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Short Communication Open Access

CHAT Communication Guide: Transitions between Patient Care Areas and Diagnostic Units

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Abstract

Background: Many baccalaureate nursing programs in Ontario, including X, ask their consolidating students to address a persistent clinical issue with a corresponding quality improvement solution. Nursing leadership often manifests as a unique combination of advocacy skills and abiding professional commitment. To succumb to complacency in a workplace where client safety is constantly vulnerable is neither a viable or caring option.

Method: The CHAT Communication Guide was developed as a change initiative targeting transitions in care between care-provider units and diagnostic or procedural departments. This tool is to be used by both the sending and returning health care provider to communicate critical patient information regarding current situation, history, assessment, and treatment.

Results: The goal of this implement is to improve patient safety, promote patient-centered care, and provide a standardized tool accessible to all health care team members.

Conclusion: Clinical innovation represents a professional obligation where transitions in care are a priority concern.

Keywords: Quality improvement; Nursing care; Patient-centered care; Transitions in care; Communication; Diagnostic units; Change initiative

Short Communication

According to Health Quality Ontario [1], "quality improvement is a systematic approach to making changes that lead to better patient outcomes and stronger health system performance" (p. 4). To critically evaluate and call attention to problems in the health system while proposing corresponding solutions exemplifies a strong dedication and responsibility to the profession and those we serve. Cultural change is far more pervasive when instituted by clinical leaders than by changing policies and procedures [2]. It is with this knowledge that many baccalaureate nursing programs in Ontario, including X, request that consolidating students address a pressing clinical issue that compromises patient safety with an enduring and feasible remedy.

According to the Health Care Compliance Association [3], miscommunications during hand-off between medical providers contribute to 80% of serious medical errors. Whether between hospital and home, specialist to specialist, or unit to unit, transitions in care are vulnerable periods for a patient's safety. Transitions from one care setting to the next often accompany changes in health status and potentiate loss of critical information, thus demand a great degree of coordination [4]. Patients undergoing transitions of care may have a new diagnosis, a new treatment, or a change in functional status that affects not only their own ability to manage their conditions, but that of persons providing health care. The WHO explains that older people with complex health issues are most likely to undergo multiple transitions of care and are at the highest risk for adverse events and safety incidents. Patients with dementia or clients with intellectual deficits may not be capable of expressing what they know and do not know of their care plan and what they have experienced in a different institution or area of the hospital. The WHO advises that the most successful strategies to improve transitions of care were communication, particularly those focusing on coordination of care [4].

For our change initiative, we focused specifically on repairing poor communication between care-provider units such as medical-surgical, emergency, intensive care and diagnostic/procedural units. We developed a communication tool using the CHAT acronym to be used when transferring patients between medical units and diagnostic departments. The CHAT Communication Guide describes the current situation, history, assessment, and treatment [5]. By necessity, the technicians receiving a patient for CT know through the physician's requisition what the patient's diagnosis is, what they may be trying to rule out, creatinine level, renal history, age, weight, and any allergies to contrast dye. However, whether the patient has IV access established, language barriers, dementias, aggressive history, falls risk, allergies, or what their code status, GCS, or recent vital signs are is unknown. We feel this is a safety gap. There are two separate CHAT Communication Guide sheets one for the sending health care provider and the other for the returning health care provider. Separating the initially joined columns into two different documents appeared to be the more user-friendly choice after hearing from colleagues who explained they may have multiple patients with multiple procedures and/or diagnostic tests. With separation of the forms, the sending health care provider can use their clinical judgement to determine if the patient's status has

not altered significantly enough to warrant filling out a second form for a patient's second procedure. Included in the form for sending health care providers to fill out is patient status, procedure to be completed, oxygen requirements, dementia, language barriers, code status, isolation precautions, allergies, falls risk, consent obtained, vital signs, IV access, diet, GCS, orientation, and pain scale, as well as other procedures booked for the same day, follow-up actions identified, and patient goals/concerns (Figure 1). Returning health care providers communicate the test/procedure performed, patient tolerance, significant events, sedation, dressings, current vital signs, drainage output, order sets, anticipated changes, and patient goals/concerns (Figure 2). To be adhered to the CHAT Communication Guide are shape-denoting, colour-coded stickers that indicate allergy, dementia, falls risk, and GCS <8 (Figure 3). The purpose of these stickers is to prompt the technician/receiving physician/nurse to quickly lay eyes on the symbol and provide care that is safe and patient-centred.

