



First Responder Accreditation

Topic 7:

Communication and Documentation

Acknowledgements

This resource has been put together to assist you in completing your First Responder Accreditation workbook.

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Introduction

Effective communication ensures that groups can work together and ensure the job is done. Communication is often difficult in a first aid environment. This module covers the importance of effective communication, some strategies for improving your communication in a first aid environment, the use and importance of patient records as a communication tool and effective handover.

Barriers to effective communication

Effective communication is very important and often challenging in first aid settings. This can be for many reasons such as:

- The patient may be distressed or scared;
- The patient may be confused;
- It may be noisy and difficult to hear (e.g. you are on duty at a music festival);
- The presence of drugs or alcohol;
- Cultural or language barriers;
- Use of medical terminology that is not understood by a non-clinical person.

Strategies for effective communication

There are a number of things to consider when attempting to communicate with patients, colleagues, friends or family of patients, members of other organisations (Ambulance officers, SES volunteers, Police Officers, etc.) or event organisers.

It is often helpful to put yourself in the shoes of the person you are trying to communicate with. This may help you to understand why your communication is not working.

Some strategies include:

DO	DON'T
<ul style="list-style-type: none">✓ Speak slowly and clearly✓ Make eye contact where possible✓ Keep it simple and accurate✓ Remain calm and confident✓ Be informative✓ Make written records (see next section on Patient Records)✓ Build a rapport with the patient to ease their fear and build trust between you and the patient	<ul style="list-style-type: none">✗ Raise your voice✗ Waffle✗ Use terminology that is inappropriate to the audience✗ Be aggressive✗ Criticise or make fun of someone when they don't understand you

For information about some of the important factors to consider when communicating with culturally diverse groups please refer to the Cultural Diversity and Communication document found at <http://members.stjohn.org.au>.

Patient records

All patients who are treated or advised must be documented on a Patient Record. These are important medical records and are a vital communication tool for the organisation. In order for these records to be effective, they must be completed clearly and accurately.

Why do we need patient records?

Patient records are important legal documents that serve a number of purposes including:

- Legal record of treatment or advice provided
- Important statistical data regarding the services provided by St John
- Risk management

Important considerations for effective patient records

There are a number of important things to remember when completing a patient record:

- Always use a pen (not a pencil) and write as clearly as possible.
- Write factual information (not opinions)
- The patient record must be completed by the person who treated the patient
- Do not use abbreviations
- Errors must have a single line drawn through them and must be initialled by the writer
- If you need to use more than one page, number the pages
- Ensure you complete the form and don't forget to sign and date it
- Always respect privacy and do not use the form for any other purpose

Please refer to the St John Patient Record document found on the St John members connect website: <http://members.stjohn.org.au> for more information about how to complete patient records.

Handover

As a First Responder you are likely to be required to perform an effective handover. When you have completed this module, you will be able to explain the need for a succinct, structured and relevant clinical handover between providers of clinical care, list the necessary information to be communicated during a clinical handover and perform a clinical handover of a patient with non-urgent and urgent clinical needs.

Effective clinical handover aims to ensure patient safety in the transfer of responsibility and accountability for the care of a patient. Handover should be viewed as part of the provision of safe patient care. As with most processes, handover is most effective when a systematic approach is applied. The communication of the information needs to be clear and accurate. St John members may be required to provide clinical handover either to an ambulance officer or other healthcare professional or to a fellow member at the end of a shift. The key element of clinical handover is to have a structured and systematic approach.

There are many structures already in use for an effective handover. The tool which is used does not specifically matter as long as there is a structure and that key information is communicated. The most commonly used prehospital structure is MIST, MISTO, Mr or Mrs MIST and more recently IMIST AMBO¹:

MIST

M	M echanism of injury / M edical complaint
I	I njuries / I nformation relative to the presentation
S	S igns (including vital signs - LOC, HR, RR, BP, Temp, SpO2 as appropriate)
T	T reatment and T rends (care provided and the effect of this care)

MrsMIST

Mrs	Mr / Mrs (a reminder to introduce the patient by name and age)
M	M echanism of injury / M edical complaint
I	I njuries / I nformation relative to the presentation
S	S igns (including vital signs - LOC, HR, RR, BP, Temp, SpO2 as appropriate)
T	T reatment and T rends (care provided and the effect of this care)

MISTO

M	M echanism of injury / M edical complaint
I	I njuries / I nformation relative to the presentation
S	S igns (including vital signs - LOC, HR, RR, BP, Temp, SpO2 as appropriate)
T	T reatment and T rends (care provided and the effect of this care)
O	O ther relevant information (that is relevant – many include AMPL also)

¹ Young et al., 2010, Ambulance service of NSW

IMIST AMBO

I	Identification (name and age)
M	Mechanism of injury / Medical complaint
I	Injuries / Information relative to the presentation
S	Signs (including vital signs - LOC, HR, RR, BP, Temp, SpO2 as appropriate)
T	Treatment and Trends (care provided and the effect / response to this care)
A	Allergies
M	Medications
B	Background (medical history)
O	Other issues

Handover ideally should be delivered uninterrupted. Following handover clinicians should clarify any outstanding issues. It is imperative that medications administered (and the timing of this) whilst in your care are communicated to subsequent care providers. A comprehensive patient handover is preferred to a poorly completed patient record. The patient record can be completed following the handover to ensure that all clinical information is documented contemporaneously for later reference. You should ensure that all patient demographic information is recorded prior to the patient leaving your care (including telephone number).

ISBAR

Another handover tool being used in Australian health care settings is ISBAR. An interactive tool is available at

http://nswhealth.moodle.com.au/DOH/DETECT/content/00_worry/when_to_worry_06.htm

This tool is recommended for clinical support settings where you may be discussing a patient with another clinician remotely by radio or telephone (such as a clinical support line or to on-site health professionals).

I	Introduction	Identify yourself, your role and your location
S	Situation	State the patients problem/s or reason for presentation
B	Background	State the patient's background or context
A	Assessment	State the clinical observations [Ensure current LOC, HR, RR, BP, Temp, SpO2 are known] State what you think the problem is.
R	Request / recommendation	What are you requesting? What do you want the advising clinician to do? <ul style="list-style-type: none">○ See the patient○ Give advice○ Advise on management○ Reassure○ Provide a recommendation