

Communicating with consumers and carers

Part 1 Pilot of evidence-based selection of communication strategies to improve communication between consumers/carers and health services



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1. Introduction

Section 01

The Victorian Quality Council (VQC) is responsible for fostering better quality health services in Victoria by working with stakeholders to develop useful tools and strategies to improve health service safety and quality.

1. Introduction

Evidence-based medicine is widely recognised as a critical underpinning of the delivery of high quality health care.¹⁻³ The importance of evidence-based medicine is reflected in Goal 5 of the *VQC Strategic Plan 2005–2008*,⁴ which is to promote safe and appropriate care by supporting and enabling clinicians to apply the best available evidence to clinical practice.

Communicating with consumers and carers is an important issue for both the VQC and the Victorian Department of Human Services. The VQC has a commitment to improving health care through the involvement of consumers. Goal 1 of the *VQC Strategic Plan 2005–2008* is to support governance and leadership in health care organisations in order to develop a culture of quality and safety improvement by:

- engaging and educating boards, managers, clinicians, consumers and other stakeholders
- encouraging, valuing and utilising consumer participation.⁴

Victoria is a leading state in the development of a policy framework for promoting good communication with, and participation by, consumers and carers in health care, from the level of individual interactions through to decision making at the levels of ward, department, service and the Department of Human Services. In early 2006 the Victorian Government released *Doing it with us not for us: Participation policy 2006-09*,⁵ which sets the strategic direction for the next three years.

This paper reports on the processes and lessons of an innovative pilot project established by the VQC, which aimed to extend the concepts and practices of evidence-based decision making for clinical care to quality improvement where communication issues were identified as paramount and can be improved.

In addition to outlining the lessons from the pilot, the information is collated into a six-step guide to assist health services to improve communication with consumers and their families, by applying an evidence-based approach to quality and safety improvement activities for effective approaches to communication. The guide is available separately at: www.health.vic.gov.au/qualitycouncil



2. Communication issues that affect the safety and quality of health care

Section 02

Communication in hospitals

Communication is integral to all aspects of health care, and can be as complex as clinical care. Countless different communication tasks are associated with health care, such as communicating with people about appointments, waiting lists, treatment and discharge.

2. Communication issues that affect the safety and quality of health care: Communication in hospitals

Communication between consumers and carers, and health services and professionals has many purposes:

- to inform a consumer when they will receive treatment and what to do when they come into hospital
- to share with a clinician health information and preferences for treatment or end-of-life care
- to involve a patient in a treatment decision
- to communicate with another department about a patient
- to ensure that a patient knows what is happening regarding their care
- to discuss options for treatment with a family member
- to educate staff to equip them with new skills, such as how to communicate bad news.

Communication and quality and safety improvement

The importance of communication to safety and quality issues has been identified in several key areas, highlighting communication as an area with opportunities for safety and quality improvement.

Analysis of sentinel events identified that poor communication between health professionals and consumers and/or their families was a contributing factor in a substantial number of those reported to the sentinel event program of the Department of Human Services (DHS) Victoria.⁶

Communication accounted for 12 per cent of complaints to the Health Services Commissioner in 2005, and was a feature of all complaints, regardless of the primary issue. 'Failure to consult' and 'wrong or misleading information' accounted for 30 per cent of communication complaints.^{7, 8}

For consumers, communication is a process of exchange — not just the provision of information by health professionals to people. The implication is that while at an individual level, good communication is embedded in relationships, the number of staff encountered in any one hospital episode of care means that good communication

must be supported by institutional support, systems, resources, policies and education.

The importance of good communication is a major theme in patient feedback literature.⁹ A summary of reports by consumer groups found that people identified that they wish:

- to be communicated with regarding their illness, treatment and care
- to be involved in decision making about their treatment, according to preference
- to be informed and make informed consent
- to have access to interpreters
- to be treated with respect
- to have their privacy respected
- not to be subject to discriminatory behaviour.

Consumers also reported that they do not always receive information about symptoms to watch out for when they are discharged from hospital.¹⁰

Consumers involved in the decision making in their own care have improved health outcomes.¹¹ In order to make decisions, consumers require comprehensive information that is presented in an appropriate manner, and they need opportunities to discuss the available options with a clinician.

Non-attendance for booked surgery is a significant proportion of day-of-surgery cancellations. Thus improving communication with patients on specific issues such as attending hospital for surgery may lead to more efficient use of resources.¹²



Improving communication

Victoria is a leading state in the development of a policy framework for promoting good communication with and participation by, consumers and carers in health care — from the level of individual interactions through to decision making at the levels of ward, department, service and the Department of Human Services. In early 2006 the *Doing it with us not for us: Participation policy 2006-09* policy framework⁵ was released, which sets the strategic direction for the next three years. This framework strengthens the importance of communication and participation at all levels of the health system.

Improving the quality and effectiveness of communication between consumers/carers and health professionals and services should lead to improvements in:

- knowledge and understanding of treatment and care processes amongst consumers/carers
- communication with patients, including greater involvement in care by consumers/carers
- confidence and skills of staff in communicating in difficult circumstances
- greater awareness of patients' knowledge and preferences by clinicians
- increased consumer/carer satisfaction with care
- health status and wellbeing of patients
- consumer health behaviours such as healthy and/or safe behaviour
- health service performance, for example, reduced waiting times or fewer adverse events.

Communication is a complex process that occurs in a variety of settings and circumstances. Several factors influence the quality and effectiveness of the communication, including:

- individual preferences
- behaviour, attitudes, language spoken and culture of consumers, carers and clinicians
- the ability of consumers to hear, read, understand and share health information and preferences for care
- the time, resources and environment available.

Ineffective communication can have serious impacts on consumer/carer experience, satisfaction and health outcomes. Therefore, improving communication has the potential to improve the quality and safety of health care and consumer/carer satisfaction. Effective strategies to improve the quality of communication between consumers/carers and hospitals need to be tailored to the purpose of the communication.

