directed **reading**
CLASSICS

essential**education**

Improving Communication For Better Patient Care

asrt®
American Society of Radiologic Technologists

Improving Communication For Better Patient Care

ANNE SCOTT, B.S.R.S., R.T.(R)

Communication failures in radiology departments stem from a variety of sources and significantly influence the success of patient care. This article reviews the communication responsibilities of health care providers, identifies how errors are made and how they become medical mistakes and provides methods for improving communication within radiology departments.

This ASRT Directed Reading Classic was originally published in Radiologic Technology, January/February 2007, Vol. 78/No. 3.

After completing this article, the reader should be able to:

- *Discuss the communication responsibilities of health care professionals.*
- *Identify types of communication failures that lead to medical errors in radiology.*
- *List ways to improve provider-patient communication.*
- *Recognize the financial impact of medical errors on radiology departments and the entire health care system.*
- *Describe methods to improve departmental cohesiveness and effectiveness.*

Radiology departments should strive to improve communication. Patient safety and quality of care depend on the accurate and timely transmission of information. The Institute of Medicine (IOM) report *To Err Is Human: Building a Safer Healthcare System*, which listed errors in health care as the leading cause of death and injury, explained the need for a systems approach to modify the conditions that contribute to error. A major reason for accidents in medicine is that the continuum of care includes a chain of events where faults can grow and evolve.[1] A recent report by the United States Pharmacopeia stated that poor continuity of patient care within radiology departments resulted in 7 times more medical errors than in any other department, including intensive care units, between 2000 and 2004.[2]

Communication failures that contribute to discontinuity of care stem from a variety of manageable problems, ranging from a lack of interpersonal communication skills to barriers in the work environment to suboptimal use of computer networking tools. In addition, medical errors in radiology are more likely than other medical errors to result in the need for additional care and the consumption of further resources.[2] Patients can suffer when caregivers do not communicate effectively with each other. Common results of inadequate communication include anaphylactic shock when allergies are overlooked, delay of critical treatments if images are not sent to physicians and unnecessary radiation exposure when the wrong examinations are performed. It may be beneficial to approach the problem of discontinuity by focusing on the effectiveness of the care provided. Was the patient helped or harmed by the care received? Were time and resources within the department used wisely? How did the patient feel about the care, and would he or she recommend the facility to others?

A recent article by Brennan et al[3] suggested health care institutions should go beyond counting and categorizing errors to focusing on making care more effective as a whole. The authors argued that "moving away from a focus on saving lives solely by preventing errors and instead emphasizing the implementation of evidence-based practices to improve the quality of care will yield better long-term results."[3] Part of the reasoning behind this approach is the underreporting of errors and accidents and the lack of initiative to

change practices that lead to mistakes in medical facilities. Radiology personnel cannot simply be told to make fewer mistakes; they must be taught and encouraged to use better communication practices to prevent them. According to the Institute of Medicine of the National Academies, "Instruction in safety improvement requires knowledge about working in teams, using information and information technology, quality measurement and communicating with patients about errors."[1]

Radiologic technologists play an important role in the movement toward better communication. They must communicate directly with the patient, the patient's family, radiologists and numerous other staff. The American Registry of Radiologic Technologists (ARRT) and the American Society of Radiologic Technologists (ASRT) Code of Ethics establishes the expectation for good communication. (See Table 1.) Effective communication includes the display of professional conduct, an attitude of respect toward other professionals and the patient and the responsibility to act as a patient advocate through all aspects of the patient's care.[4] It is not enough to process patients accurately through the radiology department; caregivers must welcome patient participation and encourage patients to ask questions about any concerns they have.

Many clinical and quality performance standards included in the ASRT *Practice Standards for Medical Imaging and Radiation Therapy* focus on the caregiver's ability to communicate with patients and coworkers.[5] Technologists not only need to be able to gather, document and transmit patient information, but they also must verify procedures to be performed by communicating with other personnel. Professional performance standards embody the necessity for teamwork, collaboration and collegiality between radiologic technologists and other health care providers for the most effective patient care.[4]

Effective care includes preventing injuries and improving quality, but it also means that less time and fewer resources will be wasted, frustration between medical professionals and between patients and their providers will be reduced and staff turnover will decrease. Radiology personnel and patients all benefit from more effective care practices.

Communication With Patients

Improving the effectiveness of treatment planning and delivery can begin with improving communication between patients, their representatives and family members and their health care providers. In an article about communication strategy on trauma rounds, Schiller stated, "Communication failure is the root of much dysfunction in health care and improvement would be well received."[6] Patients suffer when instructions are not given clearly or when they do not understand directions. A recent paper by Meyer[7] analyzed an Agency for Healthcare Research and Quality (AHRQ) handout for patients that provided tips to improve patient-physician interactions. Although information in the handout was designed to empower patients, Meyer suggested that health care professionals also have an important role in empowering patients. Because patients visit many different clinics and receive treatment from different providers, continuity of care can be disrupted and vital information about a patient's condition might not be shared among caregivers. The AHRQ handout advises patients not to assume that all of their health care providers know their complete patient history. Providers also should not assume the patient's complete history will be adequately transmitted to the patient's next provider. Meyer further suggested that health care professionals can help each other by communicating clearly with everyone involved in the patient's care and by working with patients to "improve communication and greatly reduce the likelihood of preventable errors."[7]

Radiologic technologists are frequently responsible for acting as patient advocates, taking patient histories, providing instructions for fasting before contrast studies and explaining postexamination care. Thus, it is important that technologists give explicit instructions, answer questions promptly and completely, coordinate patient care efficiently and work together with the patient.[7] This responsibility includes being thorough in their questioning and ensuring the patient understands all instructions. Meyer suggested asking specific instead of general questions, such as "Are you taking any prescription drugs, over-the-counter medications or any herbal supplements?" instead of "Are you taking any drugs?"[7] When a patient is unable to answer questions or comprehend instructions, the patient's family or guardian should be involved in both the history-taking and the decision-making processes. By encouraging family participation, feelings of stress and frustration toward staff are reduced and system dysfunction is less frequent.[6]

Cultural Considerations

All patients deserve the same quality of care, regardless of native language, race, ethnicity or physical disability. Furthermore, providing substandard care because of cultural, physical or language barriers is a form of discrimination. Organizations are required by