Safety Fundamentals for Person Centred Communication

Implementation Guide

October 2020

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

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Background and Development

The Clinical Excellence Commission (CEC) promotes and supports improved clinical care, safety and quality for the NSW public health system. One of the core strategies of this mission is our focus on improving person centred care (PCC). PCC reflects the patient-clinician relationship of 'human-centred care' (NSW Ministry of Health 2020) and is recognised as a fundamental domain of healthcare quality and safety (Frankel et al 2017; Institute of Medicine 2001). It involves partnering with patients, their families and carers in decisions about their care and shifts focus away from the interests of healthcare providers to thinking more about what matters to patients (Berwick 2009). The focus on PCC is not just because it is the right and human thing to do but also because of the known benefits for patients, staff and organisations (e.g. see Casimir et al 2014; Deek et al 2016; Doyle et al 2013). PCC also embodies the Australian Charter for Healthcare Rights.

In NSW Health, we are doing well in many facets of PCC. For example, of the more than 17,000 patients who shared their experiences of care in the Adult Admitted Patient Survey in 2018, 83% of patients said that their nurses were 'always' kind and caring. Moreover, 78% of patients said that their doctor 'always' answered their questions in an understandable way. Both measures improved significantly between 2014 and 2018, reflecting the good work of healthcare staff. However, there is still opportunity for improvement, particularly to involve patients and their families and carers more in their care. In the same survey, nearly half (40%) of patients reported that they did not 'definitely' feel involved in decisions about their care as much as they wanted to be and more than half (60%) said that health professionals did not 'completely' discuss their worries or fears with them. Unfortunately, these two measures have not improved over recent years (BHI 2020). These results vary between hospitals and health services, reflecting variation in PCC organisational maturity.

A plethora of resources exist to help staff build relationships and partner with patients (and their families and carers, to the extent patients choose) in decision making. We brought together a select group of these, informed by evidence and our consumer and clinician networks, to help healthcare staff with identifying and applying these in practice. We called these the *Safety Fundamentals for Person Centred Communication*, reflecting the emphasis on improving communication, PCC and safety, and the relationship between these elements. We acknowledge that these resources are available and (to varying degree) are being used in practice. Our aim is to promote wider awareness of, and support further embedding of, these resources across all NSW Health care providers. These resources complement our existing Safety Fundamentals for Teams to promote improved clinical care, safety and quality for the NSW public health system.

The Safety Fundamentals for Person Centred Communication

The Safety Fundamentals for Person Centred Communication include:

- **Hello My Name Is**… A simple phrase used at the start of a healthcare relationship. It recognises that healthcare is an interaction and relationship between two human beings.

- **What Matters to You?** A question to capture important individualised information about a person that can influence their care experience and outcomes.

- **Teach Back** A conversational method to help patients understand and recall important information.

- **REACH** A staged process of escalation that recognises that patients, and their families and carers, may detect deterioration before healthcare staff. REACH is an acronym that stands for **R**ecognise, **E**ngage, **A**ct, **C**all, **H**elp is on its way.

- **Reflect to Care** A framework to initiate and build a culture of reflective practice.

- **Patient Delivered Handover** A process that acknowledges the patient as the expert in the daily handover. Prompting questions are provided to guide the patient delivered conversation.

- **Conversational Health Literacy Assessment Tool (CHAT)** Ten open-ended questions that can be used conversationally as part of the patient assessment process to explore health literacy support needs.

  Further information about each Safety Fundamental and supporting resources are available from the Person Centred Care page on the CEC website.

Features

A key defining feature of each Safety Fundamental for Person Centred Communication is the specific focus on supporting PCC communication. Communication is critical to improving all aspects of PCC, including each of the eight dimensions as described by the Picker Institute pictured below.

Picker Institute Europe (2020)

Other features of the Fundamentals include:

- A practical resource with potential to bring quick measurable gains to patient experience.
- Behaviour focused: can change behaviour of staff and how they interact within the team and with patients, their families and carers.
- Important: staff recognise that the activity will have a meaningful impact on patient experience.
- Evidence-based: either through research or quality improvement measurement.
- Measurable: specific enough that it is possible to determine whether the process or behaviours occur.
- Sustainable: achievable and sustainable without substantial renovations, capital expenditures, or the purchase of new equipment or technology.

Aims

The overall intent of the Safety Fundamentals for Person Centred Communication is to improve safety and quality of care by improving the capability of staff and teams to deliver person centred practice.