3. Effective communication strategies

Section 03

Overview of the literature

There is a plethora of available literature in the area of health communication in addition to several Cochrane¹³⁻¹⁸ systematic reviews of trials of communication and participation interventions. These reviews identified that some communication strategies are more effective than others, and were selected to illustrate the increasing availability of systematic reviews and controlled trials to test, evaluate and summarise the evidence of effects of interventions and the range of interventions available for different purposes (see Table 1).

3. Effective communication strategies

High quality trials of clinical interventions in communication are not always available or feasible for ethical or practical reasons. There may be gaps, such as, no systematic summary of the evidence or no good quality trials of an intervention. Improving communication in health care requires a deliberative process of examining the best available evidence — not just evidence from systematic reviews. Effective quality improvement activities rely on a combination of the best available evidence, experience and judgment of hospital staff, consumers and carers, and consensus regarding best practice. This is the basis of an evidence-informed approach.

An intervention-based approach to communication and participation

A broad definition of an intervention is an action or program with a coherent objective to bring about certain identifiable outcomes.¹⁹

Taking an intervention-based approach to communication means that each communication strategy can be assessed in terms of the characteristics of interventions. These characteristics include that the strategy is:

- purposeful and planned
- formalised
- structured
- explicit
- repeatable
- sequenced
- modifiable
- classifiable.

Communication interventions are then targeted at achieving a specific outcome, for example, compliance with a health management plan or attending a scheduled appointment (see Table 1 for more examples). Communication interventions can also be assessed for effectiveness in the same way that a treatment or medication is evaluated.

Table 1: Interventions for communication and participation — examples for key processes in hospitals

Common interactions or processes	Relevant communication interventions
Seeking treatment in the emergency department	<ul style="list-style-type: none"> ○ Communication with patient/family member during triage ○ Use of interpreters ○ Pamphlets on how to manage minor illness
Making appointments/ attending for treatment	<ul style="list-style-type: none"> ○ Booking letter ○ Patient reminder systems ○ Communication protocols involving: phone calls, letters, handouts, verbal instruction, translated materials ○ Use of interpreters
Diagnostic tests	<ul style="list-style-type: none"> ○ Personalised information on risks ○ Test-request-report protocols which include information for treating doctors and patients ○ Communicating the outcome of a test ○ Counselling for unclear or 'bad' results ○ Communication of genetic risk assessment
Decision making for treatment	<ul style="list-style-type: none"> ○ Information pamphlet ○ Decision aids to involve people in treatment decisions ○ Personalised risk information ○ Advance directives ○ Family and treating clinicians' conference
Treatment	<ul style="list-style-type: none"> ○ Informed consent, involving verbal plus written information ○ Communication about the outcome of the intervention or procedure ○ Family teamwork to maintain treatment post-discharge
Critical or difficult communication issues	<ul style="list-style-type: none"> ○ Informed consent procedures associated with autopsy ○ Requesting consent for donation of organs ○ Communication of results of autopsy ○ Discussing uncertainty in diagnosis, test results or prognosis ○ Discussing unanticipated outcomes of treatment ○ Communication skills training for doctors
Participation in a clinical trial	<ul style="list-style-type: none"> ○ Written information ○ Video for informed consent to participate in trial
Coping with or managing health problems	<ul style="list-style-type: none"> ○ Health education classes ○ Self-help groups ○ Interactive health care applications, for example, video games
Discharge from hospital	<ul style="list-style-type: none"> ○ Verbal plus written information ○ Written instructions on medications ○ Provision of medication reminder packaging for medicines ○ Phone call follow-ups
Audit and review	<ul style="list-style-type: none"> ○ Complaints systems ○ Consumer feedback methods ○ Training consumers to be researchers ○ Training consumers to be involved in quality and safety processes
Planning	<ul style="list-style-type: none"> ○ Consumer involvement in committees ○ Citizen juries

4. Pilot projects

Section 04

Project overview

Evidence-based medicine is widely recognised as critical to the delivery of high quality health care. However, the application of these principles to quality improvement strategies is less common. The VQC commissioned three pilot projects to extend the concepts and practices of evidence-based decision making to quality improvement. These projects undertook an evidence-based approach to the selection of quality improvement strategies in the area of communication. The systematic literature review for each pilot site was commissioned from the Cochrane Consumers and Communication Review Group (CC&CRG). The processes, tools and experiences that developed throughout the project were collated to develop the *Guide for an evidence-informed approach to improving communication and participation*, available at www.health.vic.gov.au/qualitycouncil.

Three metropolitan hospitals were approached. These had general and specialist services and senior clinical and quality improvement staff prepared to commit time and resources to lead the project at their site. At each site there was recognition that improving communication with consumers and carers would lead to improvements in quality and safety. Only metropolitan sites were selected, for reasons of manageability within the resources and scope of the project.

4. Pilot projects: Project overview

Each hospital established a steering group to advise on the development and operation of the project, and a smaller working group with responsibility for each project. In consultation with the CC&CRG, the three hospitals identified a wide range of communication issues which, affected health outcomes for consumers, staff morale, resources and service efficiency and costs.

Each site, along with the CC&CRG, then selected one priority issue. Selection was based on these criteria:

- the size of the problem
- its relation to safety, quality and organisational goals
- staff readiness
- resources for change
- consideration of organisational barriers and facilitators.

Several tools were developed for the project to assist with selecting and prioritising one communication issue. These tools are included in the appendices and the guide on how to use them.

The issues chosen and the site responsible were:

- communication issues in the perioperative stage of day surgery which affect the postoperative experience of patients — Northern Health, Broadmeadows Health Service
- communication with people from culturally and linguistically diverse (CALD) backgrounds who seek treatment in the emergency department — Southern Health, Dandenong Hospital
- communicating and supporting decision making about vaginal birth after caesarean section (VBAC) — Royal Women's Hospital.

