DAILY COMMUNICATION BETWEEN CLINICIANS AND INPATIENTS/FAMILIES

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Please find following a summary of a literature search and relevant results. All articles can be provided in full - email library@monashhealth.org for a list of the articles you require.

QUESTION

Is there a gold standard for clinician to patient and family communication for hospital inpatients – the what, who, and when of standard daily communication.

RESULTS

ONLINE RESOURCES (GREY LITERATURE)

INFORMATION FROM OTHER HEALTH SERVICES

The Royal Children's Hospital Melbourne. (2023). **Nursing clinical handover** [nursing guideline]. Link.
- "The involvement of patients and their families/carers in the paediatric setting during handover is an important tool to maintain communication and promote family cantered care."

Western Health. (2020). **Updating N.O.K. Cheat Sheet (ICU)**. Link.
- To be used by staff when providing a routine update to patients' NOK during COVID-19.

Western Health. (2019). **Childrens' Ward Operating Guideline**. Link.
- See pp. 8-9 – describes bedside nursing handover and medical handover, both of which involve communicating with patients and/or families

Peninsula Health. (2019). **Frankston Hospital Patient and Visitor Information Guide**. Link.
- "Nursing handover takes place at your bedside at each change of shift. …Peninsula Health encourages you, and if you wish, your family, to be involved in handover discussions in order for you to be informed and involved in your care and treatment options."

Alfred Health. (n.d.). **Keeping you safe & comfortable** [patient information]. Link.
- "Clinical handover involves the sharing of information between staff involved in your care, including you and your family."

CONFERENCE ABSTRACTS & POSTERS – ACUTE CARE

Note that these items are abstracts and posters only; no full-text is available. Click the links to view the abstract or poster in its entirety.

B. McGillen, et al. (2023). **Innovating family patient centered rounding for inpatient acute care rounds**. *Journal of Hospital Medicine*, *18*(Supplement 1), S415. View available information (p. 415). Conclusion(s): FPCR in adult medicine is a novel concept that has the potential to increase value in patient care. The inclusion of a support person in the rounding process can help decrease repetitive

testing, improve discharge planning, unify patients and their support system with the healthcare team, and improve adherence to overall care plans.

T. Pedersen et al. (2022). **Using IT systems to improve the frequency of family and next of kin updates**. *Future Healthcare Journal.* View available information.
This quality improvement project (QIP) aimed to assess how often the multidisciplinary team (MDT) updates NOK on the complex care wards in North Bristol NHS Trust (NBT). Previous attempts to use ward round prompt sheets to prompt doctors to update NOK were found ineffective in improving the frequency of NOK update. This cycle implemented the use of the IT application 'Careflow' to document when NOK updates occurred. This was used as a prompt for discussion at the twice-daily MDT board round on Gate 28b (a complex care ward in NBT).

S. L. Rose, et al. (2022). **Plan of care visits: An innovative standardized communication process for bedside engagement**. *Journal of General Internal Medicine*, *37*(Supplement 2), S188-S189. VIew available information (pp. 188-189)
Plan of Care Visits (POCV) is a standardized bedside rounding process in which the daily plan of care is discussed with patients, nurses, and clinicians as equal partners. We examined the associations of POCV occurrence documented in the EMR and patient perceptions of POCV with patient experience. CONCLUSION(S): While documenting POCV in the EMR was not associated with patient experience or reduced readmissions, when patients found them frequent and helpful, POCV were strongly associated with better patient experience and reduced readmissions.

CONFERENCE ABSTRACTS & POSTERS – CRITICAL CARE

Note that these items are abstracts and posters only; no full-text is available. Click the links to view the abstract or poster in its entirety.

L. Karnatovskaia, et al. (2023). **Family communication in the ICU: challenges and solutions**. *Critical Care Medicine*, *51*(1 Supplement), 274. View available information.
We surveyed an interprofessional group of medical intensive care unit (MICU) stakeholders to identify their concerns surrounding family communication and solicited recommendations for performance improvement. Our rounding template was modified to discuss the family communication plan each day using a tiered structure (brief summary/introduction on admission; update; serious update/acute event; goals of care; transition to comfort) and clarify which team members will be present for the conversation. Afternoon rounds were also modified to routinely confirm successful family contact and address any concerns.

A. Thomson, et al. (2021). **Improving communication and family connection with a new asynchronous video messaging service within adult critical care, during the COVID-19 pandemic**. *Anaesthesia*, *76*(SUPPL 5), 70. View available information (p. 70).
We implemented a new secure method of asynchronous video messaging, called vCreate (Windsor, UK). This tool, previously used in the neonatal critical care setting, was an entirely new concept in adult critical care and it provided a means to send regular visual updates via pre-recorded videos to document patient progress.

