

Communicating Clearly and Effectively to Patients

How to Overcome Common Communication Challenges in Health Care

A White Paper by Joint Commission International



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Executive Summary

Effective communication between health care providers and patients and their families is essential to safe, quality care. Studies have clearly shown that poor or missing communication between providers and patients can lead to patient harm or even death. This white paper from Joint Commission International provides a high-level overview of common communication challenges and shortcomings, including the following:

- Inadequate handovers or transitions of care
- Poor discharge planning and inadequate or unclear patient instructions
- Language problems such as limited English proficiency, literacy, and health literacy of patients
- Cultural barriers and misunderstandings
- Age-related challenges
- Errors in test results and medical orders

The white paper then identifies solutions to improve these common health care communication problems, offering tools, tips, and strategies. The white paper concludes with how Joint Commission International standards address these challenges with evidence-based best practices that lead to improved health care communication and thereby better patient outcomes.

Communicating Clearly and Effectively to Patients

How to Overcome Common Communication Challenges in Health Care

While much has been written about the doctor-patient relationship, modern health care has fostered relationships with numerous providers for many patients. A patient receiving care for one or more medical conditions may communicate regularly with several different health care providers located in multiple settings. Hospitalized patients may encounter two to three different shifts of staff each day, as well as various physicians, nurses, and teams making rounds and other staff administering tests or providing treatment. In ambulatory settings in various locations, a patient may see a primary care provider as well as different specialists, along with staff associated with each of them.

As a result, a patient often must piece together communications of varying quality to assemble a picture of his or her health status—a picture that still likely lacks the proper context, completeness, and accuracy. In some cases, this unclear picture can result in serious problems. Inadequate communication can lead to malpractice claims, patient harm, and/or death. Communication failures in United States hospitals and medical practices were responsible at least in part for 30% of all malpractice claims, resulting in 1,744 deaths and \$1.7 billion in malpractice costs over five years, according to the Risk Management Foundation of the Harvard Medical Institutions.¹ Of Massachusetts General Hospital residents surveyed by Kitch and colleagues, 59% reported that one or more of their patients had been harmed during the residents' most recent clinical duty due to problematic and ineffective communication.²

Ineffective communication has become such a major concern that both The Joint Commission and Joint Commission International (JCI) have incorporated recommendations relating to communications into National Patient Safety Goals (NPSGs) and International Patient Safety Goals (IPSGs) respectively to address the problem.^{3,4} All U.S. and internationally accredited health care organizations are expected to comply with these goals, which address aspects of communication including correct patient identification, proper handoff communication among caregivers, the safe use of high-alert medications, and more. In addition to these goals, Joint Commission and JCI hospital standards, recommendations and tools assist health care organizations wishing to improve their communications. These evidence-based solutions have worked well for many organizations.

Common communication shortcomings or challenges

Throughout the care process, patients and their families expect to receive sufficient information to understand the goals of their care and to make knowledgeable decisions. At the end of a hospital stay or when a caregiver transfers the care of a patient to another provider, a thorough summary of this information is generally given to the patient, including discharge and follow-up care instructions. However, every patient has different learning capacities and literacy skills, often relating to language preferences, cultural backgrounds, and age differences. In addition, health care providers often work according to varying standards and cultural norms, leading to substandard communication and mistakes that could have been avoided.

The factors highlighted in the following paragraphs are common contributors to communication lapses that can lead to suboptimal patient health outcomes. All these factors are affected by the pressure of working in a sometimes understaffed, fast-paced care health care environment, which contributes to errors caused by multitasking, interruptions or distractions, memory lapses, fatigue, stress and sleep deprivation—all potentially compromising the safety of patients.