Once the issue was selected, a project officer from the CC&CRG worked in a supporting role with each hospital site to provide research expertise. The range of potential communication interventions relevant to the issue was mapped and literature to inform analysis of the problem, and assessment of the effectiveness of relevant interventions was searched for, selected and appraised. In discussion with each site, the findings were translated and applied to inform decision-making processes for quality improvement strategies. The following section uses the six stages of the guide to illustrate actions taken at each hospital.

Northern Health — Broadmeadows Health Service

Broadmeadows Health Service (BHS), a campus of Northern Health, operates a stand-alone day procedure and endoscopy unit where a range of different surgeries are performed, including general surgery, ophthalmology, orthopaedics, gynaecology, paediatrics and endoscopy. Patients are taken from the waiting lists of four different hospitals, which are a part of three major Victorian public health services.

Diagnostic analysis and prioritising an issue

Several quality indicators are regularly collected and analysed, including:

- fail-to-attend rates
- surgery cancellations
- number of consumers with a CALD background
- post-discharge data.

The day surgery unit (DSU) identified that a significant number of operations were cancelled on the day of surgery. Late cancellations mean that operating lists are not fully utilised and waiting times for surgery are increased. Further analysis showed that most cancellations resulted from people not arriving for their booked surgery, suggesting that communication processes between the health service and the consumer could be improved. There were previous attempts to improve attendance for booked surgery, which targeted specific steps in the perioperative process, but these had limited success.

The multiple referral sources to the DSU, in addition to patient volume pressures, mean that several opportunities where communication between health care agencies and consumers could break down. The main areas identified as contributing to ineffective communication include:

- multiple points of referral
- incomplete or inadequate referral information
- incomplete documentation of patient history
- unknown interpreter requirements.



The limited success of previous quality improvement activities aimed at improving patient flow in the DSU meant a different approach was required. In this project the decision to change the current processes was based on these criteria:

- a systems approach to improving and strengthening communication was required, due to the multiplicity of entry points, people involved and contacts with the consumer
- improving communication as a system should eliminate some of the current inefficiencies and fragmentations in the current process
- application of the evidence on effective consumer communication was required to make the process of review more efficient and improve the probability of getting it right
- that improving communication should improve both the quality and safety of the consumer experience
- all written communication should aim to improve the health literacy of individuals.

Setting up the quality improvement process

This project aimed to improve the perioperative experience for patients of the DSU by identifying and addressing communication issues at several stages where communication with consumers occurs. Success would be measured by the existing quality indicator data sets and satisfaction surveys.

A working group was convened, comprising the quality manager, health information manager, unit manager, community liaison officer, general manager, a project officer with an interest in health literacy and evidence-based practice and a consumer. A project officer was appointed to undertake the work for this project and additional expertise was sought at various stages.

The communication interventions were all directed at consumers; however, several internal processes and staff would also be affected by process improvements.

Strategies to engage consumer and staff interest in the project included:

- a consumer was recruited to advise on issues and recommendations associated with communication processes in the DSU
- communication strategies developed for the project were presented to the Community Participation Advisory Committee (CPAC)
- individual staff were consulted to provide expertise to the project
- education regarding the changes was provided to the DSU staff
- scripts were developed to assist staff to provide consistent messages
- strategies were piloted with a small group of consumers
- there was opportunity to reflect on current practice and investigate a range of areas which had been identified over time.

Mapping the communication issue

The referral, admission and discharge processes for DSU were comprehensively mapped (see Figure 1), all points of communication with consumers were identified and any problems or issues of uncertainty were noted. Each communication point and the associated process were assessed for improvement in relation to:

- the evidence to support each step
- the outcome of consumer focus group
- the ability to achieve the process with current resources
- opportunities to improve quality and safety
- the opportunity to improve the comprehensiveness of data collection.

When these factors indicated that a change would lead to improvement, the process was adjusted accordingly.

Figure 1: Mapping the points of communication for the day surgery experience

1. Consultation with specialist.
2. Letter sent to patient:
 - to confirm that they have been listed for specific surgical procedure at Broadmeadows Health Service (BHS)
 - instructions to return a completed health survey (required by BHS to plan surgery)
 - instructions to return a completed patient registration form.
3. On receipt of the completed health questionnaire and registration form, the day surgery unit (DSU) will decide if the patient is appropriate for day procedure:
 - if all information is clear, then the patient receives approval by the DSU to proceed with the next stage of the communication and preparation process for surgery
 - if needed, phone contact will be made if there are areas needing clarification with the patient and tests organised.

Question: At this point, does the preadmission nurse ask if the patient needs help with understanding the process so far, for example, literacy or language issues?
4. The theatre booking unit telephones the patient and a date for surgery is organised.

Question: Are there any other issues discussed in this phone call?
5. A booking letter is sent to the patient stating: date, time, place, surgeon and type of procedure.
 - Preoperative instructions (for specific procedures) are also sent to the patient.
6. Phone contact to the patient (approximately one week before surgery).
 - The preadmission nurse telephones the patient approximately one week before surgery to confirm:
 - procedure date, and time

Question: What other details?

 - receipt and understanding of instructions regarding fasting, bowel preparation

Question: What other details?

 - postoperative care (carer, transport home)
 - any other questions that the patient may have
 - any other details the patient may require reassurance about.

Question: Are any anxiety-related issues related to the surgery discussed with the patient?
7. Day of surgery.
 - Contact is made with the patient to confirm the need for an interpreter if postoperative care instructions are to be translated.

