An exploratory study of healthcare professionals' perceptions of interprofessional communication and collaboration

Verhaegh, Kim J.; Seller-Boersma, Annamarike; Simons, Robert; Steenbruggen, Jeanet; Geerlings, Suzanne E.; de Rooij, Sophia E.; Buurman, Bianca M.

Published in:
Journal of interprofessional care

DOI:
10.1080/13561820.2017.1289158

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2017

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

Copyright
Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

Take-down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): http://www.rug.nl/research/portal. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.

Download date: 16-01-2020
An exploratory study of healthcare professionals’ perceptions of interprofessional communication and collaboration

Kim J. Verhaegh, Annamarike Seller-Boersma, Robert Simons, Jeanet Steenbruggen, Suzanne E. Geerlings, Sophia E. de Rooij & Bianca M. Buurman

To cite this article: Kim J. Verhaegh, Annamarike Seller-Boersma, Robert Simons, Jeanet Steenbruggen, Suzanne E. Geerlings, Sophia E. de Rooij & Bianca M. Buurman (2017) An exploratory study of healthcare professionals’ perceptions of interprofessional communication and collaboration, Journal of Interprofessional Care, 31:3, 397-400, DOI: 10.1080/13561820.2017.1289158

To link to this article: http://dx.doi.org/10.1080/13561820.2017.1289158
An exploratory study of healthcare professionals’ perceptions of interprofessional communication and collaboration

Kim J. Verhaegh, Annamarike Seller-Boersma, Robert Simons, Jeanet Steenbruggen, Suzanne E. Geerlings, Sophia E. de Rooij, and Bianca M. Buurman

Interprofessional communication and collaboration during hospitalisation is critically important to provide safe and effective care. Clinical rounds are an essential interprofessional process in which the clinical problems of patients are discussed on a daily basis. The objective of this exploratory study was to identify healthcare professionals’ perspectives on the “ideal” interprofessional round for patients in a university teaching hospital. Three focus groups with medical residents, registered nurses, medical specialists, and quality improvement officers were held. We used a descriptive method of content analysis. The findings indicate that it is important for professionals to consider how team members and patients are involved in the decision-making process during the clinical round and how current social and spatial structures can affect communication and collaboration between the healthcare team and the patient. Specific aspects of communication and collaboration are identified for improving effective interprofessional communication and collaboration during rounds.

Introduction

Clinical rounds are an essential organisational process within the hospital setting and play an important role in the flow of clinical information and coordination of care. Key clinicians involved in the patients’ care come together on a daily basis to appraise patients’ progress, consult the medical record, inform the patient, and allow for collaborative planning in relation to the needs of the patient (Gurses & Xiao, 2006). Furthermore, rounds have been a principal strategy for clinical education and are considered essential for helping physicians and nurses in training to achieve clinical competence (e.g., Gonzalo et al., 2013). However, studies show that the information exchange between nurses, physicians, and patients during clinical rounds is often unstructured and patients are not fully included in the discussion about their treatment goals (e.g., Weber, Stockli, Nubling, & Langewitz, 2007).

The objective of this study was to explore perceptions of healthcare professionals (nurses, physicians, and other staff members) on effective interprofessional communication and collaboration during clinical rounds.

Methods

We adopted an exploratory qualitative study design to explore how healthcare professionals perceive effective communication and collaboration during clinical rounds.

Data collection

Healthcare professionals from a 1,024-bed university teaching hospital in the Netherlands were invited to attend a focus group meeting where they explored and clarified their views about the ‘ideal’ round through discussion. This study took place in March and April 2011 at the Academic Medical Centre in Amsterdam.

We used a purposive sampling approach to set up an interprofessional panel of healthcare professionals. Participants for the focus group interviews were invited to participate by e-mail. Selection was based on working experience of a minimum of 5 years and professional background (3 residents, 27 nurses, 5 medical specialist, and 13 hospital staff members who were engaged in quality improvement and had a background in medicine or nursing). The participants were divided over three smaller focus groups based on a mix of professional backgrounds.

