Strategies for Improving Clinician Communication: Focus Groups

Background
Teamwork and good communication are essential to providing high-quality care. According to the Joint Commission (2008), clinician communication is consistently the most frequent contributor to adverse events in hospitals. The goal of this multisite study was to explore the contexts of communication among pediatric clinicians and elicit clinicians’ recommendations for solutions to improve communication and enhance patient safety.

Methods
- Conducted 63 audio-taped focus groups, each lasting approximately 60-90 minutes, using a standardized protocol; themes covered the breadth of clinician communication issues related to patient safety. Inquiries included: (1) effective and problematic communication between clinicians; (2) “work-arounds;” and (3) solutions.
- Using Atlas.ti™, a qualitative analysis software program, data from the focus groups was coded and evaluated to identify issues around clinician communication.

Results and Conclusions
- Overall, 300 clinicians participated representing all of the CPQSC institutions, involving a wide range of healthcare professions (e.g., nurses, physicians, respiratory therapists, pharmacists) and professional levels (e.g., ward nurse, nurse manager; resident, fellow and attending physicians) to discuss safety issues in clinician to clinician communication.
- Results have been aggregated across institutions and findings included identifying several key contexts for communication, including: (1) Standardized communication; (2) Transitions of care; (3) Assessment of patient acuity; (4) Teamwork; and (5) Team culture.

Future Directions
- The qualitative analysis yielded valuable information for developing future research and interventions as well as peer-reviewed publications.
- This project identified several key problematic contexts for communication that led to subsequent research projects focused on these themes: standardized communication, transitions of care, and assessment of patient acuity.
- The findings have served as compelling evidence to continue investigating approaches for improving communication and teamwork as a means to improve pediatric safety.

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