Effective Communication saves lives: extra Q&A

As the speakers were not able to answer all the questions at the time, they answer some of the remaining questions here.

Question: How do you factor in or disregard the fact that some patients do not want to communicate their health details up to the point of critical incidents - eg opting out of my health record?

Answer: Health communicators need to be respectful of patients' wishes and adapt accordingly.

Question: My elderly parents had great difficulty understanding health practitioners with a strong accent. They lived in any area where most practitioners had such accents. I lived interstate and had to travel to be with them when they needed medical help. However, I was not allowed to answer for them, so did my best to act as a translator. Also, once my dad developed dementia, I still wasn't allowed to answer for him - so he would say he didn't have any problems, but he did. Any comment?

Answer: On the issue of elders struggling with a clinicians' unfamiliar accent: the clinician has a responsibility to make themselves understood. If this is difficult, clinicians should support the patient to have language support for themselves to understand the clinician (analogous to a clinician arranging an interpreter, but in this case, the patient arranges the "interpreter"), which as you say is often the family member. Once your father developed dementia, there needed to be a heightened awareness that he might not be competent and seek additional support to understand his needs. Both these seem like cases where "patient autonomy" is used to justify poorer care.

Question: I have seen nurses handing over at the bedside but I've never seen doctors do that. I wonder whether it would be possible because it might turn into more of a ward round and not be efficient time-wise.

Answer: Good point. There are places where doctors do hand over at the bedside (ICU, NICU, etc). More interesting would be a handover of the patient to the doctors (see http://familyintegratedcare.com/about-ficare/). Takes training, patience and time.

Question: Would anyone on the panel be able to suggest an approach to communicating to another healthcare member or treating team that they have made a mistake?

Answer: This happens all the time and there are different approaches. I'm not sure if the question relates to a medical error? The simplest is to do this in an informal way - a discussion between health practitioners. Outlining what happened, where a mistake happened, how it happened, and (maybe together) think of how to avoid this in the future. More formally, patients are discussed in MM meetings or quality safety meetings – that's where an analysis of system errors should be done and suggestions for improvement (is it

education? Time? IT? Protocols?) made. It is hard to admit to a mistake - but necessary for all to share and learn from them. And, of course, this should also be communicated to the patient/carer.

Question: Hanna do you think that your voice recording would work in a team discussion with multiple persons taking turns talking? This is a key challenge in MDT case discussions. We tend to lose key discussion points in our clinical records every day in Mental Health.

Answer: Indeed, a discussion in a noisy environment is a lot harder case for automated speech recognition than, e.g., a single clinician recording their speech in a quiet office environment. Some steps to take towards a solution here are for each clinician in the discussion to have their own (directed noise cancelling lapel) microphone (to be used to identify when they are speaking and then use their tailored speech recognition engine on their speech) and one or more microphones in the room to facilitate noise filtering. In addition to my papers (e.g., https://link.springer.com/article/10.1186/1472-6947-14-94 and https://medinform.jmir.org/2015/2/e19/), I recommend having a look at, e.g., https://academic.oup.com/jamia/article/23/e1/e169/2379888, https://academic.oup.com/jamia/article/26/4/324/5315910 , https://arxiv.org/pdf/2008.11897.pdf, and https://onlinelibrary.wiley.com/doi/abs/10.1111/jocn.15261 .

Question: What learnings can we take from this about refining our everyday interactions to ensure that a real understanding is reached?

Answer: practice 'teach back'. But that barrier of not wanting to seem 'dumb' when asking questions has a long history. Without tackling this and seeing questions as a safety measure we have a long way to go.

Question: I am interested in the assumptions behind Hanna's reverse question to Paul. Could you give us some more detail about what you mean by information loss - perhaps an example? And how the conclusions you drew were arrived at?

Answer: The statistics I used and argument I made were as follows: Regardless of verbal handover being accurate and comprehensive, anything from two-thirds to all of this information is lost after three to five shift changes if handover notes are not taken or they are taken by hand (Pothier et al., 2005; Matic et al., 2011). In contrast, effective clinical handover has been shown to reduce communication errors in healthcare as well as improve patient safety and care (Australian Commission on Safety and Quality in Health Care, 2012). See https://academic.oup.com/jamia/article/22/e1/e48/702116 and references therein for more information. Please note that the statistics provided by Prof Slade's more recent work emphasise my argument; their severity percentage is even higher. As she summarised these findings in the event advertisement, "In Australia alone it is estimated that 500,000 people per year are harmed by the hospitals they go to for help, that is, they suffer from an avoidable or preventable critical incident caused by something in the hospital. When these incidents are investigated over 90% are found to have a communication failure component—these can be misunderstandings between patients and clinicians, for example with diagnosis or treatment options or illegible patient records, or for omissions and failures to clarify ambiguities and confusions in the handover process. Hundreds of patients we have interviewed say they don't feel heard, they often don't understand what is being said to them and all too frequently they are not even part of the conversation about what's happening to them."

Question: Can the panel provide some Communication Strategies that are widely used in facilitating effective health communication?

Answer: There are some systems aiming to standardise certain common situations. For handover use ISBAR, for escalating concerns use CUSS or PACE models.

Question: Misinterpretation can happen even in the same English language we use on a day to day basis among clinicians alike and that's where errors happen in my clinical field. What are the panel's views on this?

Answer: Appreciating the importance of communication and knowing where the breaks in patient safety are likely to occur, which is often communication and use a known structure tool for communicating at all stages.

Question: This webinar has been excellent, is there a way we can register our interest for upcoming events from the Institute so we don't miss out?

Answer: Yes, you can join our mailing list from our website: https://slll.cass.anu.edu.au/centres/ich/home

Question: Thank you for the great discussion. Can you please let us know how do we access the recording?

Answer: Yes, you can access the recording at this link: https://youtu.be/xc1bCgdaqFs

Many thanks to all participants for their excellent questions!