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Review article

Communication tools among professionals in intensive care: An integrative review

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Abstract

Introduction: Communication is important to ensure safety in demands regarding patients, processes and staff in intensive care units (ICUs), a complex area that requires good communication and dynamism in order to achieve positive results for patients. Hence, the identification of tools that may provide improvements in communication among professionals working in the ICU in the scientific literature is essential. Objective: To map in the literature the types of tools for improving communication among professionals in intensive care. Method: Rand integrative vision performed between April and May 2021, with searches in the medline, LILACS and BDENF databases. We used the descriptors: "Patient Safety"; "Intensive Care Units"; "Applications of Medical Informatics", with Boolean operator "AND". The search covered articles published between 2016 and 2021, full texts, in the Portuguese, English and Spanish languages. Duplicates, case reports, annals, editorials, letters to the editor, dissertations and theses were excluded. Results: We identified two categories: tools for changes of shift and tools for transfers of care. Conclusions: Communication tools are effective because they reduce the incidence risk of errors in direct patient care.

Keywords: Patient safety; Health communication; Intensive Care Units; Applications of medical informatics.

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Introduction

Patient safety has been a subject of permanent interest in different scenarios of the hospital environment, especially in intensive care units (ICUs). The ICU is a highly complex care area, intended for the hospitalization and treatment of patients with serious clinical, medical and/or surgical conditions. The demands of these patients involve great risk to life and therefore require specialized professional attention.[1]

The theme of this study focuses on the goal of patient safety,[2] recommended by the World Health Organization for improving communication between medical professionals. Studies indicate that inadequate communication represents one of the major causes in more than 70% of adverse events (AEs) in patient care, such as medication errors, incorrect identification of patients, and inadequate prescription.[2]

The theme is justified by the great importance that effective communication has on the routine of a complex unit such as an ICU. The standardization of language within the multiprofessional team is an effective instrument for ensuring security in the performance of the routine of demands regarding patients, processes and the team.

Since the ICU is a sector with complex activities and patient profiles, it is an environment with an intense pace of work and requires professionals to pay great attention to the performance of daily tasks, where any misstep can lead to irreversible damage. Therefore, communication must be accurate and understandable to all those involved, and no information should be lost at any time during the care of patients or the changeover of professionals.[3]

In addition, communication problems that occur in a hospital environment, especially in the ICU, can

cause disturbances in the routine activities of the multidisciplinary team, leading to disagreements among the staff and causing them to blame themselves for errors. This scenario generates emotional fatigue among those involved; delays or omission in providing care to the patient, with consequent risks of damage; and increases in hospital expenses and length of stay.[3]

The occurrence of these AEs is caused mainly by failures in the passage of information, long and exhausting working hours, noise pollution in the ICU environment, stress and inadequate hospital management.[4]

With the objective of guaranteeing effectiveness, improvements and safety of health care, some information standardization strategies have been developed to ensure clear, objective, concise, efficient, timely and comprehensive communication among teams. Nevertheless, these strategies must be implanted concomitantly with changes in both the behavioral and cultural aspects of institutions in order to produce norms that promote patient safety.[5]

Since ineffective communication between teams that provide care can generate failures in the continuous therapeutic plan and thus result in direct damage to critically ill patients, actions must be implemented to improve processes in order to minimize the risks inherent to the communication gaps among professionals. Thus, the establishment and implementation of care protocols are of fundamental importance in the prevention of errors and incidents in the daily routine of professional activities in health care.[6]

Highlighting this topic is important because effective communication leads to a reduction in human errors, improves the quality of care provided to the patient, strengthens ties within the team and reinforces the bond of trust in mutual work, in addition to providing safety in work processes. Hence, studying the recommended tools for improving communication among professionals can contribute to better quality of care, since it enables improvements in knowledge and techniques in the healthcare field, optimizes the daily work of teams, standardizes language among professionals and care and assistance units, with the objective of reducing unnecessary harm to the patient.