For **patients***:

- Improve patient involvement in decisions about their care (shared decision making)
- Improve patient understanding of their healthcare condition and management (health literacy)
- Improve patient experience and health outcomes

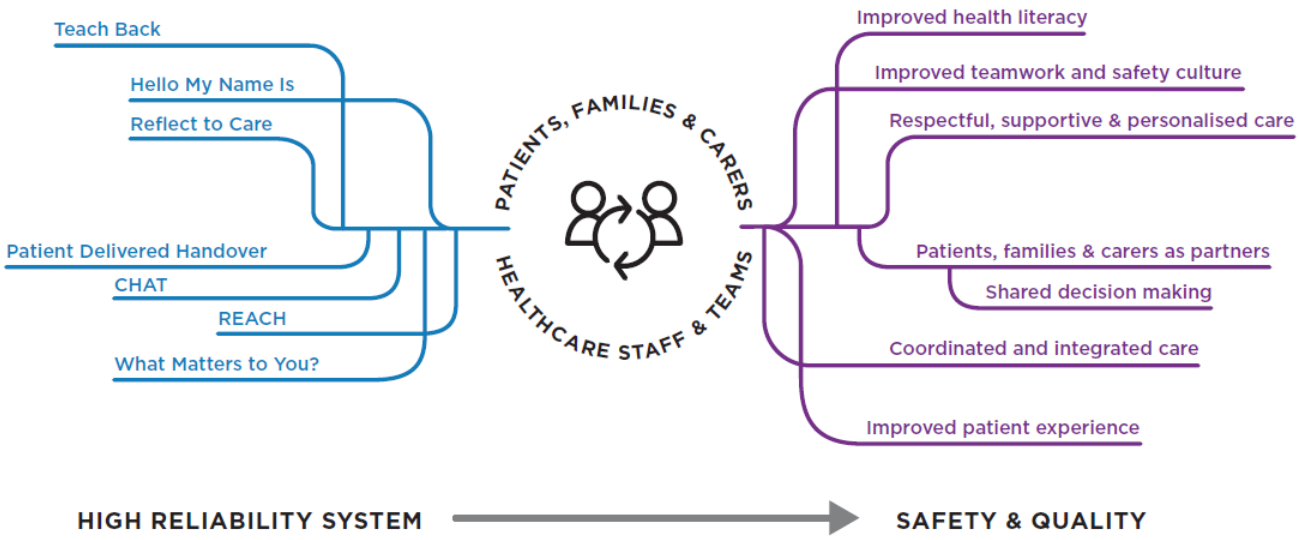
*The term 'patient' includes carers and family members, where the patient chooses to involve these persons in their care.

For **healthcare staff and teams**:

- Increase staff knowledge of, confidence and skills in using, person centred communication strategies (such as Teach Back and What Matters to You)
- Increase staff usage of person-centred communication strategies
- Improve staff experience

For **healthcare organisations**:

- Support a culture of safety and quality and high reliability
- Reduce adverse events and costs related to poor communication between staff and patients
- Provide a set of resources and strategies to support organisations in meeting their accreditation and performance agreement requirements



Target Audience

This document was designed to be read by frontline clinicians (nurses, doctors and allied health staff) and their managers, organisational development staff, clinical governance staff, safety and quality staff and patient experience staff.

Guidance on who should use each of the Safety Fundamentals for Person Centred Communication is provided in the supporting resources available from the CEC's PCC webpage.

Note that some of the Fundaments may also be relevant for non-clinician healthcare staff who interact with patients, their families and carers. For example, all healthcare staff can use Hello My Name Is when engaging with patients. Teach Back may also be useful for front-of-house ward clerks and reception staff who may be asked to provide way-finding directions. All staff should be familiar with their local patient, family and carer activated escalation system ('REACH'). Hospital porters and food services staff may also benefit from understanding the What Matters to You fundamental, as this may assist them with better meeting patient needs.

Applying the Safety Fundamentals in Practice

It is important to keep in mind that the Safety Fundamentals provide guidance for staff and teams to effectively engage and build collaborative relationships with patients, their families and carers. They should not be thought of as a recipe or checklist, or of something that you 'do to' patients. We want staff to be aware of and comfortable applying the Safety Fundamentals, while integrating them into their own individual communication style. Patients need to feel that the communication is authentic and not be aware that something is being applied or done to them.

In practice, the Safety Fundamentals should be thought of as part of a broader change to disrupt the 'them and us' relationship dynamic in healthcare. (Seale 2016) The Safety Fundamentals help to support this shift to work together more collaboratively with patients. We encourage you to keep this intent front of mind when applying the Safety Fundamentals in practice.