1. Inadequate handovers. Inadequate handover communication, also referred to as handoff communications or transitions of care, is a major factor contributing to adverse events, including sentinel events causing significant harm or death to patients. These handovers occur between health care practitioners (for example, physician to physician, physician to nurse, nurse to nurse, and so on); between different levels or locations of care in the same hospital (for example, emergency department to surgery); between providers at two different organizations (for example, hospital to home care); and between health care practitioners and the patient and family (for example, at discharge).⁵

Joint Commission data indicate inadequate handovers are a factor in 80% of all adverse events, which include wrong-site, wrong-procedure, or wrong-patient surgeries; treatment delays; medication errors; and falls. Research indicates that only 8% of medical schools “teach how to hand off patients in formal didactic session.”⁶ Factors contributing to inadequate handovers include incomplete patient assessment or medical record review, a culture that does not support open communication among team members, problems related to illegible handwriting, and confusion caused by abbreviations. In addition, a lack of standardized procedures explaining how to do effective transitions within an organization—and the failure of leadership to develop standards and train staff to use them—contribute to inadequate handoffs as well.

2. Inadequate discharge planning or instructions. Discharging a patient without a well-considered plan can lead to readmission, lack of adherence to the plan, and difficulty with managing medications and follow-up

treatments. A common mistake by providers is giving patients information including complex and unfamiliar terminology shortly before discharge, without taking the time to explain it and make sure the patient understands it. Providers working in understaffed organizations can find themselves under pressure to discharge patients “quicker and sicker” without a detailed discharge plan.

3. Limited English proficiency as well as literacy and health literacy deficiencies. A Joint Commission study of patients with limited English proficiency in U.S. hospitals examined the characteristics—impact, type, and causes—of adverse events experienced by these patients versus patients who could communicate well in English. Some degree of physical harm occurred to 49.2% of the patients with limited English proficiency, but to only 29.5% of the patients who spoke English well. Among those who suffered harm, 47% of the patients with limited English proficiency had moderate temporary harm or worse, compared with only 25% of the patients who could speak English well. The rate at which patients with limited English proficiency suffered permanent or severe harm or death was 3.7%, compared with 1.4% of the patients who spoke English well.⁷

Statistics from the United Nations Educational, Scientific, and Cultural Organization (UNESCO) Institute of Statistics show that about 750 million adults (about 16% of the world’s adult population) lack basic literacy skills.⁸ Even a higher percentage may have health literacy deficiencies. For example, more than 89 million people in the United States (about one in four) have limited health literacy. A Canadian study showed that 60% of Canadian adults have limited health literacy skills, and studies from Europe, Australia, and Latin America have reported similar findings.⁹

4. Cultural barriers. Providing efficient and effective care requires having conversations in which the provider and patient both understand the meaning of words, concepts, and metaphors.¹⁰ Establishing this kind of effective communication often requires a provider to share cultural knowledge with a patient. Bridging the cultural gap often requires extra effort or resources. Cultural differences

also affect the working relationships between providers, as physicians and nurses, for example, sometimes have different value systems relating to how patients are cared for and treated.^{11,12}

5. Age-related challenges. Children mature at different rates and have different capacities to understand and participate in decisions about their health care. While living with a chronic or terminal illness can greatly accelerate a child's level of maturity, children who seem capable of making rational decisions still need support from their families. There are particularly unique challenges associated with communicating with adolescents. For example, adolescents may not readily disclose information for fear of being judged. Adolescents are the least likely of all age groups to receive medical care, yet are the age group most likely to engage in high-risk behaviors that may result in a need for medical care.¹³

At the opposite end of the age spectrum, elderly patients have their own set of unique considerations. Some elderly patients may have cognitive deficits or hearing disabilities, which make communication more challenging. Multiple comorbidities also contribute to miscommunication between caregivers and elderly patients. Effective communication with patients and families is particularly important at the end of life, especially when communicating with families about withdrawing of life-sustaining treatment.

6. Errors in medical orders and test results. Verbal orders or test results, given both in person and over the telephone to patients and fellow providers, are another type of error-prone communication. Different accents, dialects, and pronunciations can make it difficult for the receiver to understand the order or result. Sometimes, drug names and numbers sound alike, such as erythromycin and azithromycin or 15 and 50, affecting the accuracy of the order or result. Background noise, interruptions, and unfamiliar drug names and terminology often compound the problem.

