Team Name: Critical Care and Medicine Team Team Lead: Director - Acute Community Hospitals Approved by: Regional Lead - Acute Care & Chief Nursing Officer	Reference Number: CLI.4510.PL.009 Program Area: Across Hospital Units Policy Section: General
Issue Date: March 4, 2019 Review Date: Revision Date: October 17, 2023	Subject: Communication Whiteboard in Acute Care

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POLICY SUBJECT:
Communication Whiteboard in Acute Care

PURPOSE:
To outline expectations in the use of the Communication Whiteboard for patients in hospital.

BOARD POLICY REFERENCE:
Executive Limitation (EL-01) Global Executive Restraint & Risk Management
Executive Limitation (EL-02) Treatment of Clients

POLICY
The Communication Whiteboard is an evidence-informed practice implemented to:
- involve the patient and family/designates as active members in their treatment plans, discharge planning and promote the patient's highest level of independence and safety;
- support discharge planning on admission by enhancing communication of actions required by the patient and heath care team to achieve ultimate recovery and discharge goals, inclusive of an estimated discharge date;
- provide staff with individualized patient care planning needs (i.e. transfer techniques);
- prepare the patient both psychologically and physically for planned tests or treatments and for discharge, inclusive of arrangements for transportation; and
- provide a mechanism for patients, their family or designates to document questions they have for healthcare team members.

It is expected that the Communication Whiteboard is populated and updated every shift.

DEFINITIONS:

Communication Whiteboard - a dry erase board located at each bedside that serves to document aspects of the patient's care, treatment plan and discharge goals and is readily available for each patient, family or designate and healthcare team member. While each patient room has a generic Communication Whiteboard, in Obstetrics Units, they contain sections specifically adapted for the birthing person and baby.

IMPORTANT POINTS TO CONSIDER:

- To achieve the purposes of the Communication Whiteboard, it is critical that the information be documented and updated on every shift.
- Areas supporting safe care for patients and staff must be completed within 24 hours of admission, including the sections reflecting patient's name or initial, staff's need to Use Care upon the Violence Prevention Program screening process, the patient's risk to fall, for skin breakdown and the transfer and bed mobility technique to be used.
- A Communication Whiteboard in a patient's room that is not updated can send subtle messages to the patient that communication with them and involving them as an active member in their care and treatment plan is not a priority.
- Patients are provided information on the use of the Communication Whiteboard and their role in using same within the Patient Handbook in Acute Care (CLI.4510.PL.008).

PROCEDURE:

1. The Communication Whiteboard is mounted on the wall in proximity to the inpatient bed.
2. Provide each patient with electronic access to or a hard copy of "What you and Your Family Need to Know" handbook on admission that encourages their active participation with the healthcare team in planning their care, treatment and discharge. It also explains the purpose of the Communication Whiteboard.
3. Invite patients to document their questions and "What is Important to Me" on the whiteboard for the healthcare team to review. Patients can request that certain information not be documented on the whiteboard.
4. Documented information on the patient's Communication Whiteboard are compliant with the Personal Health Information Act. If in doubt about writing information, discuss same with the patient and seek their verbal consent. Document the discussion and outcome in the patient's Integrated Progress Note and Kardex if they wish that certain information not be written on the Communication Whiteboard. Information on the Communication Whiteboard is of a general nature.

Example of appropriate and inappropriate statements:

Appropriate Statements	**Inappropriate Statements**
Waiting for Dr. D. Smith Consult	Surgery Consult
Note date of tests/appointments-to St Boniface General Hospital Feb 3/12	Colonoscopy 03/12 SBGH
IV Antibiotics for 3 days	IV A/B
Waiting for blood work	Waiting for white blood count
Weaning off oxygen	Titrating O2

Occupational therapy, physiotherapy	OT/PT
Standing appointment at Health Sciences Centre MWT 10am	Treatment plan for dialysis
Instruction at 1:30, 3:30	Diabetic teaching
Teaching at 1:30	Teaching you how to use your urinary bag
Walk with 1 person to bathroom	SBA

5. The admitting nurse documents the known patient care components on the Communication Whiteboard. Areas supporting safe care for patients and staff must be completed within 24 hours of admission, including the sections reflecting patient's name or initial, staff's need to Use Care upon the Violence Prevention Program screening process, the patient's risk to fall, skin breakdown and the transfer and bed mobility technique to be used.
6. Nurses and Health Care Aides assigned to the patient maintain and update the Communication Whiteboard with their name at the start of every shift during bedside reporting.
7. At each shift, the patient's assigned nurse maintains and updates all information components of the Communication Whiteboard reflective of the patient's treatment plan documented in their health record, Kardex or care plan.
8. Allied health team members actively involved in the care of the patient also document their name and designation and update appropriate areas of the Communication Whiteboard. This may include Social Worker, Physiotherapist, Occupational Therapist, Dietician, Speech Language Pathologist or other.

