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 al 2007). 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 (Mascioli et 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.

Measures for Principle E

Most organisations already have measures in place to seek patient views on quality of communication, satisfaction with handling of complaints and reporting of incidents. Audits of the efficacy of nursing handovers and the utility of nursing records are less widespread.

Examples of the types of indicators that could be used to determine conformity with Principle E include monitoring the percentage of:

- Records which include a discharge plan that is being implemented.
- Handovers that comply with best practice standards.
- Teams that conduct regular documentation audits, including review of the accuracy and timeliness of record content.

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.

USEFUL RESOURCES


(all websites last accessed: March 22 2011)

References