Questions: Do preadmission or surgical staff make any other contact with the patient? If so, what kind, how is it done and by whom?
8. Surgery performed.
9. Patient arrives in post anaesthetic care unit (PACU).
 - PACU nurse gives postoperative instructions verbally and in writing, including:
 - general things to do, and not to do
 - after-effects of anaesthesia
 - activity
 - eating and drinking
 - procedure-specific wound care
 - pain, including what to expect, how to manage it and written instructions about analgesia
 - complications, and when to contact a doctor or ED, including supplying phone numbers of hospitals
 - Postoperative prescription medication (if any) is explained to the patient, as well as where to purchase the medication
 - A postoperative review appointment slip is given to the patient if they need to return to the referring doctor (communicated verbally and documented)
 - Postoperative review is discussed only if the patient has an appointment with the surgeon (at specific sites), communicated verbally and documented.
10. The PACU nurse telephones the patient 24 hours after discharge about postoperative management and care.

Questions: What exactly is discussed in this call? What documentation is used?

Search for studies

The mapping process led to the development of a range of key search terms, including:

- terms for day procedures: day care, ambulatory surgery, preoperative, perioperative and postoperative care
- terms associated with communication: education, training, instruction, information, support, counselling
- terms associated with different media for communication: pamphlet, audiovisual and so on.

The issues identified all related to the timing, content and method of communication. The search terms focused on knowledge retention, compliance with treatment and satisfaction with information provided.

Selecting, appraising and summarising the evidence

Evidence was assessed for level of evidence and applicability to communication issue. The literature review identified that:

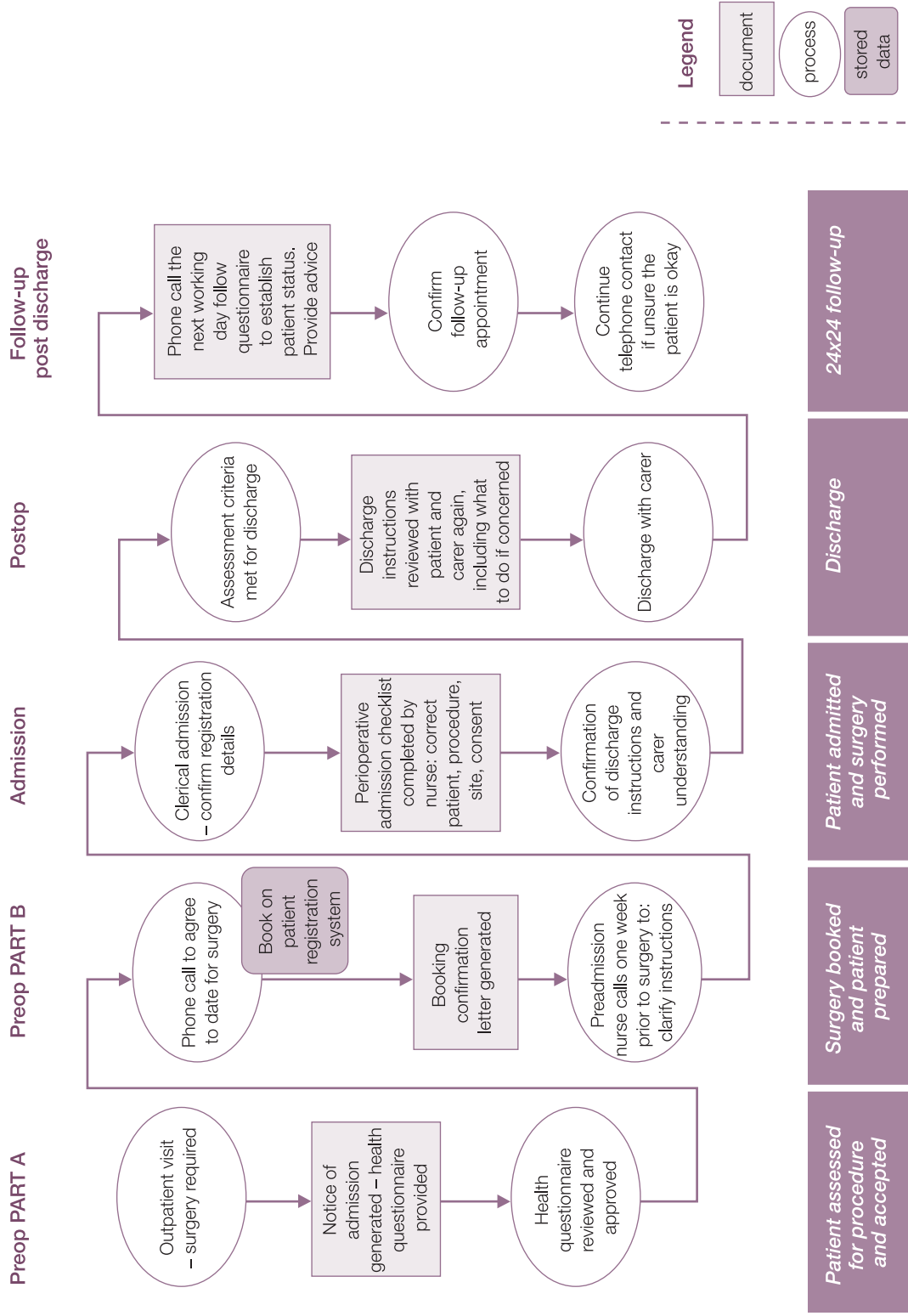
- preoperative screening of consumers reduces the rate of cancellations (Level 3.2)
- the timing and format of information relating to the procedure and what to expect afterwards affected consumer and carer knowledge retention and satisfaction (Level 1–4 and Qualitative)
- preadmission written information outlining procedures is effective in terms of knowledge retention (Level 2)
- preadmission written information regarding postoperative care increases consumer satisfaction and outcomes (Level 2–4 and Qualitative)
- written plus verbal, discharge information is more effective than verbal information alone (Level 1).

This evidence was used to inform the changes made to the communication and day surgery processes.

Translating and applying the evidence

The map of communication points was reviewed in light of the evidence, and a revised map was drawn with new or modified processes and communication points, supported by the evidence and available resources for implementation (see Figure 2).