Completion of Communication Whiteboard:

Within 24 hours of admission and as required, complete the essential Communication Whiteboard care plan sections including:

1. Patient's name or initials
2. Use Care: The risk for patients to experience responsive or violent behavior is noted in the **Use Care section**, and is critical to inform providers of risk and patient specific care plan measures to be implemented.
3. Risk for falls: The patient's **Risk for falls** is noted when the patient assessment identifies a risk for falls or the patient has fallen. Patients are informed of their risk for falls and are provided information on their role in preventing falls and safety measures to reduce the risk of falls. The patient's documented care plan is reviewed by staff and identifies individual care plan interventions that are to be implemented.
4. Skin Breakdown: The patient's **Risk for Skin breakdown** section is completed based on risk assessed within the Braden Scale. The **Reposition section** is completed as per individual patient needs. Patients are informed of their risk for pressure injury and are provided information on their role in preventing pressure injuries. The patient's documented care plan is reviewed by staff to identify the individual care plan interventions that are to be implemented to prevent pressure injuries.
5. Transfer and bed mobility technique to be used: The **Transfers and Bed Mobility** section identifies the representative logo with the transfer technique assessed as required for each individual patient and is consistent with the Safe Client Handling Injury Prevention Program

(SCHIPP). Patients are assessed before each mobilization change. If the staff member does not feel that the patient can be safely mobilized using the noted logo technique, the patient is reassessed by a nurse or physiotherapist and the transfer technique is updated on the patient's care plan, chart and communication whiteboard. The patient is informed of their role in supporting safe transfers and mobility.

6. The assigned nurse or other healthcare provider as appropriate completes the **Goals of mobility** section, identifying patient goals that will assist in their recovery. Example: walk 4 times per day to the window.
7. Complete the **Pain Scale** section as applicable by asking the patient to identify their level of pain. Evaluate pain management throughout the shift and update accordingly. Monitor and update throughout the patient's stay. Document the pain using a scale of 0 – 10 as indicated by the patient, including the time assessed.
8. Document the **Estimated Discharge Date** once the healthcare team have collaborated with the patient on the plan of care and treatment. Discharge planning starts at time of admission and is adjusted based on patient condition and care plan. Note date and time of discharge and update as more information is known. Example: Discharge when Home Care services are in place. Estimated Friday March 2, 2019. Discharge Planning is critical to assisting the patient/family to prepare and make arrangements for discharge.
9. Complete the **Tests/Appointments** section with information on upcoming tests or appointments to provide the patient/family with information for planning purposes. Example: Health Sciences March 9, 2019 1000 am for test. Family/designate to transport.
10. Complete the **Personal aids/devices section to readily identify** hearing aids, glasses and dentures that patients require to support optimal function.
11. Complete and update as indicated the **Intake/Output, nutritional requirements and restrictions section to** readily inform providers and the patient of requirements within their treatment plan.
12. Encourage the patient, family or designate to complete the **Patient/Family Communication/What Matters to You** section with any questions they have for the Health Care team and identify what is important to them during their stay.
13. The Health Care team reviews any questions noted on the communication whiteboard and responds directly with the patient, family or designate and erases the question one it has been discussed with the patient.

<u>Completion of the Communication Whiteboard for Obstetrics:</u>

For Obstetrics, the health care provider will **also** complete within 24 hours of admission and update as required the following sections on the Communication Whiteboard for Obstetrics:

- Maternity Section
    - Birthing person's name or initials
    - Pain Management Plan/Treatment
        - Update throughout Labour, Delivery and Postpartum.
        - Assess Pain routinely using the **Pain Scale** and document treatment based on patient specific care plan.
        - Complete postpartum (PP) self-medication program (see Medication Self Administration CLI.6010.PL.046).

- Estimated Discharge: Plans for discharge are updated for both patient and newborn.

- Newborn Section
  - Newborn's Name, Birthdate and Time of Birth
  - Newborn Care
  - Collaborative communication and sharing between the health care team and parents of the newborn, is updated frequently as the newborn care plan evolves.

Incorporate and update the Communication Whiteboard with all care transitions to with the intended goal of involving the patient as an active partner with the health care team in treatment and discharge planning leading to safer care and better patient outcomes. The Communication Whiteboard is a reflection of the care requirements within the patient Kardex/care plan and health record.

On Discharge or **transfer** erase all information on the communication whiteboard as part of terminal cleaning procedures.

Staff Education

The Health Care Team reviews this policy and the Communication Whiteboard mockups (CLI.4510.PL.009.SD.02 and CLI.4510.PL.009.SD.04) as part of their orientation to familiarize themselves with expectations and their role in the use of the Communication Whiteboards.

Quality Improvement

At minimum bi-annually, complete the Communication Whiteboard in Acute Care Audit (CLI.4510.PL.009.FORM.01):

- The Regional Centres conduct the audit by reviewing 10 patient rooms/communication whiteboards on each inpatient unit (exception: Obstetrics units: 5 patients CLI.4510.PL.009.FORM.02).
- The Acute Community Sites conducts the audit by reviewing a minimum of 5, maximum of 10 patient rooms/communication whiteboards on each inpatient unit.

The local interdisciplinary team reviews audit results, identifies opportunities for improvement and develops an action plan. The results and the action plan are submitted to the respective program.

SUPPORTING DOCUMENTS:

CLI.4510.PL.009.FORM.01	Communication Whiteboard in Acute Care Audit
CLI.4510.PL.009.FORM.02	Communication Whiteboard for Obstetrics Audit
CLI.4510.PL.009.SD.01	Communication Whiteboard in Acute Care
CLI.4510.PL.009.SD.02	Communication Whiteboard in Acute Care Mockup
CLI.4510.PL.009.SD.03	Communication Whiteboard for Obstetrics
CLI.4510.PL.009.SD.04	Communication Whiteboard for Obstetrics Mockup
CLI.4510.PL.008	Patient Handbook in Acute Care
CLI.6010.PL.046	Medication Self Administration