Links to the National Safety & Quality Health Service Standards

Safety Fundamental	National Standard Link	Action
Hello My Name Is…	2: Partnering with Consumers 6: Communicating for Safety	2.6, 2.7, 2.10 6.3, 6.10
What Matters to You	1: Clinical Governance 2: Partnering with Consumers 3. Preventing and Controlling Healthcare-Associated Infection 4: Medication Safety 5: Comprehensive Care 6: Communicating for Safety 7: Blood Management 8: Recognising and Responding to Acute Deterioration	1.11b 2.2, 2.6, 2.7, 2.8, 2.10 3.3 4.3 5.3, 5.10, 5.13, 5.14, 5.20, 5.30b 6.3, 6.8d, 6.9, 6.10 7.3 8.3
Teach Back	2: Partnering with Consumers 3. Preventing and Controlling Healthcare-Associated Infection 4: Medication Safety 5: Comprehensive Care 6: Communicating for Safety	2.2, 2.6, 2.7, 2.8, 2.10 3.3 4.3, 4.11 5.3 6.3, 6.9, 6.10
REACH	1: Clinical Governance 2: Partnering with Consumers 6: Communicating for Safety 8: Recognising and Responding to Acute Deterioration	1.11b 2.6, 2.7 6.3, 6.9, 6.10 8.3, 8.6e, 8.7, 8.10
Reflect to Care	2: Partnering with Consumers	2.7, 2.8, 2.10
Patient Delivered Handover	1: Clinical Governance 2: Partnering with Consumers 3. Preventing and Controlling Healthcare-Associated Infection 4: Medication Safety 5: Comprehensive Care 6: Communicating for Safety	1.11b, 1.13a 2.2, 2.6, 2.7, 2.8, 2.10 3.3 4.3 5.3, 5.13, 5.14, 5.30b 6.3, 6.8, 6.9, 6.10
CHAT	2: Partnering with Consumers 4: Medication Safety 5: Comprehensive Care 6: Communicating for Safety	2.2, 2.6, 2.7, 2.8, 2.10 4.3, 4.11 5.3, 5.10, 5.13 6.3, 6.9, 6.10

(Australian Commission for Safety and Quality in Health Care 2017)

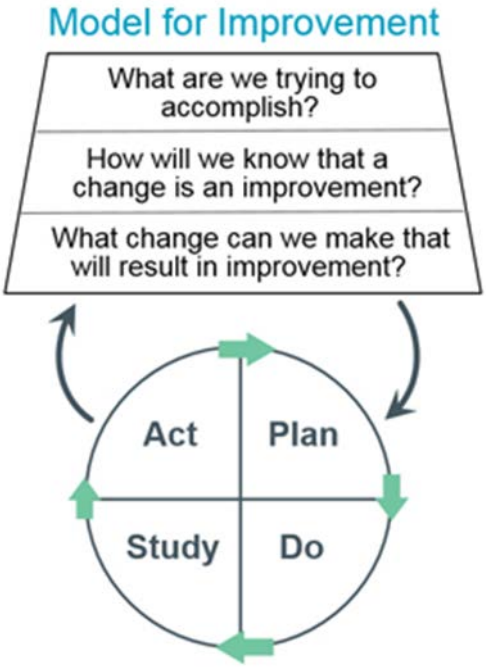
Safety Fundamentals and Accreditation

Implementing the Safety Fundamentals for Person Centred Communication will support healthcare organisations demonstrate that they are meeting specific actions in all eight of the *National Safety and Quality Health Service Standards.*

Implementation

Getting Started

A good place to start when considering how to use the Safety Fundamentals for Person Centred Communication is to apply the Institute for Healthcare Improvement's Model for Improvement (pictured below). This model has been used extensively to effectively implement health service improvement. The model can be used as a guide to develop a local implementation and evaluation plan. More information on evaluation is detailed in the next section.



Institute for Healthcare Improvement 1996

As a first step, it is important to define the issue or problem to be addressed in your local context, e.g. high/increasing number of clinical incidents or patient complaints related to staff-patient communication and/or low/decreasing patient experience scores. Clearly defining the issue/s to be addressed will help with informing your aims and objectives, i.e. what are you trying to accomplish? A useful method to help guide and organise your thinking is to apply program logic. This involves thinking about bigger picture outcomes, such as improving patient experience and reducing clinical incidents, as well as more immediate changes such as increased staff knowledge of, confidence and skills in using, person centred communication strategies (e.g. Teach Back, What Matters to You). It also involves thinking about what inputs and activities you will need, or what changes to make, to help achieve your aims and outcomes. An example is provided on the next page.