The third author (RS) moderated the meetings and attempted to encourage each participant to talk freely, while the second author (ASB) assisted by asking probing questions and keeping notes during the process. The moderator and assistant (RS and ASB) are health professionals trained in paediatrics and cardiology and currently involved in management. Each meeting was audiotaped and lasted approximately 60 min. The first author (KV) transcribed each meeting verbatim utilising field notes and entered into MAXqda2. A debriefing session was held by the team after each meeting.
### Table 1. Themes, sub-themes, and illustrative data extracts.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
<th>Illustrative quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure of the medical round</strong></td>
<td>Preparation</td>
<td>What I do find important, before the doctor and the nurse start their ward round, is that they prepare for it. This means they've carried out the necessary checks, and the nurses know what questions they want to ask. (Quality improvement officer D3:8)</td>
</tr>
<tr>
<td><strong>Timing of the medical round</strong></td>
<td>I think you have to be prepared to shake off old habits. For example, we all talk about doing, say, ward rounds in the morning. We all have a fixed way of thinking. Why shouldn't you do ward rounds in the afternoon? (Nurse D2:3)</td>
<td></td>
</tr>
<tr>
<td><strong>Communication tool</strong></td>
<td>The patient does have a problem list, for which actions have been organized. And it's important that these actions are followed up. Has any action been undertaken? Have the tests been done? Have the things been measured that should have been measured? (Physician D3:2)</td>
<td></td>
</tr>
<tr>
<td><strong>Decision-making</strong></td>
<td>I think it's a very important opportunity for communication between the nurse and the doctor, where nurses explain their views about the patient, and where doctors explain how they are thinking and the direction in which they see the management of the patient going. (Nurse D1:5)</td>
<td></td>
</tr>
<tr>
<td><strong>Roles and responsibilities</strong></td>
<td>I don't totally agree with that, always discussing things with a nurse. Because that suggests that the junior doctor should make decisions in such a way that the nurse agrees. After all, the junior doctor makes a lot of decisions in which the nurse has no input. (Physician D3:4)</td>
<td></td>
</tr>
<tr>
<td><strong>Knowledge and expertise</strong></td>
<td>But we don't just make medical decisions during a ward round, so... I mean they [doctors] decide on management, and decisions are based on that. [...] It seems to me that you discuss something together and of course as a nurse you can give advice, but it's the doctor who makes the final decision. That seems perfectly clear to me. (Nurse D3:9)</td>
<td></td>
</tr>
<tr>
<td><strong>Care planning</strong></td>
<td>Yes, they're not the ones leading the discussion [senior nurse]; the patient's primary nurse does that. But they're the ones who will report when things are going systematically wrong on the ward and who give feedback to the nurse. (Nurse D3:5)</td>
<td></td>
</tr>
<tr>
<td><strong>Learning on the job</strong></td>
<td>Short-term care planning is focus for physician: A 24-h care plan is the maximum I think. (Physician D2:5)</td>
<td></td>
</tr>
<tr>
<td>**Long-term care planning is focus for nurses: I'd also like to see a care plan for the patient. This should include discharge and transfer of course, but maybe it should also include what the patient's needs are if he's transferred to a nursing home or to home care; what the patient is physically and mentally capable of, and draw up a care plan for that. (Nurse D2:5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patients' role</strong></td>
<td>Participating in decision-making process I think [...] that the patient has an important role to play in decision-making. You have to give the patient the opportunity to participate in what's happening. (Nurse D1:6)</td>
<td></td>
</tr>
<tr>
<td><strong>Active role of patients:</strong></td>
<td>I think the patient should know what tests he's going to have, but that's completely different from getting them involved in decision-making. (Physician D2:5)</td>
<td></td>
</tr>
<tr>
<td><strong>Non-active role of patients:</strong></td>
<td>Patients should have a role. I think both, yes, maybe it's rather specific, but on our ward we have a 'sit-down' pre-ward-round briefing at the computer, when we look at everything in the system. And then we go to the patients to tell them what we've discussed. Takes a bit more time perhaps, but it means you've got the complete picture. (Physician D1:3)</td>
<td></td>
</tr>
<tr>
<td><strong>Geographical movement across spaces</strong></td>
<td>One-stage spatial organisational structure of the medical round excluding patients: In an ideal situation you'd do the whole ward round by the bedside, because then you can check everything with the patient, and the patient knows straight away where he stands. And then you don't just give the patient a summary of something, which means things get overlooked. (Quality improvement officer D1:1)</td>
<td></td>
</tr>
</tbody>
</table>

to evaluate the quality of the session, improving the skills of
the team and checking the responses.

