



Information exchange in oncological inpatient care – Patient satisfaction, participation, and safety



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A B S T R A C T

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Purpose: This prospective pilot study aimed to investigate patients' perception of information exchange and its associations with patient satisfaction, participation and safety at inpatient oncology wards.

Methods and sample: Consecutive patients with cancer who spent ≥ 3 days at an oncological inpatient ward at the Department of Oncology, Karolinska University Hospital during the study period (March–August 2013) were invited to respond to EORTC-IMPATSAT32 measuring patient satisfaction and a study specific questionnaire. Data on changes in medication and fall risk assessments was collected from the patients' electronic health records.

Key results: A total of 104 patients (58%) participated in the study. Patients rated doctors' and nurses' information provision lower than their technical and interpersonal skills, and 13% considered the information exchange "excellent". Changes in medication were registered for 83% of participating patients, which 56% of the patients were aware of. Fall risk assessment was registered for 73% of responding patients, and 39% reported having discussed risk of falling during the hospital stay. The Downton Fall Risk Index scores were not associated with actual falls or fall prevention actions.

Conclusions: Deficits were found on information exchange and information provision between health care professionals and patients. This might have a negative impact on known patient safety risks such as medication errors and falls. More effective strategies to perform fall risk assessments in an oncological inpatient setting are needed. Further studies evaluating interventions to improve participation and information exchange are necessary to increase patient satisfaction, participation and safety in oncological inpatient care.

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Introduction

Communication in health care is both complex and demanding. Providing patients and their families with adequate information concerning treatment and care is a challenge in most health care organisations. Traditionally, models of one-way *information transfer* have been used, which presuppose the health care provider as the expert communicator and the patient as a more passive receiver of information. However, *person-centred care* is driven by the patients' needs and preferences and has proven to increase patient satisfaction, participation and safety (Alharbi et al., 2014; Zucca et al., 2014). This demands a shift to *information exchange*, a two-way

dialogue where both patients and health care professionals contribute in partnership. A mutual exchange of information is also a prerequisite to ensure the understanding of the information, in both directions (Kreps, 2009; Lee and Garvin, 2003).

Patient satisfaction in cancer care is an important dimension in high quality service and can be described as the extent to which the patients' health care experience matches the level and quality of care they expect. Studies have shown significant associations between patient satisfaction, adherence to treatment and high quality communication between patients and their health care providers (Bredart et al., 2005; Chow et al., 2009; Tomlinson and Ko, 2006).

Current Swedish laws also put clear demands on the health care system to meet both patients and their families' rights to influence their own care. Patient participation is described as the health care staffs' recognition and respect of each patient's unique knowledge and individual view of different aspects of health and health care,

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rather than just the invitation to be involved in decision making regarding treatment options (Eldh et al., 2006; Longtin et al., 2010).

Patients' participation and perception of information are important, both for patient satisfaction and safety. In a recent, unpublished, survey from our department more than 50% of hospitalized cancer patients stated that the information exchange between shifts was insufficient. Well-informed patients are more likely to adhere with treatment recommendations, which is essential for the outcome and safety (Murphy et al., 2012). Several technical strategies to prevent errors have been implemented at many cancer centres (computerized prescribing, bar coding etc.) but involvement from patients and family members during hospital stays have also been described as an important safety strategy (Cohen, 2007; Martin et al., 2013). Patient participation is heavily promoted in patient safety contexts but there are few examples where interventions have been systematically evaluated (Hall et al., 2010; Lipczak et al., 2011; Schwappach, 2010). However, previous research have shown that cancer patients are willing to be more involved in patient safety, but that health care professionals rarely explain or discuss safety risks or preventive interventions (Martin et al., 2013; Schwappach and Wernli, 2010).

Two well-known patient safety risks for hospitalized cancer patients are medication errors (Lipczak et al., 2011) and falls (Capone et al., 2012; Spoelstra et al., 2013; Wolf et al., 2013). Medication errors might be particularly risky in oncology care with the use of extremely potent drugs where inadequate information exchange may have severe consequences (Cohen, 2007; Kullberg et al., 2013).

