovered that:

- Mr Treddle had no close family and lived alone in a caravan park
- the caravan park was 12 kilometres from his GP and the closest shops; he did not drive and there was no public transport
- Mr Treddle had macular degeneration and could not read the instructions written on the discharge summary or on his medication containers
- Mr Treddle had attempted suicide on two occasions.

Mr Treddle had been in hospital for a week and had interacted with numerous healthcare professionals, but during his hospitalisation Mr Treddle had not shared any of the information that he had discussed with the volunteer driver during the 40-minute car ride.

- *Why do you think this might have been?*
- *How could the healthcare professionals have interacted with Mr Treddle in a person-centred way that allowed him to feel comfortable in sharing his personal situation with them?*
- *How might the lack of person-centred care evident in this situation have impacted on Mr Treddle's safety and wellbeing post discharge?*

Person-centred care is an ongoing process that requires professional competence, sound interpersonal skills, self-awareness, commitment to patient care and strong professional values (Australian College of Nursing, 2014). The Australian Commission on Safety and Quality in Health Care (ACSQHC, 2017) advocates that person-centred care may help address some of the health inequalities experienced by vulnerable or disadvantaged populations, such as the young, elderly, disabled or mentally ill; those from culturally and linguistically diverse backgrounds, or rural and remote areas; and Aboriginal and Torres Strait Islander peoples.

Person-centred care and patient safety

The literature increasingly demonstrates that there are many benefits to person-centred care (for patients, healthcare professionals and healthcare organisations). Foremost among these is improved communication and patient safety. Studies show that when healthcare professionals, patients and families work in partnership, the quality and safety of healthcare rises, costs decrease, and provider and patient satisfaction increase (Institute for Patient- and Family-Centered Care, 2013).

Organisations in which person-centred care is practised in a consistent way have reduced numbers of clinical errors, decreased readmission rates, lower infection rates (Institute for Patient- and Family-Centered Care, 2013), fewer medication errors (Bolster & Manias, 2010), decreased mortality rates and a shorter average length of stay (Institute for Patient- and Family-Centered Care, 2013; Meterko et al., 2010). In the care of patients with chronic conditions, studies indicate that person-centred care can improve disease management, reduce anxiety and improve quality of life (Bauman, Fardy & Harris, 2003; Stewart et al., 2000).

'Person-centred care should be a component of undergraduate and postgraduate education for all healthcare professionals' (ACSQHC, 2011).

Person-centred language includes verbal and nonverbal communication. Asking patients how they prefer to be addressed establishes the foundation for a therapeutic relationship. By contrast, referring to a patient as 'a bowel resection' or 'the one with dementia' deprives them of the respect to which they are entitled. The use of acronyms such as AIDET (Acknowledge, Introduce, Duration, Explanation, Thank you)—see Box 3.2—can help healthcare professionals communicate in a person-centred way.

BOX 3.2 **Using AIDET to improve communication and promote person-centred care**

1. **Acknowledge the patient.** Smile and make eye contact. Call the patient by his or her name. Consider the patient's prior experiences of healthcare.
2. **Introduce yourself.** Your name and role, and what you're planning to do.
3. **Duration of process/procedure.** Provide the patient with the length of time expected for processes, procedures, waiting, etc.
4. **Explanation.** Discuss what you're doing and why, what is next, and what procedures or tools you are using. Clarify whether the patient understands your explanation and has any questions. (Remember: explore—explain—explore.)
5. **Thank you.** Thank the patient for their time, information and cooperation.

Attitudes that promote patient-safe communication

If you were asked to list the specific attributes that healthcare professionals need in order to ensure patient-safe communication, you might reflect on the clinical experiences you have had and identify specific behaviours that you believe influenced patient outcomes. Patient-safe communication behaviours (both with patients and with other healthcare professionals) were also the focus of Chapters 1 and 2. What is perhaps more challenging is to identify the attitudes, beliefs and personal values that underpin healthcare professionals' behaviours and communication style. In the following section, we make the implicit explicit by discussing how attitudes influence patient care and why *self-awareness* is pivotal to effective communication. It is important to remember that each episode of communication will make a difference; whether it is a positive difference will depend on the attitudes and behaviours of the healthcare professionals involved.

Ability is what you're capable of doing.

Motivation determines what you do.

Attitude determines how well you do it.

(Raymond Chandler)

A body of research has examined the influence of attitudes on healthcare professionals' behaviours. One recent study (Lapkin, Levett-Jones & Gilligan, 2012) identified that a student's attitude is the most significant predictor of their intention to practise in a way that enhances patient safety. This finding is supported by a meta-analysis of 87 studies that concluded there is significant evidence that attitudes and intentions can be used to predict actual behaviour (Sheppard, Hartwick & Warshaw, 1988). Although behavioural changes can occur as a result of social pressure and expectations, such changes are often short-lived if not accompanied by attitudinal changes. Attitudes are malleable and evolve over time, often in response to experiences and education.