S. Au, et al. (2019). **Determining best practices for family participation in ICU rounds**. *Chest*, *156*(4 Supplement), A1034. View available information.
Current guidelines recommend inviting family members of ICU patients to attend bedside rounds as a way to improve communication. However, there is little guidance as to how participation can be optimized so that family members feel valued as team members while respecting the vulnerabilities associated with having a critically ill loved one. We aimed to define key structures and processes,

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facilitators and barriers to patient-and-family-centered (PFC) ICU rounds, and practices or "tools" to maximize and mitigate these factors, respectively.

M. N. Jaffa, et al. (2017). **Multimodal communication enhances family centered care in the neurocritical care unit (NCCU)**. *Neurocritical Care*, *27*(2 Supplement 1), S282. View available information (p. 282).
We examine implementation of a multimodal communication strategy on clinician utilization, family engagement and satisfaction in the NCCU. Four interventions were implemented: family communication boards were installed in patient rooms; family engagement pamphlets developed; a script and schedule for family care rounds was developed; nursing and provider staff were educated on inviting families to participate in patient care team rounds.

PEER-REVIEWED LITERATURE – MOST RECENT FIRST

Articles are grouped as follows:

- Communication models & frameworks
- Family-centred rounds – Adult
- Family-centred rounds – Paediatric
- Virtual family-centred rounds
- Bedside nursing handover
- Asynchronous communication

Each article summary contains excerpts from the abstract and an online link.

COMMUNICATION MODELS & FRAMEWORKS

A. Jazieh, et al. (2018). **Involving the Family in Patient Care: A Culturally Tailored Communication Model**. *Global Journal on Quality and Safety in Healthcare*, *1*(2), 33–37. Full-text.
Our aim was to develop a patient- and family-based communication model suitable for societies with extended families. Results: A communication model was developed keeping the patient in the center of communication but involving the family through identifying the most responsible family member. To assure structured measurable contact, mandatory points of communication were defined. The model streamlines communication with the family but maintaining the patients' rights and autonomy. Conclusion: Our proposed model of communication takes into account the importance of communication with the family in a structured way. The team believes that it is going to be accepted by patients who will be explored in the pilot implementation stage as the next future step.

J. B. Seaman, et al. (2017). **An Integrated Framework for Effective and Efficient Communication with Families in the Adult Intensive Care Unit**. *Annals of the American Thoracic Society*, *14*(6), 1015-1020. Full-text.
We argue that because no single platform can achieve all communication goals, an integrated strategy is needed. We present a model that integrates multiple communication platforms to effectively and efficiently support families across the arc of an ICU stay. Our framework employs bedside/telephone conversations and family-centered rounds throughout the admission to address high informational needs, along with well-timed family meetings that attend to families' emotions as well as patients' values and goals. This flexible model uses various communication platforms to achieve consistent, efficient communication throughout the ICU stay.

FAMILY-CENTRED ROUNDS – ADULT

A. Calderone, et al. (2022). **Family Presence on Rounds in Adult Critical Care: A Scoping Review**. *Critical care explorations*, *4*(11), e0787. Full-text.
Family presence on rounds involves allowing family members to participate in daily healthcare team rounds and is recommended by critical care professional societies. The main objective of this study was to explore the impact of family presence on adult ICU rounds on family and healthcare providers. DATA SYNTHESIS: There were 16 studies included. Family reported family presence on rounds as a means of information transfer and an opportunity to ask care-related questions. Family presence on rounds was associated with increased family satisfaction with care, physician comfort, and improved physician-family relationship. Healthcare providers reported a positive perception of family presence on rounds but were concerned about patient confidentiality and perceived efficacy of rounds. Family presence was found to increase rounding time and was felt to negatively impact teaching and opportunities for academic discussions.

A. Kosack, et al. (2022). **Improving Patient Experience Scores Using Simultaneous Interpretation on Family-Centered Rounds**. *Hospital pediatrics*, *12*(12), 1019-1035. Full-text.
There is no gold standard for providing inpatient medical interpretation on family-centered rounds (FCR). We aimed to implement simultaneous, in-person interpretation of FCR for Spanish-speaking families and hypothesized improved satisfaction in care. METHODS: In-person, Spanish Equipment-Assisted Simultaneous Medical Interpretation (EASMI) was implemented in March 2018 on FCR. CONCLUSIONS: EASMI was associated with significant improvements in Child HCAHPS scores in communication domains and increased medical team and family members' satisfaction with interpretation. EASMI presents a novel method for equitable FCR for Spanish-speaking families.