Effective communication occurs in a two-way model. The read-back technique ("read back") is used to validate information transmitted during changes in shifts or within work shifts: to confirm that the information has been understood correctly, so that communication can take place more securely. This technique is also used in aviation and other industries to prevent messaging errors and has become part of the international patient safety goals of the Joint Commission International manual.[7]

Given this context, the following guiding question emerged: "What are the tools used to improve communication among professionals in intensive care units that can be found in the current scientific literature?" To answer this question, this study aimed to map the types of tools to improve communication between professionals in intensive care units that can be found in the literature.

Method

This work is an integrative literature review, based on data collected between April and May 2021. This type of study uses a method to address a specific topic, through definitions of concepts, a review of theories and evidence, and analysis of problems. The integrative review was carried out in six stages, conducted in order to identify, analyze and integrate the results of independent studies on the same subject. These stages are: elaboration of the guiding question; search or sampling of the literature; data collection; critical analysis of the included studies; discussion of results; and presentation of the integrative review.[8]

The research question was defined based on the selection of the objective and identification of the desired study. In the case of this study, P/I/C were used, that is, P (patient); I (intervention); C (context). This strategy favors the direction in which the research should be based, contributing with the most important evidence without being too general and avoiding searches outside the previously determined axis.[9]

Thus, the question was based on the health team (P), communication tools (I), and intensive care (C). Hence, the question that guided the research was: "What are the tools used to improve communication among professionals in intensive care units that can be found in the current scientific literature?"

The survey of articles took place between April and May 2021, through a search of the following databases: Medical Literature Analysis and Retrieval System Online (MEDLINE), Latin American and Caribbean Literature in Health Sciences (LILACS) and Database in Nursing (BDENF).

The descriptors were chosen through a search in controlled vocabularies of the Descriptors in Health Science (DeHS) and the Medical Subject Heading (MeSH).

After consultation, the following terms were chosen: "Communication in Health"; "Patient safety"; "Intensive Care Units"; "Applications of Medical Informatics"; "Health Communication"; "Patient Safety"; "Intensive Care Units"; and "Medical Informatics Applications". The terms were associated by use of the Boolean operator "AND".

Articles published between 2016 and 2021 were included with full texts, in Portuguese, English and Spanish. The following types of works were excluded: duplicate articles, case reports, proceedings, editorials, letters from the editor, dissertations and theses.

The search in the databases generated an initial sample of 232 articles, of which 162 from Medline, 39 from LILACS and 31 from BDENF. A prior screening was conducted, based on the title, abstract and descriptors, to assess whether these articles fell within the inclusion and exclusion criteria of the study. Thus, 33 articles were excluded due to duplication, and another 177 articles for not meeting the theme of the study, leaving 22 manuscripts for reading in full. Subsequently, the full reading was carried out and 17 studies were excluded for not answering the guiding question. In the end, the study selected five articles, as shown in the flowchart (Figure 1).

Five articles were selected for analysis, organized by journal, authors, year of publication, title, type of study and communication tools used among the health team in intensive care.

Results

Of the five articles analyzed, three (60%) were published in 2018, one in 2017 (20%) and one (20%) in 2019. With regard to language, all five studies were published in English. With regard to the type of study, there were two (40%) literature reviews, one (20%) exploratory qualitative, one (20%) action research with content validation and one (20%) quantitative descriptive (Table 1). After reading the articles, two categories were identified: instruments for shift changes and instruments for transfer of care.