Fall risk assessments are typically performed by nurses at admission. Several fall risk assessment tools exist, and even if the effectiveness is not well studied in acute care settings for specific patient populations, they are widely used (Meyer et al., 2009; Wolf et al., 2013). Fall risk assessment is seen as a quality parameter of good nursing care and often linked to financial reimbursements. Fall risk prevention actions have proven to reduce the number of fall incidences for hospitalized cancer patients to some extent (Wolf et al., 2013). However, we found no studies on patient participation in fall risk assessment or prevention regarding hospitalized cancer patients.

The main objectives of this study were to investigate patients' perception of information exchange and its associations with patient satisfaction, participation and safety at inpatient oncology wards.

Methods

Patients

This prospective pilot study was conducted at the Department of Oncology, Karolinska University Hospital, the only hospital in the region providing acute oncological inpatient care. Consecutive patients, ≥ 18 years, discharged from two of four inpatient wards after ≥ 3 days length of stay were weekly identified from discharge lists and asked for participation during the study period (March–August 2013), see below. Patients not speaking Swedish or in a terminal stage of cancer disease were excluded.

Procedures

Lists of discharged patients were collected once a week and an information letter, questionnaires (described below) together with a prepaid return envelope were sent to patients within two weeks after discharge. A reminder was sent to those not responding within one week. Patients not wishing to participate could avoid the reminder by returning the questionnaires uncompleted. This

procedure was performed by the authors with back up from one clinical nurse.

Data collection

The following data were registered from the patients' electronic health records (EHR): gender, age, length of stay, diagnosis, co-habitual status, reason for admission, treatment intention, fall risk assessment according to Downton Fall Risk Index (Meyer et al., 2009), and if medication changes were made during the hospital stay.

Changes in medication are often performed during a hospital stay and all prescribed medications are recorded in patients' EHR. Patients' awareness of prescribed medication is a prerequisite for adherence to medication, especially after discharge from hospital. Therefore, any type of changes in prescribed medication during the hospital stay were collected and then compared with patient-reported data regarding changes in medication.

The fall risk assessment (Downton Fall Risk Index) should be performed by a nurse within 24 h from admission, according to the hospital's guidelines. The index contains the following items; previous falls, current medication, impairments (visual, hearing, cognitive) and ability to walk. The scores are summed to a total score (0–11 points). The total score and preventive fall risk action are documented by the nurse in the EHR.

Questionnaires

Patient satisfaction with care was measured by a questionnaire developed within the European Organization of Research and Treatment of Cancer (EORTC) Quality of Life Group. The questionnaire, EORTC-INPATSAT32 consists of 32 items organised in 11 multi-item scales and 3 single-item scales (Bredart et al., 2005). Patients rate their perception of physician's and nurses' technical skills (3 + 3 items), interpersonal skills (3 + 3 items), information provision (3 + 3 items), availability (2 + 2 items); other hospital staff's interpersonal skills and information provision (3 items), exchange of information (1 item), waiting time (2 items); hospital accessibility (2 items), comfort (1 item), and general satisfaction (1 item). The EORTC-INPATSAT32 was specifically developed for hospitalized patients with cancer, and testing has demonstrated excellent internal consistency and convergent validity, and high reliability (Bredart et al., 2005).

We failed to identify a validated instrument assessing patient participation in the inpatient setting including involvement, information exchange, information/communication, medication, fall risk, and integrity. Therefore, we constructed items within these areas, based on the aims of the study and the literature in order to supplement the EORTC-INPATSAT32. The study specific questionnaire consisted of items on patient participation specific for inpatient cancer care including involvement (9 items), information exchange (2 items), information/communication (4 items), medication (5 items), fall risk (2 items), and integrity (2 items). The questionnaire consisted of 24 items and it is not yet tested for validity or reliability.

Statistical methods

No formal sample size calculations were performed for this prospective pilot study. The response format to the EORTC INPATSAT32 is a 5-point scale, ranging from 1 ("poor") to 5 ("excellent"). Response scores were linearly transformed to a 0–100 scale, with higher scores representing higher satisfaction (Bredart et al., 2005). Continuous variables are presented as means and standard deviations (SD). The response formats for the study specific

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