As healthcare professionals, it is important that we are aware of our own attitudes, values and beliefs, as preconceptions, assumptions and biases can negatively influence our ability to be person-centred and to engage in patient-safe communication. Healthcare professionals' personal philosophies influence how we communicate with patients, particularly those who are vulnerable (e.g. have cognitive changes, have a mental illness, are from culturally and linguistically diverse backgrounds, or are socioeconomically disadvantaged). Failure to reflect on and question our assumptions and prejudices may negatively affect our communication competence. Table 3.1 illustrates three cognitive errors that can result from flawed assumptions and beliefs.

TABLE 3.1 Examples of cognitive errors resulting from flawed assumptions and beliefs

Error	Definition
Ascertainment bias	When a health professional's thinking is shaped by prior assumptions and preconceptions (e.g. ageism).
Fundamental attribution error	The tendency to be judgmental and blame patients for their illnesses (dispositional causes) rather than examine the circumstances (situational factors) that may have been responsible. People from marginalised groups tend to be at particular risk of this error.
Overconfidence bias	A tendency to believe we know more than we do. Overconfidence reflects a tendency to act on incomplete information, intuition or hunches. Too much faith is placed on opinion instead of carefully collected cues.

Source: Adapted from P. Croskerry (2003). The importance of cognitive errors in diagnosis and strategies to minimise them. *Academic Medicine, 78*(8), 1–6.

Interprofessional and team-based communication

> *It would be naive to bring together a highly diverse group of people, no matter how talented, and expect that, by calling them a team, they will in fact behave as a team. Professional football teams can spend 40 hours a week practicing their teamwork skills in preparation for the weekend game when their teamwork really counts. Yet healthcare teams rarely spend an hour a week practicing teamwork skills, even though their ability to function as a team counts every day of every week.*
>
> **(Wise, Beckhard, Rubin & Kyte, 1974)**

Although most educational opportunities tend to focus on communication with patients, interprofessional and team-based communication is also critical to patient safety. Even the isolated general practitioner in a solo rural medical practice will routinely need to communicate with others in his/her daily work, for example a pathology laboratory (to order a test or receive results), a specialist ('The result indicates a malignancy; can you give an opinion?') or a nurse practitioner ('Can I have your advice on this patient's wound management?'). The more complex the working environment, the greater the potential for errors and the greater the need for effective communication between health professionals.

In order to communicate effectively with either patients or colleagues, healthcare professionals need to be *confident* and *knowledgeable*. This includes having a breadth and depth of domain-specific knowledge that is grounded in a solid evidence base. Just as importantly, healthcare professionals need to know the limits of their professional knowledge and skills, when to refer to other members of the team, the most appropriate person to consult, and how to access the help and advice they require. This requires *humility* about one's own limitations, recognition that they are a member of a team, *mutual respect*, confidence in their fellow team members and recognition of potential communication barriers. The transfer of appropriate information between team members, whether by written or electronic means, needs to be as seamless as possible. Communication barriers, such as the uneven uptake of technology among the team, need to be anticipated and overcome (Pierce & Fraser, 2009).

At times, raising concerns about patients and accessing help can be challenging. This is when health professionals need skills in *patient advocacy* and the ability to be *assertive* without being confrontational, judgmental or aggressive. This includes the ability to question 'up or down' the hierarchy where appropriate. Table 3.2 provides examples of behaviours that promote patient-safe communication between members of the healthcare team. Chapter 6 describes these behaviours in further detail.

In healthcare, the notion of the 'team' is sometimes more rhetoric than reality. A team is not just a group of people who are co-located or caring for the same group of patients. A team is a group of people who do collective work and are *mutually committed* to a *common purpose* (Hill & Lineback, 2012). Effective team communication skills are as important to patient safety as technical skills or expert knowledge (Katzenbach & Smith, 2004). A landmark report 'To Err Is Human' (Institute of Medicine, 1999) concluded that patient safety was a function of how well healthcare professionals perform effectively in teams. A 2006 World Health Organization report titled 'Working Together for Health' recognised that healthcare professionals are able to carry out their responsibilities more efficiently if they are members of effective teams that have well-developed interprofessional communication processes. Further, the report stated that it is not enough merely to have experience in working in a healthcare team; healthcare professionals must understand and adopt the values that underlie teamwork.

Conclusion

This chapter introduced the concept of person-centred care and discussed how it is essential to patient-safe communication. It then discussed the attributes that promote effective communication with both patients and other members of the healthcare team. This is just the beginning, however. In the chapters that follow these concepts will be expanded and applied to a wide range of different situations and patient groups. The diverse views of many different healthcare professionals will provide insights that are both illuminative and thought provoking.