S. S. Au, et al. (2021). **Best practices toolkit for family participation in ICU rounds**. *Journal of evaluation in clinical practice*, *27*(5), 1066-1075. Full-text.
Guidelines recommend inviting family members of intensive care unit (ICU) patients to rounds. We aimed to create a toolkit to support family participation in ICU bedside rounds, based upon evidence from research and in collaboration with ICU family member representatives and healthcare providers. CONCLUSION: There is consensus on general strategies for facilitating family participation in rounds and meaningful communication between family and the healthcare team during rounds as an important element of the continuum of communication in the ICU. The incorporation of these elements should be standardized, though tailored to user needs.

J. Ludmir, et al. (2019). **Family-Centered Care in the Intensive CareUnit-What Does Best Practice Tell Us?** *Seminars in respiratory and critical care medicine*, *40*(5), 648-654. Request full-text.
Family-centered care relies on an interdisciplinary approach. Its components include daily family-centered rounds, frequent family meetings, and ensuring an adequate family support environment. Each of the components of family-centered care depend on adequately trained clinical staff who are champion in empathetic communication and constantly support family member throughout an ICU stay.

U. Weber, et al. (2018). **Dedicated Afternoon Rounds for ICU Patients' Families and Family Satisfaction With Care**. *Critical care medicine*, *46*(4), 602-611. Full-text.
It was hypothesized that adding dedicated afternoon rounds for patients' families to supplement standard family support would improve overall family satisfaction with care in a neuroscience ICU., DESIGN: Pre- and postimplementation (pre-I and post-I) design. SETTING: Single academic neuroscience ICU. PATIENTS: Patients in the neuroscience ICU admitted for longer than 72 hours or made comfort measures only at any point during neuroscience ICU admission. INTERVENTION: The

on-service attending intensivist and a neuroscience ICU nursing leader made bedside visits to families to address concerns during regularly scheduled, advertised times two afternoons each week. CONCLUSIONS: Dedicated afternoon rounds for families twice a week may not necessarily improve an ICU's overall family satisfaction. Increased dissatisfaction among families who do not or cannot participate is possible.

FAMILY-CENTRED ROUNDS – PAEDIATRIC

A. Khan, et al. (2024). **Implementing a Family-Centered Rounds Intervention Using Novel Mentor-Trios**. *Pediatrics*, oxv, 0376422). Full-text.
Patient and Family Centered I-PASS (PFC I-PASS) emphasizes family and nurse engagement, health literacy, and structured communication on family-centered rounds organized around the I-PASS framework (Illness severity-Patient summary-Action items-Situational awareness-Synthesis by receiver). We assessed adherence, safety, and experience after implementing PFC I-PASS using a novel "Mentor-Trio" implementation approach with multidisciplinary parent-nurse-physician teams coaching sites. CONCLUSIONS: Hospitals successfully used Mentor-Trios to implement PFC I-PASS. Family/nurse engagement, safety climate, and harms improved in larger hospitals and hospitals with better nurse engagement and intervention adherence. Patient/family experience and teaching were not affected.

A. J. Knighton, et al. (2021). **Implementing Family-Centered Rounds in Hospital Pediatric Settings: A Scoping Review**. *Hospital pediatrics*, *11*(7), 679-691. Full-text.
The American Academy of Pediatrics and Institute for Patient and Family-Centered Care issued a joint policy statement in 2012 recommending family and nurse participation in rounds as a standard practice. OBJECTIVE: To synthesize available evidence on the state of the implementation of family-centered rounds (FCRs), including identified barriers to stakeholder acceptance and participation in FCRs in pediatric inpatient settings and implementation strategies to increase adherence and related outcomes. RESULTS: FCRs are increasingly accepted by stakeholders, although participation lags. Structural barriers to nurse and family attendance persist. The lack of a clear, consistent definition of the elements that combine for a successful FCR encounter remains a significant barrier to measuring its effect.

J. Boydston. (2018). **Use of a standardized care communication checklist during multidisciplinary rounds in pediatric cardiac intensive care: a best practice implementation project**. *JBI database of systematic reviews and implementation reports*, *16*(2), 548-564. Full-text.
This project aimed to improve thoroughness and continuity of care of patients in a pediatric cardiac intensive care unit. Specific objectives were to increase support of clinical nurse and family participation in multidisciplinary rounds (MDR), as well as full use of a multi-component Complex Care Checklist (CCC) by all nurses in this unit. Nurse participation in daily patient rounding enhances individualized goal-setting. Concomitant use of a communication checklist promotes comprehensive delivery of care. CONCLUSIONS: Project aims of enhanced thoroughness and continuity of care of patients with congenital heart defects were realized through an improved MDR process enhanced with a care communication checklist and clinical nurse participation.