Example Program Logic Model

Problem / Issue	50% of patients in X hospital said they do not feel involved in their care, as much as they want to be.			
Aim	To improve patient* involvement in their care by improving person centred communication between staff and patients. Our goal is to reduce the proportion of patients in X hospital who said they do not feel involved in their care, as much as they want to be, to 25% in six months.			
Inputs	**Activities**	**Outputs**	**Impacts**	**Outcomes**
Staff time / cost involved in undertaking the project activities	Develop (or integrate within an existing) implementation and evaluation plan Communicate plan to key stakeholders Collect and analyse evaluation data	Implementation and evaluation plan developed Education sessions delivered Staff received and read information about the Fundamentals	Increased staff knowledge of, confidence and skills in using, person centred communication strategies (e.g. Teach Back) Increased staff use of person centred communication strategies Patients feel heard, respected and listened to.	Increased patient involvement in decision making Improved patient experience scores Reduced clinical incidents and complaints related to staff-patient communication

*The term ‘patient’ may include carers and family members, where the patient chooses to involve these persons in their care.

Implementation Success Factors

Engage an executive sponsor

Executive buy-in is essential for supporting implementation. An executive sponsor might include your Clinical Service Director or Director of Nursing and Midwifery. This person should be in a position to allocate resources, or have a key say in resource allocation. This may enable a senior clinician or project officer to be allocated to develop an implementation and evaluation plan, or to deliver education sessions on the Safety Fundamentals for Person Centred Communication.

Partner with consumers

Consider how you can engage with consumers early in development of your implementation plan. Partnering with consumers will bring unique insights from the 'user' perspective of the health service. These insights provide opportunity to co-develop your plans and to ensure the needs and preferences of both staff and patients are included. For example, you could invite consumers to join a local working group to help guide communication strategies for raising awareness of REACH among patients, families and carers.

Understand your local context

Every clinical service / unit / healthcare organisation is unique. You should understand what areas of PCC you are doing well in and what areas present opportunities for improvement. This information may be available by speaking with your Clinical Governance Team, and/or by reviewing local patient experience, clinical incident and complaint/compliment data. You should also understand the patient population that your service provides care for. You will likely need to adapt how you use the Safety Fundamentals for Person Centred Communication based on your patient cohort. For example, children, adults, the elderly, persons with communication difficulties, persons with carers, Aboriginal or Torres Strait Islander persons, or those from culturally and linguistically diverse backgrounds. It is also important to understand what other similar or potentially competing initiatives are being implemented or are planned for your area.

Identify key stakeholders

Identifying key stakeholders will help to keep the right people engaged in the right way to support implementation. Key stakeholders might include the Clinical Service Director, Nursing and Midwifery Director, Medical Director, Allied Health Director, Nurse/Midwifery Unit Manager, Essentials of Care Coordinator, Senior clinicians, Educators, Clinical Governance Team and Organisational Development Team. Patients, families and carers are also key stakeholders. The value of partnering with consumers in implementation was described above.

Define the scope

It is important to define which of the seven Safety Fundamentals for Person Centred Communication you will be focussing on. Based on your local needs, priorities and existing person centred communication strategies, you may choose to focus on implementing only a select group of the Fundamentals. It is also important to identify which service areas you will be implementing these in. For example, this could be a clinal unit / ward, clinical service / facility, or organisation wide.

Establish roles and responsibilities

This involves identifying the tasks to be undertaken to meet your aims and objectives and assigning responsibility for these to certain staff or teams. Potential tasks include approval and allocation of resources to the project; review of the Safety Fundamentals for Person Centred Communication resources; development of an implementation and evaluation plan; provision of education to staff on how to use the Fundamentals; leading and championing change efforts; and collecting, analysing and reporting evaluation data. Establishing clear roles and responsibilities will help to ensure staff / teams know what is expected of them.

Consider barriers and enablers

It is important to think about what factors may enable, and what factors may be barriers toward, implementing Safety Fundamentals for Person Centred Communication. Identifying these factors early will enable development of strategies to further support implementation, i.e. by harnessing enablers and mitigating barriers. Examples of barriers identified in the literature to delivering PCC include staffing constraints and low levels of staff experience; high staff workloads and time pressures; physical resource and environment constraints; and unsupportive staff attitudes (e.g. “I already do that”) (Lloyd et al 2018). Examples of enablers include strong committed leadership to PCC, patient and family engagement, staff satisfaction and positive staff relations, staff cultural diversity; health professional values and role expectations; staff capacity building; accountability and incentives; measurement and feedback; adequate resourcing for redesign; physical environment; and a culture supportive of learning and change (Lloyd et al 2018; Luxford et al 2011).