Solutions to improve communications

Health care providers can improve communications with patients during key moments in their relationships— from

admission to discharge to follow-up care—by understanding common communication challenges and implementing solutions shown by evidence to improve communication outcomes. Improving the quality and consistency of communication along the continuum of care is a challenge facing health care providers, particularly at points of transition, or handovers, between them.

1. Improve handover communications. Communicating critical information about the patient every time he or she is transferred is essential, whether the transfer is from one care provider to another, from one level of care to another, or from one facility to another, including discharge to home. When the patient and family are included in the hand-off process, they can clarify information and ask and answer questions. Handoffs are optimally done face to face between providers; at a minimum, verbal communication should supplement written records so there is the opportunity to clarify information and ask questions.

Conducting transitions of care at the bedside has become common practice in many organizations. Transitions of care at the bedside allow for patient and family participation in the patient's care. Research conducted on six wards in two hospitals in Queensland and Western Australia demonstrated that bedside handovers (transitions of care at the bedside) were a successful means of communication in a variety of clinical settings; many organizations such as the Griffith University, Australia, developed a standard operating protocol for bedside handover.¹⁴

Keeping the patient's medical record current is an important aspect of handover communications because all health care practitioners must have information about the patient's current and past medical experiences to help make the best decisions. JCI standards require the medical record to be available during inpatient care, for outpatient visits, and at other times as needed. Making medical, nursing, and other patient care notes available to all the patient's health care practitioners is vital for the optimal care of the patient.⁵

JCI requires the use of standardized methods, forms, or tools to facilitate consistent and complete handovers of patient care, including 1) I PASS THE BATON, 2) SBAR, and 3) The Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™.

1. I PASS THE BATON

The U.S. Agency for Healthcare Research and Quality provides an effective example of a hand-off checklist of critical information, using the "I PASS THE BATON" acronym:

- I** = Introduction—Introduce yourself and your role/job (include patient).
- P** = Patient—Name, identifiers, age, gender, and location
- A** = Assessment—Presenting chief complaint, vital signs, symptoms, and diagnosis
- S** = Situation—Current status/circumstances, including code status, level of uncertainty, recent changes, and response to treatment
- S** = Safety Concerns—Critical lab values/reports, socio-economic factors, allergies and alerts (falls, isolation, and so on)

[THE]

- B** = Background—Comorbidities, previous episodes, current medications and family history
- A** = Actions—What actions were taken or are required? Provide brief rationale.
- T** = Timing—Level of urgency and explicit timing and prioritization of actions
- O** = Ownership—Who is responsible (nurse/doctor/team)? Include patient/family responsibilities.
- N** = Next—What will happen next? Anticipated changes? What is the plan? Are there contingency plans?

2. SBAR (Situation—Background—Assessment—Recommendation)

Many health care organizations have adopted the SBAR technique to standardize their processes for transitions of care. The SBAR technique was originally used by the U.S. military for nuclear submarines. A patient safety team from Kaiser Permanente in Oakland, California, developed a health care version of this technique to facilitate communication between providers during transitions of care.

- S** = Situation: What is the situation about which you are calling?
 - Identify yourself, the unit, and the patient (by using two patient identifiers—name and birthdate).
 - Briefly state the problem: what it is, when it started, and the severity
- B** = Background: Provide background information relevant to the situation, which may include the following:
 - The patient's chart or electronic health record
 - The admitting diagnosis and date and time of admission
 - A list of current medications
 - Allergies, intravenous fluids, and labs
 - The most recent vital signs
 - Lab results, with the date and time each test was performed and results of previous tests for comparison
 - Other clinical information
- A** = Assessment: What is your assessment of the situation?
- R** = Recommendation: What is your recommendation, or what do you want? For example, do you want the patient to be admitted, the patient to be seen now, or an order to be changed?