A. Khan, et al. (2018). **Patient safety after implementation of a coproduced family centered communication programme: multicenter before and after intervention study**. *BMJ (Clinical research ed.)*, *363*(8900488, bmj, 101090866), k4764. Full-text.
OBJECTIVE: To determine whether medical errors, family experience, and communication processes improved after implementation of an intervention to standardize the structure of healthcare

provider-family communication on family centered rounds. SETTING: Pediatric inpatient units in seven North American hospitals, 17 December 2014 to 3 January 2017. INTERVENTION: Families, nurses, and physicians coproduced an intervention to standardize healthcare provider-family communication on ward rounds ("family centered rounds"), which included structured, high reliability communication on bedside rounds emphasizing health literacy, family engagement, and bidirectional communication; structured, written real-time summaries of rounds; a formal training programme for healthcare providers; and strategies to support teamwork, implementation, and process improvement.

VIRTUAL FAMILY-CENTRED ROUNDS

E. Shawley, et al. (2023). **Interprofessional Telerounds in a Pediatric Intensive Care Unit: A Quality Improvement Project**. *Critical care nurse*, *43*(5), 9-16. Full-text.
LOCAL PROBLEM: A 36-bed academic, tertiary care pediatric hospital implemented telerounds during the COVID-19 pandemic. After visiting restrictions were lifted, nurses were interested in continuing telerounds for families who could not attend daily rounds. The aim of this evidence-based quality improvement project was to develop a standardized, family-centered telerounding process that satisfied parents, nurses, and physicians. CONCLUSIONS: This project demonstrated that a standardized process of secure telerounding was feasible in a pediatric intensive care unit. Families, nurses, and physicians reported satisfaction with the process. Telerounds can be implemented without considerable inconvenience to staff and enable continuation of family-centered care when parents are absent from the hospital.

M. Buba, et al. (2023). **Virtual family-centered rounds: a quality improvement initiative to adapt inpatient care during COVID-19 using a human-centred participatory design approach**. *BMC pediatrics*, *23*(1), 289. Full-text.
BACKGROUND: Family-centered rounds (FCR) are fundamental to pediatric inpatient care. During the COVID-19 pandemic, we aimed to design and implement a virtual family-centered rounds (vFCR) process that allowed continuation of inpatient rounds while following physical distancing guidelines and preserving personal protective equipment (PPE). RESULTS: Seventy-four percent (51/69) of health care providers surveyed and 79% (26/33) of patients and families were satisfied or very satisfied with vFCR. Eighty eight percent (61/69) of health care providers and 88% (29/33) of patients and families felt vFCR were useful. Audits revealed an average vFCR duration of 8.4 min (SD = 3.9) for a single patient round and transition time between patients averaged 2.9 min (SD = 2.6).,

E. A. Stelson, et al. (2016). **Perceptions of Family Participation in Intensive Care Unit Rounds and Telemedicine: A Qualitative Assessment**. *American journal of critical care : an official publication, American Association of Critical-Care Nurses*, *25*(5), 440-7. https://dx.doi.org/10.4037/ajcc2016465
OBJECTIVES: To examine perspectives of patients' family members and health care providers on family participation in rounds in the surgical intensive care unit (ICU) and the potential use of telemedicine to facilitate this process. RESULTS: Both patients' family members and health care providers described inconsistent practices surrounding family participation in ICU rounds as well as barriers to and facilitators of family participation. Family members identified 3 primary logistical challenges to participation in ICU rounds: distance to hospitals, work/family obligations, and the rounding schedule. Both family members and providers reported receptivity to virtual participation as a potential solution to these challenges.

BEDSIDE NURSING HANDOVER

E. Van de Velde, et al. (2024). **Implementing bedside handovers in mental health care: Insights from an experience-based co-design**. *Patient education and counseling*, *119*(pec, 8406280), 108051. Full-text.
OBJECTIVES: Bedside handovers have the potential to provide opportunities to increase patient involvement in mental health care. However, limited research has been conducted on this subject., METHODS: In this study, we investigate the suitability of experience-based co-design as a method for designing bedside handover in mental health care., RESULTS: The article discusses the goals of bedside handover, the preferred structure and content of the handover, its location and frequency, and the familiarization involved in it., CONCLUSIONS: EBCD proved to be a suitable method of making recommendations for involving patients in nursing handover in a mental healthcare unit of a general hospital., PRACTICE IMPLICATIONS: Nurses and mental health care patients agreed on the ISBARRT model to structure bedside handovers.

