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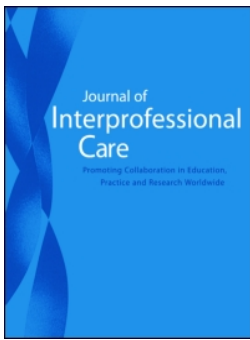
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SHORT REPORT

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## An exploratory study of healthcare professionals' perceptions of interprofessional communication and collaboration

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### ABSTRACT

Interprofessional communication and collaboration during hospitalisation is critically important to provide safe and effective care. Clinical rounds are an essential interprofessional process in which the clinical problems of patients are discussed on a daily basis. The objective of this exploratory study was to identify healthcare professionals' perspectives on the "ideal" interprofessional round for patients in a university teaching hospital. Three focus groups with medical residents, registered nurses, medical specialists, and quality improvement officers were held. We used a descriptive method of content analysis. The findings indicate that it is important for professionals to consider how team members and patients are involved in the decision-making process during the clinical round and how current social and spatial structures can affect communication and collaboration between the healthcare team and the patient. Specific aspects of communication and collaboration are identified for improving effective interprofessional communication and collaboration during rounds.

### ARTICLE HISTORY

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### KEYWORDS

Clinical rounds; coordination of care; interprofessional communication; interprofessional rounds; qualitative methods

### Introduction

Clinical rounds are an essential organisational process within the hospital setting and play an important role in the flow of clinical information and coordination of care. Key clinicians involved in the patients' care come together on a daily basis to appraise patients' progress, consult the medical record, inform the patient, and allow for collaborative planning in relation to the needs of the patient (Gurses & Xiao, 2006). Furthermore, rounds have been a principal strategy for clinical education and are considered essential for helping physicians and nurses in training to achieve clinical competence (e.g., Gonzalo et al., 2013). However, studies show that the information exchange between nurses, physicians, and patients during clinical rounds is often unstructured and patients are not fully included in the discussion about their treatment goals (e.g., Weber, Stockli, Nubling, & Langewitz, 2007).

The objective of this study was to explore perceptions of healthcare professionals (nurses, physicians, and other staff members) on effective interprofessional communication and collaboration during clinical rounds.

### Methods

We adopted an exploratory qualitative study design to explore how healthcare professionals perceive effective communication and collaboration during clinical rounds.

### Data collection

Healthcare professionals from a 1,024-bed university teaching hospital in the Netherlands were invited to attend a focus group meeting where they explored and clarified their views about the 'ideal' round through discussion. This study took place in March and April 2011 at the Academic Medical Centre in Amsterdam.

We used a purposive sampling approach to set up an interprofessional panel of healthcare professionals. Participants for the focus group interviews were invited to participate by e-mail. Selection was based on working experience of a minimum of 5 years and professional background (3 residents, 27 nurses, 5 medical specialist, and 13 hospital staff members who were engaged in quality improvement and had a background in medicine or nursing). The participants were divided over three smaller focus groups based on a mix of professional backgrounds.

The third author (RS) moderated the meetings and attempted to encourage each participant to talk freely, while the second author (ASB) assisted by asking probing questions and keeping notes during the process. The moderator and assistant (RS and ASB) are health professionals trained in paediatrics and cardiology and currently involved in management. Each meeting was audiotaped and lasted approximately 60 min. The first author (KV) transcribed each meeting verbatim utilising field notes and entered into MAXqda2. A debriefing session was held by the team after each meeting

Table 1. Themes, sub-themes, and illustrative data extracts.