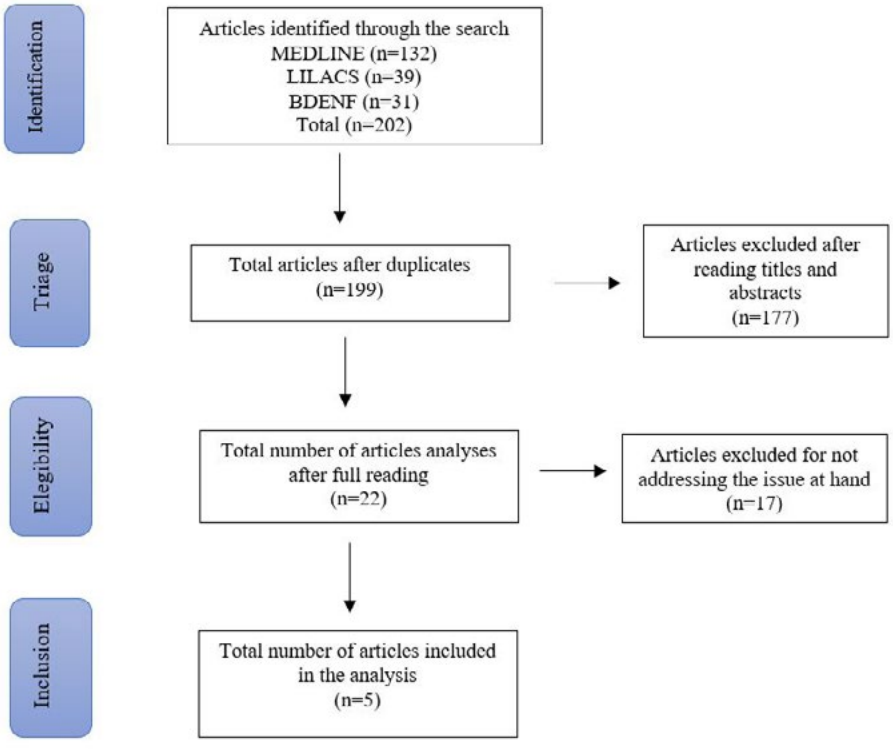

Figure 1. Flowchart of the process of search, selection and analysis of review articles

Source: Adapted from PRISMA (2015).

Table 1. Distribution of articles, according to journal, authors, year of publication, title, type of study and communication tools used among health teams in intensive care. Rio de Janeiro, RJ, 2021

Periodical/ Authors/ Year	Title	Type of study	Communication tools used among the health team in intensive care
Texto & Contexto Enfermagem/ Santos; Barros; Broca e Silva/ (2019)	Communication noise during the nursing team handover in the intensive care unit	Qualitative and exploratory	- Handover instrument
Medicina intensiva, Elsevier/ Rodríguez *et al.*/ (2018)	Handover in Intensive Care	Literature review	- Use of mnemonic tools
Escola Anna Nery/ Santos; Campos; Silva/ (2018)	Handoff communication in intensive care: links with patient safety	Integrative review	- Handoff instrument
Revista Brasileira de Enfermagem/ Corpolato *et al.*/ (2018)	Proposal for the standardization of the shift in an adult general intensive care unit	Action research, descriptive, content validation.	- Handover instrument in Checklist format - Shift change always at the bedside
Cuidarte Enfermagem/ Beccaria; Meneguesso; Barbosa; Pereira/ (2017)	Interferences in the nursing duty shift change in an intensive therapy unit	Descriptive, quantitative	- Handover instrument

Source: The authors (2022).

Discussion

Instruments for shift changes

The communication process is understood as the understanding and sharing of messages sent and received by verbal or non-verbal means, considering that the content and the way they are transmitted can influence the behavior of the people involved.[10]

Thus, we can affirm that communication among the professionals of the multidisciplinary team is essential for the safe care of patients. The risks of communication failures between these professionals can lead to errors, adverse events and a deficit in the quality of care.[11] The studies analyzed observed that communication failures among the professionals responsible for care is a weak point.[12-15]

The communication process in ICUs is complex, since this environment has its particularities, where the care of the critical patient, who is at imminent risk of death, requires close attention and continuous observation by the team, demanding immediate responses for both decision-making and adequate intervention. In this context, communication within teams needs to be effective and clear, in order to eliminate possible AEs caused by ineffective communication.[16]

Communication noise, side conversations, lack of focus on the part of the team and forgetfulness when passing on some information/intervention that was or should be provided to the patient generates vulnerability and negligent care, which can cause direct or indirect harm to the patient.[12-15]