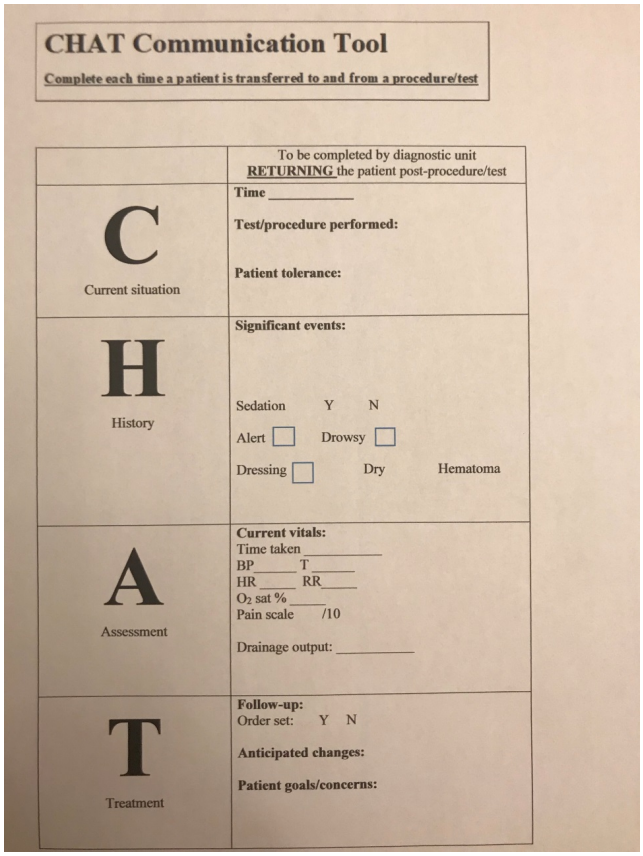

Figure 1: Patient Goals/ Concerns.

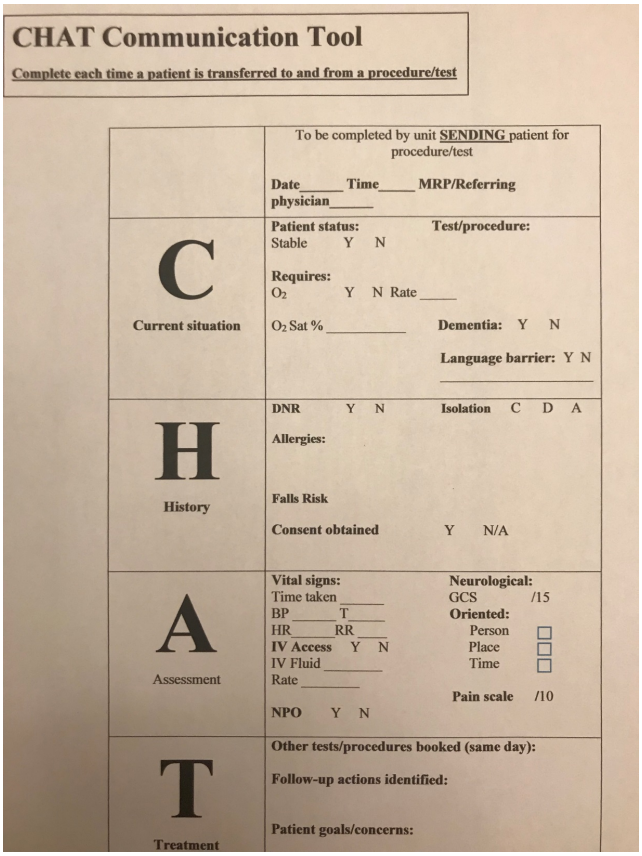

Figure 2: Patient Record.

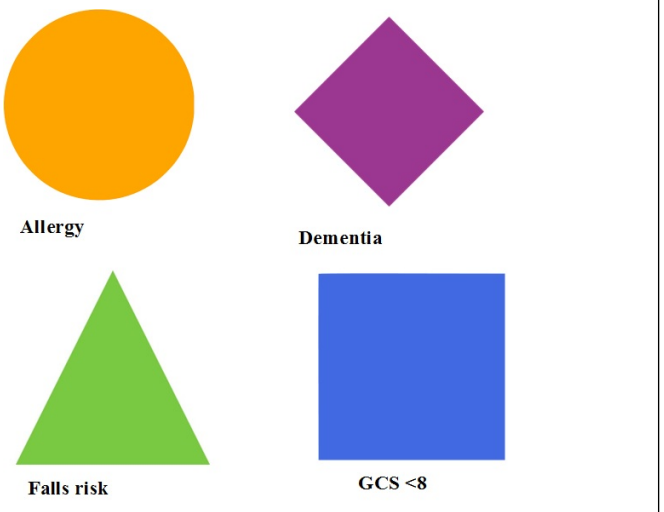

Figure 3: CHAT communication guide.

We hope to gain improved communication between medical units and diagnostic/procedural departments, thus enhancing patient safety by providing clarity of patient status and significant information not included in physician requisitions. Teamwork and consistency in health care provider communication style is a significant projected

outcome of using the CHAT Communication Guide. We hope to achieve greater situational awareness of patient condition and anticipated patient response to tests/procedures, while also enabling health care providers to provide safe and informed post-test care. By implementing the CHAT Communication Guide, we aim to avoid confusion regarding treatment plans, discrepancies in medications, missed appointments, and duplicative testing which collectively lead to fragmented patient care and dissatisfaction as well as unnecessary health care costs [6]. In addition to nursing involvement in producing and implementing the tool, we hope that compliance and acceptance of this change initiative will be elicited with the CHAT Communication Guide stickers presenting consistency with modern trends in communication.

References

1. Health Quality Ontario (2013) Quality improvement science.
2. Stanley DJ (2012) Clinical leadership and innovation. J Nurs Educ Pract 2: 119-126.
3. Health Care Compliance Association (2016) Preventing readmissions through compliant patient transitions.
4. World Health Organization (2016) Transitions of care.
5. Alberta Health Services (2010) CHAT communication tool.
6. Mansukhani RP, Bridgeman MB, Candelario D, Eckert L (2015) Exploring transitional care: Evidence-based strategies for improving provider communication and reducing readmissions. PT 40: 690-694.