S. Cho, et al. (2022). **Systematic Review of Quality Improvement Projects Related to Intershift Nursing Handover**. *Journal of nursing care quality*, *37*(1), E8-E14. Full-text.
Nursing handover is a real-time process in which patient-specific information is passed between nurses to ensure the continuity and safety of patient care. PURPOSE: The purpose of this study was to determine the effects of quality improvement (QI) projects in improving the intershift nursing handover process. RESULTS: The handover methods used in the 22 QI projects could be broadly divided into 2 types: (1) using a standardized communication tool; and (2) involving patient-participation bedside handover. CONCLUSIONS: The published research on intershift handover-related QI projects employed standardized communication tools and the patient-participation bedside handover method to reduce adverse events and handover times and increase the satisfaction of patients and nurses.

M. Street, et al. (2022). **Enhancing active patient participation in nursing handover: A mixed methods study**. *Journal of clinical nursing*, *31*(7-8), 1016-1029. Full-text.
AIMS AND OBJECTIVES: To explore: i) the frequency and nature of patient participation in nursing handover and ii) patients' and nurses' perceived strategies to enhance patient involvement in nursing handover. DESIGN: A multi-site prospective study using a mixed methods design. CONCLUSIONS: The main finding was that patient participation in handover was low and strongly influenced by a complex interplay of factors including patient and nurse preferences and perceptions. RELEVANCE TO CLINICAL PRACTICE: Handover is an essential tool in the provision of safe patient care. Patients were able to actively participate in nursing handover when they understood the purpose and timing of handover and had rapport with nurses.

S. Ghosh, et al. (2021). **Impact of Structured Clinical Handover Protocol on Communication and Patient Satisfaction**. *Journal of patient experience*, *8*(101688338), 2374373521997733. Full-text.
Single arm experimental trial was conducted to assess the effect of standard Situation, Background, Assessment, Recommendation (SBAR) protocol implementation in overall bedside nursing handover process, patient satisfaction, and nurses' acceptance. There was a statistically significant difference (P < .05) in median scores between the pre and post-intervention group on overall nursing handover and patient satisfaction regarding nursing handover. Standardization of patient's handover process is effective in terms of improving nursing handover process, patient satisfaction, and health professionals' acceptance.
Note: Checklist includes items related to communicating with patients.

G. Tobiano, et al. (2019). **Patient participation in nursing bedside handover: A systematic mixed-methods review**. *International journal of nursing studies*, *97*(gs8, 0400675), 63-77. Full-text.
OBJECTIVES: To explore how patient participation in nursing shift-to-shift bedside handover can be enacted. CONCLUSIONS: Our review showed the tension between standardising handovers and making them predictable for patient participation, while promoting tailored and flexible handovers. Further investigation of this issue is required, to understand how to train nurses to achieve this and prepare patients to do this. Many barriers and strategies identified were from QI projects and the nurse perspective, thus caution interpreting results is required.

A. Kullberg, et al. (2019). **Improved patient satisfaction 2 years after introducing person-centred handover in an oncological inpatient care setting**. *Journal of clinical nursing*, *28*(17-18), 3262-3270. Full-text.
AIMS AND OBJECTIVES: To investigate patients' satisfaction with care, 2 years after the introduction of person-centred handover (PCH) in an oncological inpatient setting, and to describe patients' perceptions of individualised care. DESIGN: A survey-based design was used with one data collection period. Patient satisfaction scores were compared with baseline data from a previous study that has been conducted in the same wards. RESULTS: Compared to the previous study, statistically significant improvements in patient satisfaction were observed in the subscales "Exchange of information between caregivers" and "Nurses' information provision" postimplementation of PCH. RELEVANCE TO CLINICAL PRACTICE: Person-centred handover seems to improve patients' satisfaction with nurses' provision and exchange of information. Nurses and managers should carefully consider the implementation process of PCH and evaluate its long-term effects.

S. Malfait, et al. (2019). **The effectiveness of bedside handovers: A multilevel, longitudinal study of effects on nurses and patients**. *Journal of advanced nursing*, *75*(8), 1690-1701. Full-text.
AIMS: To investigate the effectiveness of bedside handovers. For nurses, effects on nurse-patient communication, individualized care, coordination of the care process, job satisfaction, intention to leave, patient participation and work interruptions were measured. For patients, effects on patient activation, individualized care and quality of care were measured. CONCLUSION: The results indicate that bedside handover can be regarded as superior to more commonly used handover models as it enhances patient participation and decreases work interruptions. However, the positive image of bedside handovers, mostly based on observational, short-term and single-centred experiences, cannot be confirmed as there were no effects on any of the other measured parameters. As bedside handovers put patient participation on the agenda and negative effects are absent, implementing bedside handovers should be considered a mean for more patient-centeredness instead of a goal itself.