The fast pace at which the teams conduct their tasks is considered the main reason for the difficulties in communication among professionals, leading to failures of communication within the ICU environment becoming predictable.[16]

An important element is the organization of the team during the process of change of shift. The implementation and standardization of an easy and objective instrument that presents the main items of information about the patient is essential to guide this process and remedy the flaws described above.[12-15]

To achieve this objective, professionals should be trained and guided to not abandon the narrative approach and to go through each case in detail, by presenting their assessment and the interventions that were necessary during the shift, thus carrying out a complete, clear and effective transfer of care.[12-15]

Noise in communication is directly related to incomplete or absent information about the patient, with communication focusing on intercurrences and clinical evolution during the previous 24 hours and with little appreciation of data on assessment, care plan and the patient's clinical status. Other noise in communication relates to late arrivals, low voices, side conversations and the use of cell phones. These events generate unnecessary, wrong or ineffective procedures.[12] Knowing that communication is a key instrument to ensure quality and safety in patient care, the team must receive training in order to build a cohesive and structured relationship with an adequate set of information necessary to minimize risks and improve health safety and quality, without causing harm to the patients under care.[6]

The existence of a structured process for the modalities of information transfer, emphasizing those that are considered most relevant, with adequate identification by the professional by means of mnemonic tools is useful, but must be accompanied by a narrative approach, which adds enriching nuances.[14]

In another study, the tools developed in order to optimize shift changes showed that the standardization of nursing activities and procedures contributes to the promotion of safe patient care and improvements in the quality in health services. A specific instrument is helpful in the transmission of information during shift changes in order to ensure patient safety through the standardization of this activity.[12,15]

It is important to develop a Standard Operating Procedure and an instrument for recording information, which must be validated in terms of appearance, clarity, suitability and content. If used correctly, these tools can improve shift changes in ICUs, minimizing the risk of failures in the communication process.[13]

An instrument for transfer of care helps to pass on information in full, thus reducing instances where important patient data is forgotten, while enhancing the continuity of necessary interventions, as well as improving communication within the multiprofessional team.[17]

In response to the increase in AE incidents, the Joint Commission International (JCI) points to tools for the transfer of care as means to resolve failures arising from deficient communication. Thus, communication strategies in the health organization facilitate the process of transfer of care .[18]

Other tools for effective communication, such as shift handover instruments that are standardized and in a checklist format, showed great relevance in the opinion of nurses regarding the optimization of their daily practice, when combined with the transmission of bedside information.[18]

A variety of mnemonic instruments used in practice is mentioned in the literature, of which the most recommended in hospital environments is the ISBAR (Introduction, Situation, Background, Assessment, Recommendation).[19] Mnemonic tools were described in the 1990s and include the goals, information, strategies and roles of members in a given activity.[20]

The SBAR (Situation, Background, Assessment, Recommendation) was structured in the United States of America, initially used in the US Navy and later improved for the healthcare area. It is a structured method of communication, designed to streamline communication within professional teams, by creating a standardized information structure that allows nurses to be more direct with important information and optimizes the transmission time of this information.[21] This methodology has shown evident gains in terms of the satisfaction of the teams that use the instrument. It speeds up the transmission of information, is clear and objective, and helps to define treatment goals in conjunction with the medical team, thus minimizing the incidence of errors in emerging situations.[21]

It is also the precursor of other methods, such as ISBAR and ISOBAR (I-Identification; S-Situation; O-Observation B-Background; A-Assessment and R-Recommendations), which share the same basis, differing only in that the part related to physical observation of the patient is present in the ISOBAR methodology and absent in ISBAR. These methods are used in other parts of the world, such as Australia.[21]

Ineffective communication is one of the main factors leading to the occurrence of AEs, as well as in care transitions, which is a critical situation where communication failures happen.[6]

Thus, studies consider that the effective performance of shift changes brings great benefits to health institutions, patients and all professionals, by guaranteeing the continuity of care. The quality of the information will depend on the person verbalizing it,

the time dedicated to this task, the transfer pattern used and the team's commitment to recording the necessary information.[22]