Themes	Subthemes	Illustrative quotes
Structure of the medical round	Preparation	What I do find important, before the doctor and the nurse start their ward round, is that they prepare for it. This means they've carried out the necessary checks, and the nurses know what questions they want to ask. (Quality improvement officer D3:8)
	Timing of the medical round	I think you have to be prepared to shake off old habits. For example, we all talk about doing, say, ward rounds in the morning. We all have a fixed way of thinking. Why shouldn't you do ward rounds in the afternoon? (Nurse D2:3)
Decision-making	Communication tool	The patient does have a problem list, for which actions have been organized. And it's important that these actions are followed up. Has any action been undertaken? Have the tests been done? Have the things been measured that should have been measured? (Physician D3:2)
	Membership	I think it's a very important opportunity for communication between the nurse and the doctor, where nurses explain their views about the patient, and where doctors explain how they are thinking and the direction in which they see the management of the patient going. (Nurse D1:5)
	Roles and responsibilities	I don't totally agree with that, always discussing things with a nurse. Because that suggests that the junior doctor should make decisions in such a way that the nurse agrees. After all, the junior doctor makes a lot of decisions in which the nurse has no input. (Physician D3:4)
	Knowledge and expertise	I don't just make medical decisions during a ward round, so... I mean they [doctors] decide on management, and decisions are based on that. [...] It seems to me that you discuss something together and of course as a nurse you can give advice, but it's the doctor who makes the final decision. That seems perfectly clear to me. (Nurse D3:9)
Care planning	Knowledge and expertise	Yes, that should happen, and it saves a lot of time, because then decisions are made straight away. Doctors in training have to be able to think for themselves, that's a must. But in reality the supervisor is immediately involved in everything, and helps out straight away in making decisions; so the nursing staff doesn't have to wait an unnecessarily long time for an answer. (Physician D2:2)
	Learning on the job	Yes, they're not the ones leading the discussion [senior nurse]; the patient's primary nurse does that. But they're the ones who will report when things are going systematically wrong on the ward and who give feedback to the nurse. (Nurse D3:5)
	Participating in decision-making process	Short-term care planning is focus for physician: A 24-h care plan is the maximum I think. (Physician D2:5) Long-term care planning is focus for nurses: I'd also like to see a care plan for the patient. This should include discharge and transfer of course, but maybe it should also include what the patient's needs are if he's transferred to a nursing home or to home care; what the patient is physically and mentally capable of, and draw up a care plan for that. (Nurse D2:5) Well I think so; if I think of my own field, nursing, you have to make sure that after 4 years the nurses can do a ward round on their own. If you never let trainee nurses do the ward round and all of a sudden after qualifying they are expected to do it, then I wonder how capable they would be of doing it. (Nurse D1:4) So you must be given the opportunity—it sounds a bit strange when you're talking about patient care—to make mistakes. Providing someone corrects you, these are the sorts of mistakes—faulty reasoning, faulty decision-making—that you learn the most from. So the more you think for junior doctors (I'm really against it), the greater the risk that they never become independent. (Physician D3:2)
Patients' role	Participating in decision-making process	Active role of patients: I think [...] that the patient has an important role to play in decision-making. You have to give the patient the opportunity to participate in what's happening. (Nurse D1:6)
	Geographical movement across spaces	Non-active role of patients: I think the patient should know what tests he's going to have, but that's completely different from getting them involved in decision-making. (Physician D2:5) Two-stage spatial organisational structure of the medical round excluding patients: Patients should have a role. I think both, yes, maybe it's rather specific, but on our ward we have a 'sit-down' pre-ward-round briefing at the computer, when we look at everything in the system. And then we go to the patients to tell them what we've discussed. Takes a bit more time perhaps, but it means you've got the complete picture. (Physician D1:3) One-stage spatial organisational structure of the medical round including patients: In an ideal situation you'd do the whole ward round by the bedside, because then you can check everything with the patient, and the patient knows straight away where he stands. And then you don't just give the patient a summary of something, which means things get overlooked. (Quality improvement officer D1:1)

to evaluate the quality of the session, improving the skills of the team and checking the responses.

### Data analysis

A three-person team (KV, BB, and SG) with research backgrounds in nursing, health sciences, and medicine followed a general qualitative, descriptive method of content analysis. Asking the participants to confirm whether the interpretation of the results was correct increased the credibility of the data.

### Ethical considerations

This study was approved in February 2011 by the Medical Ethics Committee of the Academic Medical Centre in Amsterdam.