ASYNCHRONOUS COMMUNICATION

W. E. Thinnes, et al. (2023). **Written Communication, Visitation Policies, and Awareness of Medical Issues Among Intensive Care Unit Families**. *American journal of critical care : an official publication, American Association of Critical-Care Nurses*, *32*(4), 302-306. Full-text.
OBJECTIVES: To determine whether written communication increased awareness of medical issues among ICU families and whether the effect size depended on the visitation policies in place when participants were enrolled. METHODS: Families of ICU patients were randomly assigned to receive usual care with or without daily written patient care updates from June 2019 to January 2021. CONCLUSIONS: Written communication helps families correctly identify ICU issues. The benefit may be enhanced when families cannot visit the hospital.

S. Law, et al. (2023). **Engaging patients, families and professionals at the bedside using whiteboards**. *Journal of interprofessional care*, *37*(3), 400-409. Request full-text.
Whiteboards have emerged as a best practice in hospitals to promote engagement and improve information and communication, yet with limited empirical evidence regarding their value to patients, families, or interprofessional teams. We introduced whiteboards on an acute medical unit at a community hospital and conducted an evaluation using a pre-post design collecting both qualitative and quantitative data. Qualitative results highlighted improvements in communication between the care team and patients as well as family members. Implications for practice include attention to patient/family empowerment and safety, adherence to guidance for good communication, and support for regular training and education in the use of communication tools for members of the interprofessional team.

J. L. Bulger, et al. (2021). **Written Care Summaries Facilitate Communication Between Families and Providers of ICU Patients: A Pilot Study**. *Critical care explorations*, *3*(7), e0473. Full-text.
ICU providers may invite families to participate in daily rounds to inform them of the patient's condition and to support their emotional well-being. Daily written summaries of care may provide complementary benefits. DESIGN: Qualitative interviews with surrogates of ICU patients who received daily written summaries of care. SETTING: Single, urban academic medical center. INTERVENTIONS: Daily written summaries detailed each of the patient's main ICU problems, the presumed causes of each of the problems, and the medical team's plan to address each of the problems for each ICU day. MAIN RESULTS: There were four ways that written summaries affected the participant's experience: 1) providing clarity to participants regarding the patient's condition, 2) facilitating participant understanding of the patient's clinical course, 3) facilitating communication between participants and medical providers, and 4) facilitating communication between participants and other family members.

L. V. Grossman, et al. (2018). **Implementation of acute care patient portals: recommendations on utility and use from six early adopters**. *Journal of the American Medical Informatics Association : JAMIA*, *25*(4), 370-379. Full-text.
Objective: To provide recommendations on how to most effectively implement advanced features of acute care patient portals, including: (1) patient-provider communication, (2) care plan information, (3) clinical data viewing, (4) patient education, (5) patient safety, (6) caregiver access, and (7) hospital amenities. Recommendations: We summarize the experiences of 6 organizations that have implemented acute care portals, representing a variety of settings and technologies. We discuss the considerations for and challenges of incorporating various features into an acute care patient portal, and extract the lessons learned from each institution's experience.

APPENDIX

SEARCH METHODOLOGY

A systematic search was conducted for literature. The results were screened by librarians using Covidence.

SEARCH LIMITS

- English-language
- Published within the last 7 years

DATABASES SEARCHED

- Medline – index of peer reviewed articles across health sciences and medicine.
- Embase – index of biomed and pharmacological peer reviewed journal articles.
- Emcare – index of nursing, allied health, critical-care medicine and more.
- Cochrane Library – collection of databases containing high-quality independent evidence.
- Grey literature – Google, Google Scholar, Trip database, Biomed Central Proceedings.

ADDITIONAL SEARCHING

- Reference checking should be undertaken for the most relevant articles.