Integrate within existing processes and structures

Integrating plans to implement Safety Fundamentals for Person Centred Communication within existing governance structures and initiatives for improving PCC will increase the likelihood of successful implementation and may reduce duplication and ‘project fatigue’. This might include incorporating plans to implement and evaluate the Fundamentals in the existing work plan of a service’s patient experience or safety and quality committee. Other opportunities for integration may include providing education on the Fundamentals within existing staff orientation and education programs, e.g. corporate orientation, nursing and midwifery or allied health new graduate program, Junior Medical Officer orientation, team in-services and management and leadership training.

Focus on behaviour change

Implementing the Safety Fundamentals for Person Centred Communication may require a change in practice, or behaviour change. This change may be considered at the individual staff member level, team level and organisation level. Regardless, we know that behaviour change is often difficult and takes time. Incorporating behaviour change principles will help in creating the conditions for successful change. Some useful models to consider using to assist in enabling behaviour change are listed below. Despite the challenge, remember that every individual positive encounter is important and contributes to improving patient experience. Small changes in improving person centred practice to begin can help to show others that 'this is the way we do things around here' and have a ripple effect on improving culture.

- Psychology of Change (Hilton et al 2018 – Institute for Healthcare Improvement)
- EAST Framework (Service et al 2014 – Behavioural Insights Team)
- Behaviour Change Wheel (Michie et al 2011)

Test and evaluate

Applying the Model for Improvement, it is important to regularly measure whether the desired change in practice has occurred (e.g. increased staff usage of Hello My Name is, What Matters to You or Teach Back) and whether this change is affecting the sought after outcomes (e.g. more patients reporting that they feel involved in their care). It also enables identification of whether any unintended or unwanted effects are occurring (e.g. staff confusion over how to use Teach Back). Doing small tests or pilot runs and checking in early provides opportunity to adapt and refine implementation efforts 'on the run' to ensure these are achieving the desired outcomes. More detail on evaluation is provided in the next section.

Evaluation

Evaluation is important for working out whether the desired clinical practice changes are occurring and provides a source of information for continuous feedback and learning. System-wide evaluation of the Safety Fundamentals for Person Centred Communication will be reflected in state-wide patient experience survey results, feedback from staff and local health services on the utility and effectiveness of the resources, and state-wide clinical incident data.

Individual health services / units should develop an evaluation plan, alongside implementation plans, that is specific to their local context and aims. This might include evaluating implementation of one specific Safety Fundamental for Person Centred Communication, multiple Fundamentals, or a broader PCC strategy of which the Fundamentals make up one part. Most importantly, the patient voice should be included in deciding what to evaluate. What would success look like from the patient / family / carer's perspective? Key questions to consider when developing an evaluation plan are described below. These are based on the Institute for Healthcare Improvement's Model for Improvement.

- What is the issue or problem we are trying to address?

Examples: high/increasing number of clinical incidents or patient complaints related to staff-patient communication and/or low/decreasing patient experience scores.

- How will we know if the intended changes in practice are occurring?

Examples: increased staff knowledge of, and skills and confidence in using, person centred communication strategies (such as Teach Back, What Matters to You, REACH), and increased staff usage of these person-centred communication strategies.

- How will we know that a change is an improvement, or in other words, how will we measure improvement?

Examples: Improved patient experience scores, reduced clinical incidents related to patient communication, reduced patient complaints about communication and reduced staff complaints about other staff member's communication with patients

- How will we know if there are any unintended or unwanted effects?

Examples: Patient confusion or anxiety about their role in Patient Delivered Handover or escalation of care (REACH) and staff confusion or lack confidence in using Teach Back or CHAT.

Other key considerations include the method/s and timing of collecting evaluation data. Again, these will be dependent on local contextual factors, such as available resources, timing with other initiatives and activities, and level of priority. Examples of data collection methods include review of patient complaint and clinical incident data related to communication, patient experience surveys, staff surveys (e.g. of knowledge and confidence in person centred communication strategies and usage of PCC communication resources), peer observation of staff-patient communication and patient interviews / focus groups.

It is also important to consider how the results of your evaluation will be used so that the right people have access to the right information at the right time to inform continuous improvement. This will require thought on which teams / staff members are best placed to receive and apply the information in a timely manner, e.g. those at the frontline who are interacting with patients.

Useful Resources to help Develop Local Evaluation Plans

- Model for Improvement (Institute for Healthcare Improvement 1996)
- NSW Government Program Evaluation Guidelines (NSW Government 2016)
- Agency for Clinical Innovation Evaluation Guide (ACI 2013)
- NSW Health Program Logic Guide (NSW Ministry of Health 2017)

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