3 The Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

This protocol uses multiple strategies to achieve the goal of always identifying the correct patient, correct procedure, and correct site. The essential elements of the Universal Protocol are the following:

- Verifying the correct patient, procedure, and site
- Ensuring that all relevant documents, images, and studies are available, properly labeled, and displayed
- Verifying that any required blood products, special medical equipment, and/or implants are present
- Actively involving the patient in the site marking whenever possible and having the mark be visible after the patient is prepped and draped

2. Discharge patients effectively. A crucial factor in transitions of care at discharge is understanding the environment to which the patient will be returning or transferred. Can the environment sustain the treatment that has been initiated, or is a different environment required? It is imperative to understand the ability and willingness of the patient's caregiver to provide needed care. It is helpful to understand the services the patient had prior to admission, for example, home care. Care providers from such services may continue to provide ongoing care and treatment so they must be included in communications.

Effectively discharging patients requires the communication of follow-up instructions about referrals, transfers, or ongoing self-care in a standardized fashion. Following the "5 Ds of discharge" is one way of making sure the patient understands what he or she must do to ensure successful continuity of care and care outcomes.

1. **Diagnosis**—Does the patient understand his or her diagnosis and why he or she was in the hospital or receiving care from the physician?
2. **Drugs**—Does the patient know each medication he or she must take, the reason for the medication, when to take the medication, and how to administer it (swallow, sub-lingual, chew, subcutaneous, intramuscular, inhale, and so on)? Also, does the patient have the resources to obtain the medications?
3. **Diet**—Does the patient know and understand any dietary restrictions? Does the patient need a nutrition consult?
4. **Doctor follow-up**—When should the patient see the doctor next? Can the patient make the necessary appointment and get appropriate transportation? Include the name and location of sites for continuing care.
5. **Directions**—Are there any other directions necessary to increase the patient's ability to achieve optimal health? Does the patient understand, for example, when urgent care should be obtained?

Include family members in the discharge process when a patient's condition or abilities prevent him or her from understanding the follow-up instructions or when family members play a role in the continuing care process.

Provide all instructions in a simple, understandable manner in language the patient understands. If complex care instructions are given, allow enough time for patient and family comprehension. Conduct discharge conversations when the patient is not influenced by illness, lack of sleep, or medication side effects. Written instructions reinforced by verbal communication and "teach-back" are most effective, without leaving anything to memory. This process includes having the patient and participating family members repeat back the information they received to demonstrate understanding and having them perform a treatment or procedure they must do on their own at home.

When the care team changes as a result of a discharge, continuity of patient care requires that essential information related to the patient be transferred with him or her. To ensure that the new care team receives this information, the discharge summary covers the reason for admission, significant findings, diagnosis, procedures performed, medications and other treatments, and the patient's condition at transfer.⁵

3. Accommodate language and literacy needs. Accommodating patients' language and literacy needs is an important task for every health care organization. This work begins by knowing the language needs and literacy levels of the population and community served. Training staff to identify and respond appropriately to patients with literacy and language needs—including the use of medical interpreters—contributes to a patient-centered environment that values clear communication in all interactions with patients, from the reception desk to discharge planning.

Training staff members to recognize the behaviors of patients with low health literacy skills is necessary because many patients have become adept at hiding these deficiencies. Many clinicians mistakenly assume that patients can read and understand complex materials. Regardless of a patient's educational or demographic background, assume that he or she needs help understanding health conditions and treatment options and what is being done for them and why. When patients do not understand their treatments, they may become frustrated and uncooperative, which can lead to longer hospital stays, higher health care costs, opportunities for medical errors, and compromised patient safety.

Use multiple teaching methods to meet the needs of patients with different learning styles. For example, when educating patients, use pictures, models, audio recordings, or video recordings instead of only providing verbal instructions or giving them written materials.