Figure 2: Translating and applying the evidence—Broadmeadows Health Service



Royal Women's Hospital

The Royal Women's Hospital (RWH) is a tertiary referral centre that provides specialist health services for women and premature babies.

Diagnostic analysis and prioritising an issue

The RWH caesarean section rate is slowly and steadily increasing, and is now at 27.7 per cent. This rate reflects a trend in other Australian hospitals.

There are several contributing factors, including the increasing age of first-time mothers and the practice of performing caesareans for all breech presentations; supported by recent clinical trial evidence.

The implications for later pregnancies in women who have had a caesarean are of increasing concern and emerging in the evidence. Particularly the risks of haemorrhage and mortality associated with attachment of the placenta. Consequently, it is crucial that caesarean sections reflect appropriate practice and are not performed unnecessarily. Two key strategies to reduce caesarean section rates focus on the caesarean section rate in first pregnancies and supporting the option of vaginal birth after a previous caesarean section (VBAC).

The RWH identified that in 2003, 44 per cent of women with one previous caesarean section attempted VBAC at the RWH. Data collection in this area is not consistent; however, Women's Hospitals Australasia publishes voluntarily submitted VBAC data. The WHA-published rate in 2003 was 58 per cent, thus it appears that fewer women at the RWH than elsewhere attempt vaginal birth after a previous caesarean.

Choosing either a repeat caesarean or a VBAC is an area where clinical evidence is not conclusive and women's values and preferences are key factors in the decision-making process. Communication is an important component of clinical decision making. Supporting consumers to be genuinely informed about a health care decision is difficult when the clinical evidence is unclear or controversial. Where women make choices about birth options after a caesarean, clinicians will invariably struggle to communicate the evidence without inadvertently expressing their own preference.

The goal was not to convince all eligible women to try VBAC, but simply to ensure that women are provided with consistent care and have balanced and unbiased

access to information about their options in an area where the evidence is uncertain, clinical trials are not feasible, and women's values and preferences play an important part. Therefore, timely and effective communication to support an informed decision could well be key in increasing the RWH VBAC rate. At the very least, it may be instrumental in providing women with a sense of control over their final decision.

Setting up the quality improvement process

The working group comprised the Quality and Safety Unit, the Clinical Practice Improvement Unit, women's services—women's consumer publications, an obstetrician, a midwife and the Community Advisory Committee coordinator.

Communication interventions became one component of a much larger project. The primary aim was to apply the available relevant evidence to encourage an evidence-driven approach to communicating with women about their options, which would include:

- establishing consensus about what needs to be communicated to women (that is, clinical evidence)
- reviewing the evidence and laying it over the current model, in order to establish current practice, and if and how it concurs with the evidence
- reviewing current practice to discover any organisational barriers to applying an evidence-based approach
- developing and implementing a communications framework
- evaluation.

Additional data was collected specifically for this project, including an audit of health information records to identify compliance with current policy, as well as interviews with women and doctors to identify current decision-making processes. The interviews identified several issues critical to the implementation of improved communication with women.

Mapping the communication issue

Within the wider project, the timing and content of communication with women about VBAC was reviewed (see Figure 3). The effectiveness of current RWH resources about VBAC available to women and clinicians were reviewed: the content was found to be unhelpful and clinicians did not use them consistently.

Figure 3. Worked example of mapping the communication issue

Mapping the communication issue	Example from the Royal Women's Hospital (RWH)
A. Context	<p>RWH data showed that their rate of vaginal birth after caesarean (VBAC) was lower than for other hospitals. A breakdown of the data showed that the hospital was successful in helping women who chose VBAC to accomplish it. However, the VBAC rate was low. This pointed to communication with women about their options and their decision making as key issues.</p> <p>A suite of consumer resources had been developed a few years previously, but clinicians were not using them to inform women. There were concerns about some of the evidence presented. Anecdotally, there was no real consensus about the evidence for the safety of VBAC, and this was a significant barrier to communication with women.</p>
B. Purpose of the interventions and its relation to the purpose of The quality improvement exercise	<p><i>Project:</i> To ensure that decision-making processes around assessing VBAC eligibility are standardised and evidence based. <i>Interventions:</i> an intervention that formalises the decision-making process, for example, a decision aid, information pamphlet, scripted communication protocols.</p> <p><i>Project:</i> To ensure that decisions about birth options are informed by evidence and involve women. <i>Intervention issues:</i> Evidence-based content for intervention. Women's views on childbirth options need to be sought.</p> <p><i>Project:</i> To obtain consensus amongst the obstetricians on the evidence base for VBAC, and how to introduce the communication component. <i>Intervention issues:</i> integration of intervention to clinical protocols or guidelines.</p>
C. Parties involved and main direction of communication	<p>Doctors, women making choices about childbirth, midwives.</p> <p>Interventions for communication exchange between providers and consumers, shared decision making, exchanging information, evidence and views on options for childbirth, understanding what women already know.</p> <p>In situations where evidence of effects of different treatments is uncertain and patients have different preferences, there is no one right choice.</p>
D. Intervention: single or combined	Decision aids, information provision, information pamphlet.
E. Content	Women's preferences for childbirth options after a caesarean highlighted that women's decision making incorporates personal as well as clinical factors. Information on women's views about content were included in a Cochrane systematic review.
F. Format	Paper based, other media possible, but need to consider language/translation issues and costs.
G. Timing	Women can make a decision at any time before or during pregnancy.

Southern Health— Dandenong Hospital

Southern Health is the largest public health service in Victoria, and provides health services to Melbourne's south-eastern suburbs. Dandenong Hospital is one of Melbourne's major acute hospitals, and provides a range of services to people living in Dandenong and surrounding areas.

Diagnostic analysis and prioritising an issue

Communication with consumers from culturally and linguistically diverse (CALD) backgrounds in health care settings is a universal issue, and of particular relevance to Southern Health, given the demographics of its catchment. A third of people attending Southern Health emergency departments were not born in Australia and eight percent indicated their preferred language was not English.