### Results

Three major themes emerged that present suggestions to improve interprofessional communication and collaboration between the healthcare professionals and patients on a general medical ward. Themes, subthemes, and illustrative quotes are shown in Table 1. From the perspectives of the healthcare professionals, structuring the round could contribute to effective communication and collaboration between healthcare professionals. Second, according to the participants, nurses and physicians were the main participants of the decision-making process during the round and had different views on care planning. Last, the participants disagreed about patients' role in decision-making. Some healthcare professionals only wanted to inform patients about the outcome of the round, others wanted to give the patient an active role in the decision-making process during the round.

### Discussion

The results from this study suggest a number of barriers and facilitators which affect effective interprofessional communication and collaboration during rounds between health professionals. First, our results suggest that the structure of rounds can be improved on several domains. Preparation was identified as a key element to conduct effective clinical rounds. It has been suggested before that holding a pre-round briefing not only helps physicians and nurses in gathering all the relevant patient information, but also in raising their comfort level (Abdool & Bradley, 2013). Participants identified that the organisation and planning of the round needs to be re-prioritised. Currently, the round takes place in the morning, which is one of the busiest moments of the day. Clinical rounds could be timetabled and hospitals could rethink their processes to ensure better collaboration and delivery of care (Dingley, Daugherty, Derieg, & Persing, 2008). According to the participants, a communication tool can be used to improve interprofessional communication and collaboration. Others (Thomassen, Storesund, Softeland, & Brattebo, 2014) have found that using a safety checklist in medicine to structure communication reduces adverse events, morbidity, and mortality. In addition, the ward round lead could summarise the daily plan for the patient and set goals for the next 24 h till discharge, which

is also the primary goal of the daily round according to the participants.

Second, our results also suggest that members of the interprofessional team have different views on care planning. Nurses are focused on and have an active voice in decision-making about longer-term care planning, such as discharge planning. On the other hand, physicians are more focused on short-term care planning, such as diagnosis and treatment. However, participants agree that discussing both short- and long-term care planning are important in discharge planning. Furthermore, participants differed about the roles and responsibilities during the round. Physicians reported to have the leading and decisive role in medical decision-making. Therefore, a clear division of roles and responsibilities can support the organisation of the round. However, strong leadership is required to strengthen communication between physicians and nurses and develop a team culture. Leaders of teams must ensure that all members of the team are involved in decision-making (Hale & McNab, 2015). Participants expressed that interprofessional communication and collaboration in clinical rounds improves when members of the team are equipped with the right clinical knowledge and expertise. Currently, junior health professionals lead the round, which are in a training process. The presence of a senior nurse or supervisor at the round could improve the efficiency and safety of the care process. Furthermore, training and educating needs of junior health professionals could be identified during the round.

Last, the participants, who were hesitant to include patients in decision-making, described that patients did not have the right resources to actively participate in decision-making. Our results are in line with others (Legare & Witteman, 2013), showing that involving patients in decision-making has not been widely adopted by healthcare professionals. In addition, the spatial structure of the medical round can be another reason for patients' passive role in decision-making during the round. The participants expressed that decisions are made across different spaces during the round and patients were not considered to be a member of the interprofessional team. Others (Liu, Manias, & Gerdtz, 2013) have described that the use of space is associated with the level of active engagement of nurses, physicians, and patients. However, involving the patient in discharge management, for example, shows positive results in patient outcomes such as reduced length of stay and hospital readmission (Coleman, Parry, Chalmers, & Min, 2006).

This study has a number of limitations. For example, we conducted a small explorative study at a single university teaching hospital, which limits the transferability of findings from this study setting to others. The study is also limited as we did not explore the views of patients and other healthcare professionals such as therapists or social workers.

### Concluding comments

In summary, the findings of our study indicate that it is important for healthcare professionals to consider how team members and patients are involved in the decision-making process during the medical round and how current social and spatial structures can affect communication and collaboration between the healthcare team and the patient. This study identified specific aspects of

communication and collaboration for improving effective inter-professional communication and collaboration during the medical round. Future research should explore the views of patients on effective communication and collaboration during rounds.

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## Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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