4. Overcome cultural barriers. JCI standards require hospitals to reduce cultural barriers when communicating with patients.⁵ Respect patients' cultural preferences, and eliminate barriers to health care access and delivery of services. Keep in mind the needs of your diverse patient population. Patients may be aged, have disabilities, or speak multiple languages or dialects.

5. Meet age-related needs. Primary school children may be able to participate in their health care decisions, but parents make final decisions about their care. Clinicians can give children age-appropriate information about their care, but should understand that children of this age may agree or disagree with their plan of care without fully understanding its implications.

Uphold confidentiality with all patients. It is particularly important to reassure adolescents that everything discussed is confidential. Explain all medical procedures fully before commencing. Some adolescents are able to make the same types of decisions as adults. To ensure that an adolescent can make appropriate health care decisions, assess the adolescent's ability to understand and communicate relevant information, think and make choices with a degree of independence, and assess the potential benefits, risks, and consequences of multiple options.

The following tips from the U.S. National Institute on Aging can help clinicians communicate better with elderly patients.¹⁵

- Introduce themselves clearly by name and role.
- Assess and compensate for vision and hearing problems that can affect communication.
- Establish respect from the outset by using formal terms of address, such as Mr., Mrs., or Ms.
- Decrease anxiety by asking questions about family or outside interests.
- Avoid rushing elderly patients, and give them enough time to talk about their concerns.
- Speak slowly to give patients time to process what is being said.
- Try not to interrupt patients early in the interview because when interrupted, patients are less likely to reveal all their concerns.

- Use simple, common language, and ask patients if they understand what is being said.
- Tell the patients when changing the subject.
- Give clues such as pausing briefly, speaking a little bit more loudly, gesturing toward what will be discussed, gently touching the patient, or asking a question.

When educating elderly patients, consider asking if they have brought or are wearing the right eyeglasses. Use alternatives to printed materials, such as tape-recorded instructions, large pictures or diagrams, or other aids if elderly patients have trouble reading because of either sensory impairment or low literacy skills.

6. Communicate accurate medical orders and test results. JCI standards recommend limiting verbal communication of prescription or medication orders to urgent situations only, when immediate written or electronic communication is not feasible and when the prescriber is present and the patient's chart is available. Other exceptions include during a sterile procedure or life-threatening emergency.⁵

JCI standards also require the development of guidelines for requesting and receiving test results on an emergency or STAT basis, the identification and definition of critical tests and critical values, and the identification of to whom and by whom critical test results are reported. Monitoring compliance with reporting critical test results is vital. Furthermore, it is important to *write down*, or enter into a computer, the complete order or test result by the receiver of the information. The receiver should *read back* the order or test result, and the sender must confirm that what has been written down and read back is accurate.⁵

JCI standards can help improve your organization's communications with patients

In addition to what has been covered above, JCI standards provide these recommendations:⁵

- Communicate the expected cost of care clearly to patients and/or their families.
- Orient patients to the inpatient environment and equipment related to the care and services provided.
- Inform patients about all aspects of their medical care and treatment, and encourage them to participate in care and treatment decisions, including having the right to refuse or discontinue treatment, withhold resuscitative services, and forgo or withdraw life-

sustaining treatments (based on the laws, regulations, and culture of the country).

- Obtain patient informed consent for surgery, anesthesia, procedural sedation, use of blood and blood products, and other high-risk treatments and procedures through a process defined by the hospital and carried out by trained staff in a manner and language the patient can understand.
- Prepare a written statement of patient and family rights and responsibilities that is given to patients or visible to the outpatient population. Develop a statement that is appropriate to the patient's

age, understanding, and language. When written communication is not effective or appropriate, the patient and family need to be informed of their rights and responsibilities in a language and manner they can understand.

By following evidence-based practices developed to improve communications, health care providers can develop better relationships with patients, leading to better health outcomes. JCI stands ready to assist through its standards and other tools designed with the needs of patients and providers in mind.

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