Anecdotal evidence and analysis of adverse events yielded information that indicated there were many instances where the health care received by consumers from CALD backgrounds failed to meet their needs and expectations. The quality of care for CALD consumers can be affected by suboptimal communication.

Communication breakdown is a common and high-risk source of adverse patient experiences and outcomes, which can lead to preventable morbidity and mortality and increased health care costs. Consumer satisfaction results and a review of interpreter usage shows that although professional interpreters are available, they are rarely used in the emergency departments.

In deciding which communication issue would be addressed, organisational capability to complete the project was considered. It was very important to ensure the objectives of the project remained achievable, and that appropriate resources were available to facilitate implementation within the timeframe. The initial plan to pilot the project across Southern Health—Monash Medical Centre (Clayton) and Southern Health—Dandenong Hospital was modified. Dandenong Hospital was chosen as the pilot site due to the strong commitment from the emergency department and its clinical champions.

Setting up a quality improvement process

The aim was to enhance the quality of care and the consumer experience through improved communication with consumers from CALD backgrounds in the emergency department. The quality unit undertook responsibility for the project.

In addition to the data used to identify the issues, several specific measures were developed for the project:

- use of professional interpreters in the emergency department
- number of complaints from CALD consumers using the emergency department
- number of compliments from CALD consumers using the emergency department
- staff survey regarding interpreting services and resources for CALD consumers
- consumer telephone survey regarding issues/barriers in the emergency department.

Several structural and organisational barriers to deriving information and coordinating improvement efforts were identified as the project developed. While there is a wealth of expertise and resources within the health service, identification and access to them proved challenging. A stakeholder map to ensure all resources were identified would have been beneficial. Linking in to existing committees and stakeholders to identify opportunities for advancing the project with a group that is already committed was vital.

Mapping the communication issue

The pro forma developed for the project, (see Appendix 1) highlighted communication with CALD consumers as a key issue. The quality unit also mapped the existing pathway for the treatment of CALD consumers in the emergency department at Dandenong Hospital. This mapping exercise identified the existing processes, including tools used in interactions and communication issues and barriers. Focus groups were also held with nursing staff in the emergency department and with consumers to discuss the issues. These consultations identified that the environment was a stressful place for people, particularly those from CALD communities. Consumers did not understand critical internal processes such as triage. There were enormous time pressures on staff, and interactions with patients and their families had to occur in a very short time. There

Search for studies

The literature was reviewed for relevant evidence which could be applied to communicating with women about VBAC. The scope of the review included:

- decision making
- the content of information
- the format of information
- the context in which information is delivered
- the organisational context.

The results were compared to the current processes for communicating with women. This helped to identify which of the current processes were supported by evidence and where evidence could be applied to improve processes.

Selecting, appraising and summarising the evidence

The communication issues predominantly concerned decision making.

1. Effective communication for shared decision making has five key steps:

- ask about and understand the woman's experiences, knowledge and expectations
- build partnerships by acknowledging the complexity or difficulty of the issue
- provide evidence, but with a balanced discussion of the uncertainties
- present recommendations after integrating the doctor's clinical evidence with the woman's values and preferences
- check for understanding and agreement (Level 1).

2. Decision aids:

- are effective as a communication tool in preference-sensitive situations (Level 1)
- show promise in facilitating informed decision making (Level 2)
- leaflets did not assist shared decision making (Level 3 and 4).

3. Information format:

- effective information is provided in a variety of formats (Level 1)
- decision trees can track the progress of decision making in birth options (Level 3)
- disseminating leaflets without discussion does not facilitate informed decision making (Level 3).

4. Organisational context:

- clinicians may be reluctant to offer choice when it opposes their own values or preferences (Level 2)
- the method of dissemination of leaflets supports informed compliance, rather than informed decision making (Level 3 and 4).

Decision aids were a key communication strategy for women. See Figure 4 for a summary of the evidence regarding decision aids.

Translating and applying the evidence

This project had elements and strategies outside the scope of the Communicating With Consumers project. The communication strategies are listed below.

1. Resources and information opportunities for women including:

- discharge information following the primary caesarean incorporating the reasons for the caesarean and future birth options
 - the adoption of a decision aid: Birth Choices—What is Best for You
 - childbirth education classes specific to women who have had a previous caesarean.
 - hospital-wide promotion of resources and information opportunities
 - hospital supported support groups
 - six-week review following a caesarean.
2. Decision making: to encourage clinicians to adopt the five steps for shared decision making. These five steps to be integrated into the clinical practice guideline, the obstetric tool, and be available online and in clinics (laminated copies).

Several improvements could be made using the evidence alone:

- ensure as much as possible a consistent hospital approach to VBAC information
- develop decision aids (with improved content) which are incorporated into the clinical practice guideline – improve content, ensure staff consultants and consumers are involved in development
- training opportunities for consultants around using a decision aid
- improve record taking (VBAC tool, hand held record) to ensure that women's beliefs and views are recorded
- aim for continuity of care for VBAC women.

Figure 4: Sample of appraising the evidence: decision aids

Level 1 evidence

Decision aids are increasingly used as a communication tool to assist doctors and consumers in preference-sensitive situations. Formats and media vary, and these include pamphlets and videos. Quality decision aids have several components, including, a description of treatment options, and information to help people understand the options, consider the personal importance of possible benefits and harms, and participate in decision making.

A Cochrane review¹⁷ of 34 trials of decision aids found that they are better than usual care in terms of these outcomes:

- knowledge
- decisional conflict and indecision
- realism of expectations
- active involvement in decision making.

Decision aids decrease the rate of major surgery.

Information for women considering a VBAC should also include:

- the risks of VBAC and elective caesareans
- warning signs to be aware of in labour
- information about the philosophy and policies of the hospital and staff
- strategies to improve the chances of a successful VBAC
- information about the probability of success with specific caregivers.