Instruments for the transfer of care

The use of an instrument for the transfer of care of a patient involves the transfer of responsibility to another team that will receive the patient, as well as the transfer of care itself.[23]

Handoff was configured as a gold protocol for the standardization of communication in patient transfers, bearing in mind the importance of communication among medical, nursing and pharmaceutical teams in the care of hospitalized patients, regarding processes involving the filling of drug prescriptions, test results, procedures, diet therapy, adverse drug reactions, comorbidities and any information relevant to the required care.[23]

The handover is an instrument used to transfer a case from one professional to another. Normally, this exchange of information about the patient occurs during shift changes, usually in exchanges between 12 or 24-hour service teams, thus characterizing a very important tool to ensure the continuity of quality care that is free from adverse events. It is a widely efficient, effective and simple protocol that has shown expressive results, guaranteeing safe care based on information about the patient's status, previous disease history, allergies, procedures performed, pending issues, among others.[24]

It is noteworthy that in intensive care, for example, there is no defined consensus on what information is essential for a flawless transfer of care, and the mention of information that is assumed to be vitally important is often forgotten. A study carried out in Rio de Janeiro showed that, despite the use of this instrument for transferring patients, professionals failed to describe significant information when transferring care between shifts. This finding corroborates the need for continuous training in communication skills to improve team engagement, as well as for follow-up action to standardize and update the instrument, as required.[25]

In another study, the data prioritized in the handover of patients were information regarding medication, water balance, patient history, invasive devices, skin lesion or integrity, therapeutic proposal, pending issues, allergy and nursing care. The authors state that subjective data, such as complaints, pain reports, family-patient interaction, coping with the disease, and fears related to diagnosis and treatment should also be taken into account in the transfer of care, in order to relate signs and symptoms and to optimize nursing care and planning.[26]

Effective communication is essential to the extent that failures in the transfer among units with no verbal passage, patient identification or omission of these, begin to become routine, since these are considered to be important enabling circumstances for potential damage. In addition, failures in relation to the assistance itself are highlighted, for example, the transmission of vital signs, which if erroneously passed, become an issue for the use of information.[23] Such information, about patients or their therapy, when cited wrongly, turns into communication noise, causing failures and damage to the effectiveness of the care provided. This disorganization can lead the client to be harmed, the quality of care provided to decrease, duplication or lack of interventions, whether therapeutic or not.[27]

Factors listed as interference in the transfer of care were described in a recent study. These included: ringing alarms that are not responded to, parallel conversations, low tone of voice, lack of clarity and objectivity, interruptions, assistance to patients during communication (especially in cases of emergency) and the ringing of cell phones. Since these are the most important enemies of communication that is free from noise and interference, those involved in this process should pay close attention in order to avoid losses generated by distractions in the information necessary for a flawless transfer.[27]

Healthcare professionals, especially nurses and nursing technicians, should recognize that standardized transfer of care improves and facilitates communication and ensures that no information is lost along the way.[28]

Knowing that communication is a key instrument to ensure quality and safety in patient care, the team must receive training in order to build a cohesive and structured relationship, with an adequate set of information necessary to minimize risks and improve health safety and quality, without generating losses and damages to the patients under care.[6]

In addition, it is important to note that the transfer of care is described as the continuity of the patient's treatment from one professional to another and includes the transfer of responsibility, and both complete and updated information about clinical status, therapeutic plan or necessary interventions.[1]

Conclusion

In view of the above, communication tools for professionals in the ICU, such as instruments for shift changes and transfer among units are effective, since they reduce the incidence of risks, damages and errors in direct patient care.

Studies on this theme are scarce, despite its great importance. Most of the articles addressed instruments for handover and transfer of care related to the patient, without showing other tools that could be used by health professionals in other situations, such as in relation to processes and the team.

Studies should be carried out to evaluate the use of tools or instruments at times other than shift change or transfer of care, and also to assess their effectiveness in common situations of communication between professionals in the ICU, such as sector organization, human resources, processes involving the prescription of drugs and other procedures.

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