SEARCH TERMS

Concept	MeSH headings	Keywords
Clinician-patient	Professional-Patient Relations/, Nurse-Patient Relations/, Physician-Patient Relations/, Professional-Family Relations/	Clinician(s) or physician(s) or nurse(s/ing) or doctor(s) or surgeon(s) or worker(s) or provider(s) or staff or allied health + patient(s) or family or families or carer(s) or consumer(s) or inpatient(s) or in-patient(s) or NOK or next-of-kin. Medical or surgical or clinical + staff or personnel or team(s) or unit. Health(care) professional(s) or health care professional(s) or health(care) practitioner(s) or health care practitioner(s).
Communication	*communication/, *health communication/	Routine(ly) or daily or regular(ly) or frequent(ly/cy) or schedule(d/ing) or set time(s) + communicate(d/s/ing/ion) or update(d/s) or updating or phone or phonecall(s) or call or calls or SMS or text message(s/ing) or contact(ed/ing). Telephone or SMS + update(s/d/ing). Communicat(e/d/ing/ion) + model or framework(s) or plan(s/ing/ned) or policy or policies or procedure(s) or protocol(s). Medical or nursing + update(s/ing/ed). Family or families or carer(s) or NOK or next-of-kin + participat(e/s/d/ing) + round(s). Family(ies) + round(s).

Inpatient setting	Hospitalization/, exp Hospitals/, Inpatients/, exp Hospital Units/, Adolescent, Hospitalized/, Child, Hospitalized/	Inpatient(s) or in-patient(s) or ward(s) or hospital(s) or ICU or academic medical center(s) or academic medical centre(s) or acute care or trauma center(s) or trauma centre(s) or bedside or bed-side. Admission or inpatient(s) or in-patient(s) or hospital + unit(s) or department(s) or wing. Patient(s) + admission or admitted.
Gold standard/best practice	Practice Guidelines as Topic/, Benchmarking/, Consensus/, Consensus Development Conferences as Topic/, Consensus Development Conference/, Practice Guideline/	Best practice(s) or Gold standard(s) or guideline(s) or Recommend(ed/ation/s) or Consensus or exemplar or standard practice.

MEDLINE SEARCH STRATEGY

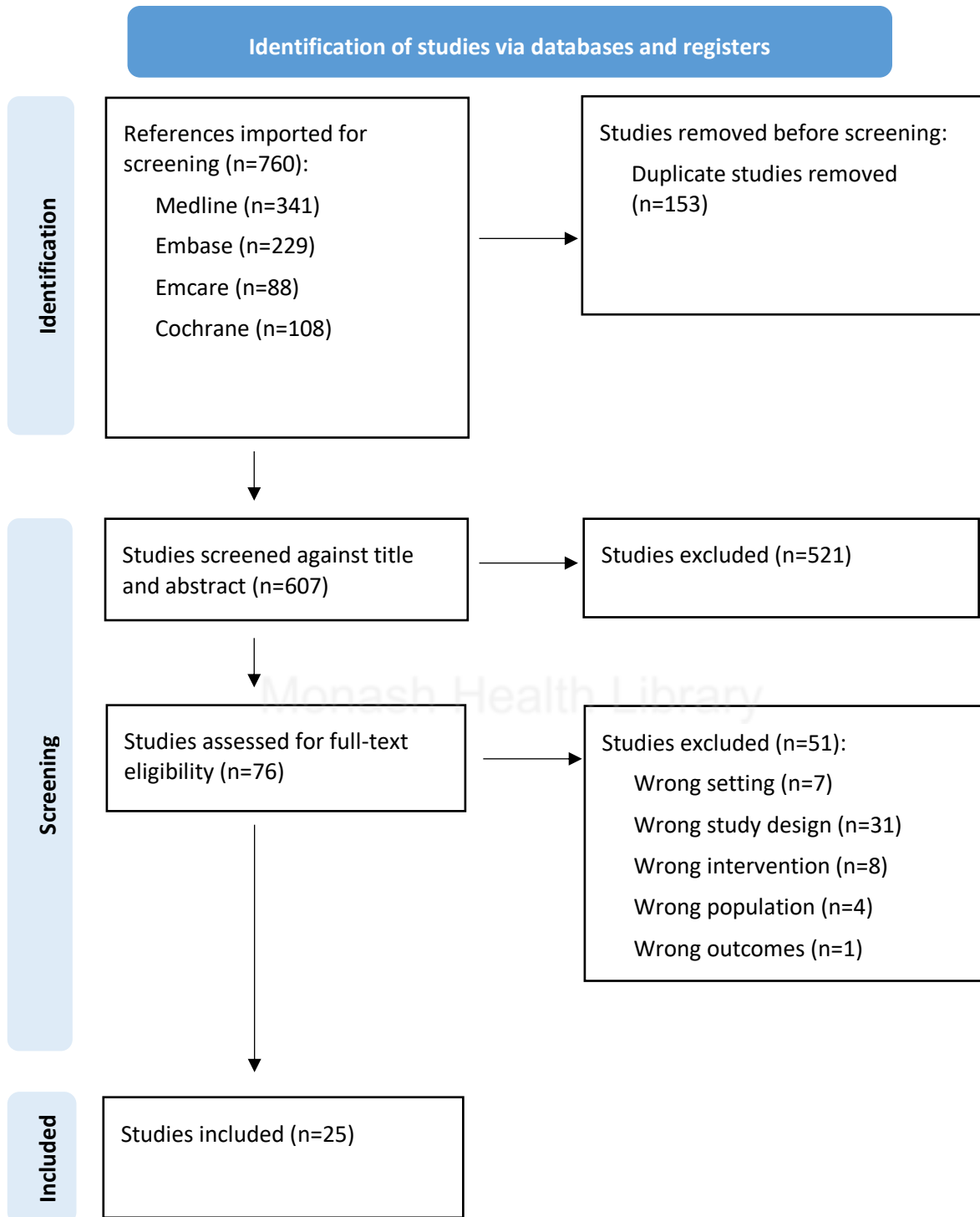Ovid MEDLINE(R) ALL <1946 to January 17, 2024>