TABLE 3.2 Teamwork and communication behaviours that promote patient safety

Domains	Patient-safe communication behaviours
Person-centred care	Including patient/family in discussion
	Seeking and considering patient's social and medical history
	Equipping patients with the skills to identify problems and to play an active role in their management
Communication and interaction	Maintaining eye contact (if appropriate)
	Demonstrating open body language
	Being polite and friendly
	Active listening
	Discussing together
	Asking questions
	Coordinating actions
	Expressing concerns freely
	Speaking up when unsure
	Communicating openly
Teamwork and cooperation	Awareness of and respecting the roles of team members
	Supporting others
	Understanding the needs of the team
	Recognising when a team member needs help
	Managing conflict
	Asking for help
	Valuing others' contribution
	Sharing accountability and responsibility
Problem solving and decision making	Collaborative problem solving
	Shared option generation
	Shared risk assessment
	Shared decision making
	Reviewing outcomes
Leadership and management	Taking the initiative
	Maintaining clinical standards
	Delegating
	Demonstrating gradated assertiveness
	Creating a 'no-blame' culture
Situational awareness	Noticing and anticipating—identifying future problems and discussing contingencies
	Recognising the capabilities of others, cross-checking, and contacting outside sources when necessary
Adherence to guidelines	Being familiar with and adhering to relevant guidelines, policies and evidence-based resources
Documentation	Documenting clearly, accurately, contemporaneously and concisely
	Accessing and clarifying medical records
	Using electronic communication processes

Source: Reprinted from *Nurse Education Today*, *32*(8), Levett-Jones, T. Gilligan, C., Lapkin, S. & Hoffman, K., Interprofessional education for the quality use of medicines: Designing authentic multimedia learning resources, 934–8. Copyright (2012) with permission from Elsevier. Based on *AORN Journal*, *87*(4), Anderson, M., Leflore, J., Playing it safe: simulated team training in the OR, 772–9 (2008).

Critical thinking activities

Charmel and Frampton (2008) suggest that person-centred care is not merely philosophical, it is sound business practice. Consider this statement as you reflect on the story below.

> *We arrived in the ward—a very frightened, confused and depressed woman and her worried husband—and were kept waiting for a long time without explanation.*
>
> *In due course the psychiatrist appeared. He addressed my wife directly. I was ignored, but I tagged along. The family unit of a man and his wife had become a patient and an appendage. We entered the room. Then ominous silence for a while. No introductions; the doctor without a name. No introductions or explanation [as to] who might have been the unknown young observer sitting in on the consultation. The patient had become an item on a conveyor belt. The doctor faced the desk and had his back to us. At no time did he turn round to face us. I entered the discussion only when I felt that my comments were needed since my wife, because of her mental state, could not answer all the questions. I felt that my presence was not welcome.*

Source: Australian Commission on Safety and Quality in Health Care (ACSQHC) (2011), *Patient-Centred Care: Improving Quality and Safety through Partnerships with Patients and Consumers.*

1 How do you think patient safety could have potentially been affected by the communication that occurred in this scenario?
2 If you could turn back the clock and 're-script' this scenario, how would you change the interaction so that person-centred and patient-safe communication was evident?
3 If person-centred care is 'sound business practice', how might the type of interaction described in this story affect the 'business' of a healthcare organisation?

According to a systematic review conducted in 2009, the most effective way to promote patient safety using a person-centred approach is through communication training for healthcare professionals (Zolnierek & DiMatteo).

4 Reflect on your educational experiences and identify whether, and to what extent, your learning has enhanced your ability to communicate effectively and practise in a patient-safe manner. Then consider the learning opportunities that you have independently negotiated, or could negotiate, to ensure that your communication skills are patient-safe and person-centred.
5 Reflect on your attitudes and consider how they have the potential to enhance or detract from your ability to be person-centred and clinically safe.

Teaching and assessment activities

Too often, healthcare professionals think that person-centred care is synonymous with being kind and caring. While it does include these attributes, person-centred care also includes specific clinical behaviours that have a direct impact on patient safety. The following activity can be a classroom-based discussion, individual reflection or written assessment item. If it is undertaken in the classroom, students should work in small groups.

Using *evidence-based resources*, describe specific behaviours and attitudes that would help to facilitate person-centred care that is designed to improve:

- medication safety
- infection control
- clinical reasoning
- care of a confused older person
- care of a person with persistent pain
- care of a person from a non-English-speaking background
- care of a person who is angry or aggressive.

Further reading

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Web resources

Come into My World—How to Interact with a Person Who Has Dementia: This educational resource focuses on person-centred care. It includes a workbook and series of communication interactions that are both positive and negative, and demonstrates how organisations and healthcare professionals can promote the use of a person-centred approach. <nursing.flinders.edu.au/comeintomyworld/media/video.php?video>

Institute for Patient- and Family-Centered Care: This US website provides numerous practical resources, including assessment tools, publications and multimedia resources, produced by the institute and other leading patient-centred care organisations.
<www.ipfcc.org>

World Health Organization—Patients for Patient Safety: This website is designed to ensure that the perspective of patients and families is a central reference point in education and in designing systemic quality and safety improvements.
<http://www.who.int/patientsafety/patients_for_patient/regional_champions/en>

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