Consumers said information given to women should include:

- the evidence base of practical information about pain relief and interventions
- the specific risks and benefits of vaginal and caesarean births
- the options for pain relief in labour
- that information giving should be interactive, and that women should be able to get more information if they wanted.

Level 2 evidence

The decision aid shows promise in facilitating informed decision making in pregnancy.

Level 3 and 4 evidence

- women did not find leaflets helpful in decision making
- pragmatic usage resulted in many leaflets being withheld from women because staff disagreed with their contents
- staff felt choices mentioned in leaflets were not available locally
- women made choices on the basis of their previous experiences of childbirth, but were often met with resistance if their preference contradicted clinical norms
- staff sometimes expressed a strong dislike for an option in the leaflet
- women tended to comply with a health professional, and rarely talked about their own preference
- health professionals either minimised risk or emphasised harm to drive a particular intervention
- continuity of midwifery care created an environment more likely to encourage a trusting relationship and the ability to ask questions.

Figure 5: Applying the evidence at RWH

What we know**We have these:**

- one-on-one childbirth education for women
- a tour of RWH for VBAC women
- books and web-based information, quality tested and available through the Women's Health Information Centre
- obstetric assessment VBAC tool to manage to delivery of information to women and record the care management.

Flyer

Generally available and on display throughout the hospital. It describes:

- hospital philosophy: 'we know that VBAC is safe for many women but we promote choice'
- what the risks are
- what other information is available.

Brochure

- meant to be provided to women by consultant at 12 weeks in the context of a discussion about VBAC
- hospital philosophy: no strong position either way on VBAC, encouraging informed decision making
- outlines the risks and benefits
- encourages the doctor to discuss and record (on the brochure) the woman's personal risk—encouraging discussion with doctor.

Video

- to be offered to women at 26 weeks
- personal stories.

We do not know:

- what is discussed at childbirth education classes and on the tour
- what information is given out in the WHICH, and if it is useful
- how many women are seeing the video, or if it is useful
- if the obstetric tool is useful or being used
- if the information in the brochures are disseminated, and if this is useful.

What can we learn?**From the audit:**

- how many consultants are passing on the existing information
- if there is any correlation between women receiving information and the decision they make along the way.

From midwives:

- information given on tour and in education classes
- how they deal with the information needs of women.

From women:

- what they know about VBAC when they were faced with the decision
- what they remember about the information they were given and what else they needed
- how influential was the information
- their clinician's view of VBAC
- if the clinician expressed an opinion about the information
- how the clinician presented the information
- if they felt able to express their own beliefs or feelings about VBAC
- if they felt satisfied with the decision they made.

From consultants:

- their views on VBAC and existing brochures
- how they inform women about their choices
- when they think women make up their mind about VBAC
- if they presented women with their options
- if they thought women made decisions based on information or from other sources.

Southern Health— Dandenong Hospital

Southern Health is the largest public health service in Victoria, and provides health services to Melbourne's south-eastern suburbs. Dandenong Hospital is one of Melbourne's major acute hospitals, and provides a range of services to people living in Dandenong and surrounding areas.

Diagnostic analysis and prioritising an issue

Communication with consumers from culturally and linguistically diverse (CALD) backgrounds in health care settings is a universal issue, and of particular relevance to Southern Health, given the demographics of its catchment. A third of people attending Southern Health emergency departments were not born in Australia and eight percent indicated their preferred language was not English.

Anecdotal evidence and analysis of adverse events yielded information that indicated there were many instances where the health care received by consumers from CALD backgrounds failed to meet their needs and expectations. The quality of care for CALD consumers can be affected by suboptimal communication.

Communication breakdown is a common and high-risk source of adverse patient experiences and outcomes, which can lead to preventable morbidity and mortality and increased health care costs. Consumer satisfaction results and a review of interpreter usage shows that although professional interpreters are available, they are rarely used in the emergency departments.

In deciding which communication issue would be addressed, organisational capability to complete the project was considered. It was very important to ensure the objectives of the project remained achievable, and that appropriate resources were available to facilitate implementation within the timeframe. The initial plan to pilot the project across Southern Health—Monash Medical Centre (Clayton) and Southern Health—Dandenong Hospital was modified. Dandenong Hospital was chosen as the pilot site due to the strong commitment from the emergency department and its clinical champions.

Setting up a quality improvement process

The aim was to enhance the quality of care and the consumer experience through improved communication with consumers from CALD backgrounds in the emergency department. The quality unit undertook responsibility for the project.

In addition to the data used to identify the issues, several specific measures were developed for the project:

- use of professional interpreters in the emergency department
- number of complaints from CALD consumers using the emergency department
- number of compliments from CALD consumers using the emergency department
- staff survey regarding interpreting services and resources for CALD consumers
- consumer telephone survey regarding issues/barriers in the emergency department.

Several structural and organisational barriers to deriving information and coordinating improvement efforts were identified as the project developed. While there is a wealth of expertise and resources within the health service, identification and access to them proved challenging. A stakeholder map to ensure all resources were identified would have been beneficial. Linking in to existing committees and stakeholders to identify opportunities for advancing the project with a group that is already committed was vital.

Mapping the communication issue

The pro forma developed for the project, (see Appendix 1) highlighted communication with CALD consumers as a key issue. The quality unit also mapped the existing pathway for the treatment of CALD consumers in the emergency department at Dandenong Hospital. This mapping exercise identified the existing processes, including tools used in interactions and communication issues and barriers. Focus groups were also held with nursing staff in the emergency department and with consumers to discuss the issues. These consultations identified that the environment was a stressful place for people, particularly those from CALD communities. Consumers did not understand critical internal processes such as triage. There were enormous time pressures on staff, and interactions with patients and their families had to occur in a very short time. There

was insufficient understanding of the availability and role of interpreters by patients and staff.