1   Professional-Patient Relations/ or Nurse-Patient Relations/ or Physician-Patient Relations/ or Professional-Family Relations/   151711
2   ((clinician* or physician* or nurs* or doctor* or surgeon* or worker* or provider* or staff or allied health) adj5 (patient* or family or families or carer* or consumer* or inpatient* or in-patient* or NOK or next-of-kin)).tw,kf.   362393
3   (((medical or surgical or clinical) adj (staff or personnel or team* or unit*)) and (patient* or family or families or carer* or consumer* or inpatient* or in-patient* or NOK or next-of-kin)).tw,kf.   34648
4   ((health* professional* or health care professional* or health* practitioner* or health care practitioner*) adj5 (patient* or family or families or carer* or consumer* or inpatient* or in-patient* or NOK or next-of-kin)).tw,kf.   24168
5   1 or 2   476415
6   (*communication/ or *health communication/) and (routine* or daily or regular or frequen* or schedul* or set time*).tw,kf.   4627
7   ((routine* or daily or regular* or frequen* or schedul* or set time*) adj4 (communicat* or update* or updating or phone or phonecall* or call or calls or SMS or text messag* or contact*)).tw,kf.   26568
8   (((telephone or SMS) adj2 updat*) and (routine* or daily or regular* or frequen* or schedul* or set time*)).tw,kf.   13
9   ((communicat* adj3 (model or framework* or plan* or policy or policies or procedure* or protocol*)) and (routine* or daily or regular* or frequen* or schedul* or set time*)).tw,kf. 1318
10   (((medical or nursing) adj update*) and (routine* or daily or regular or frequen*)).tw,kf. 12
11   ((family or families or carer* or NOK or next-of-kin) adj3 participat* adj3 round*).tw,kf.   33
12   (famil* adj3 round*).tw,kf.   505
13   6 or 7 or 8 or 9 or 10 or 11 or 12   31977
14   Hospitalization/ or exp Hospitals/ or Inpatients/ or exp Hospital Units/ or Adolescent, Hospitalized/ or Child, Hospitalized/   590410
15   (inpatient* or in-patient* or ward* or hospital* or ICU or academic medical center* or academic medical centre* or acute care or trauma center* or trauma centre* or bedside or bed-side).tw,kf.3718978
16   ((admission or inpatient* or in-patient* or hospital) adj10 (unit* or department* or wing)).tw,kf.   192498
17   (patient* adj4 (admission or admitted)).mp. 167650
18   14 or 15 or 16 or 17   3930112
19   Practice Guidelines as Topic/ or Benchmarking/ or Consensus/ or Consensus Development Conferences as Topic/ or Consensus Development Conference/ or Practice Guideline/   202635

20   (Best practice* or Gold standard* or guideline* or Recommend* or Consensus or exemplar or standard practice).tw,kf.   1512992

21   19 or 20 1591437

22   5 and 13 and 18 and 21   305

23   limit 22 to (english language and last 7 years)   150

Note: A multifaceted search strategy was employed, in addition to the base search above. Contact your Monash Health librarian for more information.

PRISMA CHART

Identification of studies via databases and registers

Identification

References imported for screening (n=760):

Medline (n=341)

Embase (n=229)

Emcare (n=88)

Cochrane (n=108)

Studies removed before screening:

Duplicate studies removed (n=153)

Screening

Studies screened against title and abstract (n=607)

Studies excluded (n=521)

Studies assessed for full-text eligibility (n=76)

Studies excluded (n=51):

Wrong setting (n=7)

Wrong study design (n=31)

Wrong intervention (n=8)

Wrong population (n=4)

Wrong outcomes (n=1)

Included

Studies included (n=25)

www.monashhealth.org/library