**Data analysis**

A three-person team (KV, BB, and SG) with research back-
grounds in nursing, health sciences, and medicine followed a
general qualitative, descriptive method of content analysis.
Asking the participants to confirm whether the interpretation of
the results was correct increased the credibility of the data.

**Ethical considerations**

This study was approved in February 2011 by the Medical Ethics
Committee of the Academic Medical Centre in Amsterdam.

**Results**

Three major themes emerged that present suggestions to
improve interprofessional communication and collaboration
between the healthcare professionals and patients on a general
medical ward. Themes, subthemes, and illustrative quotes are
shown in Table 1. From the perspectives of the healthcare
professionals, structuring the round could contribute to effective
communication and collaboration between healthcare profes-
sionals. Second, according to the participants, nurses and phy-
sicians were the main participants of the decision-making
process during the round and had different views on care plan-
ning. Last, the participants disagreed about patients’ role in
decision-making. Some healthcare professionals only wanted to
inform patients about the outcome of the round, others wanted
to give the patient an active role in the decision-making process
during the round.

**Discussion**

The results from this study suggest a number of barriers and
facilitators which affect effective interprofessional communication
and collaboration during rounds between health professionals.
First, our results suggest that the structure of rounds can be
improved on several domains. Preparation was identified as a
key element to conduct effective clinical rounds. It has been
suggested before that holding a pre-round briefing not only
helps physicians and nurses in gathering all the relevant patient
information, but also in raising their comfort level (Abdool &
Bradley, 2013). Participants identified that the organisation and
planning of the round needs to be re-prioritised. Currently, the
round takes place in the morning, which is one of the busiest
moments of the day. Clinical rounds could be timetabled and
hospitals could rethink their processes to ensure better collabora-
tion and delivery of care (Dingley, Daugherty, Derieg, & Persing,
2008). According to the participants, a communication tool can be
used to improve interprofessional communication and collabora-
tion. Others (Thomassen, Storesund, Softeland, & Brattebo, 2014)
have found that using a safety checklist in medicine to structure
communication reduces adverse events, morbidity, and mortality.
In addition, the ward round lead could summarise the daily plan
for the patient and set goals for the next 24 h till discharge, which
is also the primary goal of the daily round according to the
participants.

Second, our results also suggest that members of the interpro-
essional team have different views on care planning. Nurses are
focused on and have an active voice in decision-making about
longer-term care planning, such as discharge planning. On the
other hand, physicians are more focused on short-term care
planning, such as diagnosis and treatment. However, participants
disagree that discussing both short- and long-term care planning
are important in discharge planning. Furthermore, participants
differed about the roles and responsibilities during the round.
Physicians reported to have the leading and decisive role in
medical decision-making. Therefore, a clear division of roles and
responsibilities can support the organisation of the round.

In summary, the findings of our study indicate that it is important
for healthcare professionals to consider how team members and
patients are involved in the decision-making process during the
medical round and how current social and spatial structures can
affect communication and collaboration between the healthcare
team and the patient. This study identified specific aspects of
communication and collaboration for improving effective inter-professional communication and collaboration during the medical round. Future research should explore the views of patients on effective communication and collaboration during rounds.

Acknowledgement

We would like to thank the clinical teams for participating in the focus group meetings.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

ORCID

Kim J. Verhaegh http://orcid.org/0000-0003-1082-4890
Suzanne E. Geerlings http://orcid.org/0000-0002-8518-3576
Sophia E. de Rooij http://orcid.org/0000-0001-5130-1987

References