Four key issues relating to effective communication with CALD consumers were identified, including:

- examination of organisational support
- awareness of current organisational systems/practices/resources
- understanding of staff and professional skills, experiences and attitudes
- awareness of patients' knowledge, rights and responsibilities.

Strategies considered included:

- staff training in:
 - cultural competency
 - awareness of government legislation, policies and practices
 - awareness of in house policies and protocols
 - awareness of interpreting services and materials that could aid communication with CALD consumers
 - communication skills
- use of professional interpreters
- working in a supportive organisational culture at all levels.

Search for studies

Mapping led to a range of key terms for searching the literature, focusing on those terms that would capture literature relevant to people from CALD communities. These included:

- ethnic
- transient
- migrant
- refugee
- non-native
- those associated with literacy, communication barriers and English as a second language.

A systematic literature review was undertaken, focusing on:

- interpreter utilisation
- development of tools to assess interpreter requirements
- education of staff in complaints processes

- education for consumers regarding participation in their own health care.

Selecting, appraising and summarising the evidence

There was a lack of high-level evidence to support interventions in any of these areas, so the review was widened to address the main concerns expressed by consumers, namely: waiting times, communication and interpreters. The objectives were revised as a result of the literature review and refined to assisting the emergency department staff, in order to:

- assess triage Category 3 and 4 consumers for their language needs
- apply appropriate strategies to access interpreting services and CALD resources
- appropriately use interpreters to inform consumers of relevant information regarding their ongoing treatment and care.

Using the available evidence, consensus was reached by the steering committee regarding a preliminary selection of strategies. These strategies were presented to key parties in the Dandenong Hospital emergency department to seek feedback and to assist implementation planning.

The communication strategies selected for implementation include existing Southern Health resources, modified resources and new resources developed for the purposes of this project. Factors that influenced choice of strategies were: the available evidence, existing expertise within the organisation and resources available to facilitate implementation.

The issues identified related to the degree of consumer centeredness of interactions and the availability of relevant information to consumers. In relation to CALD consumers, this equated to cultural awareness of staff and use of professional interpreters.

Strategies supported by evidence:

- remote interpreting services are more effective and satisfying than proximal interpreting services (Level 2)
- 'cultural code cards' are effective for rapid management and evaluation
- customer service training leads to a decrease in complaints
- education in working with interpreters increases interpreter usage (Level 3)

- written plus verbal discharge information is more effective than verbal information alone (Level 1)
- cartoon illustrations are an effective way of conveying information and may produce increased compliance (Level 1).

Translating and applying the evidence

Two main areas were identified for improvement: the provision of education to staff and use of tools to facilitate communication:

- education:
 - cultural competency and how to access and use professional interpreters
 - communication skills/customer service training
 - development of guidelines on how to access and use professional interpreters
 - development of a new CALD intranet site with Internet links
 - supportive organisational culture at all levels
 - ongoing education/project presentations
 - inclusion of cultural diversity and interpreter services information in general hospital, medical and nursing orientation
- tools:
 - translated signage for the emergency department
 - translated patient information for general patient education and education regarding ED processes and rights to interpreters
 - development of a multicultural video
 - 'language identification cards'
 - communication cue cards—'ward words'
 - identifying language needs at triage (decision aid)
 - purchase of phones to enable simultaneous translation of communication between clinician and consumer.

5. Lessons

Section 05

The timelines for this project were based on identifying relevant communication issues, possible strategies and assessing the evidence to support the strategies. At each site the communication issue was part of wider quality and safety improvement issues, with corresponding process redesign and change management implications. Each project required leadership, clinical champions, good data on the cause of problems or indicators of problems, time and resources, evidence reviews, consultative and deliberative processes, training and senior organisational support.

5. Lessons

The implementation of each project took longer than anticipated.

An evidence-informed approach strengthened and made more systematic the quality improvement approach and implementing systematic change. The changes implemented were at an organisational and systems level, rather than targeting individuals leading to service improvements at each site. This finding is supported by international literature on implementing change in hospitals.²⁰ The profile of communication issues was raised at each site, and existing communication processes were improved or standardised.

The CC&CRG was funded by the VQC to undertake the role of knowledge broker or translator, and this was supplemented in some hospitals with additional research into patients' views or staff awareness of available resources.

The participating hospitals concluded that evidence from evaluation studies offered:

- a point of reference or guidance
- information on which interventions were effective and those that were not
- information on uncertainty about the benefits of an intervention
- information on potential harms
- information about gaps in research.

This pilot demonstrated that using an evidence-based approach is an effective quality improvement strategy for communication issues. The CC&CRG provided considerable expertise to the sites in the search for and assessment of the evidence. Tools developed for the project are included in the appendices.



6. References

Section 06

6. References

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Appendix 1
Pro forma for collecting
communication issues



Section 07



Name of unit		
Staff member		
Describe the communication issue that is of interest or concern and why		<i>For example, discharge summary instructions for patients who speak English as a second language.</i>
Provide a brief background/history to this issue		
Who is involved in this issue? Is it clinicians, other staff members, consumers, carers?		<i>For example, consumer, carer, staff.</i>
Have you noted or collected any information or research or measures associated with this issue? If so, please describe.		
Has this issue been described or targeted in any of these areas? Please tick and describe briefly.	Please tick below	Describe details below
Patient satisfaction surveys		
Complaints/patient advocacy system		
Reported as an adverse event		
Reported as part of the patient monitoring system (for example, patient incident monitoring system)		
Reported as part of sentinel event monitoring		
Reported as part of or is a quality performance indicator		
Reported as a part of a coronial enquiry finding or recommendation		
Discussed with colleagues in your unit		
Discussed with patients or family members		
Experienced or observed by staff members		
Identified through internal audit or self-assessment systems in the organisation		
Identified through a review of clinical indicators as part of EQiP		
Identified through infection control program		

