Overcoming Communication Barriers Between Providers and Communication Vulnerable Patients (Not Related to Language or Culture)

Many assistive technologies and low tech tools can help to overcome communication barriers and allow patients to more effectively participate in their own treatment and rehabilitation in health care settings. Such tools are available to help people communicate more effectively in their current communication settings, as they make the transition through care in a hospital, in rehabilitation centers, and at home. These tools and strategies go well beyond "talking boxes" and picture boards—they include a comprehensive collection of communication strategies that provide external support for many different types of people in health care settings. The use of such strategies in health care settings can significantly reduce medical miscommunications and allow for more successful patient-provider communication.

People sometimes associate some of these tools and strategies only with people who enter the medical setting already burdened by complex communication needs. However, these tools and strategies can be used in a much wider range of health care settings and situations to improve communication. For example, intensive care units (ICUs) may provide an appropriate location for using both low-tech and high tech speech generating devices, as so many ICU patients temporarily cannot rely on their usual powers of speech and require aid in communicating their questions and needs to caregivers. Several articles are now available to provide concrete examples of how augmentative communication devices can prove useful in the ICU.

One article in particular exemplifies New Jersey University Hospital’s use of communication picture boards to bridge communication barriers between health care professionals and patients. The New Jersey Department of Health and Senior Services (NJDHSS) has distributed more than 2,200 boards to facilities across the state in its efforts to ensure that every patient receives effective medical care. The article strongly advocates the use of communication boards, stating that they should become an integral part of the U.S. Department of Health and Human Services’ “Effective Communication in Hospitals” program. Although communication boards may not be an appropriate tool for diagnosing diseases or requesting consent, they are useful for everyday communication purposes.

Other articles suggest that training in effective communicating is imperative to improving patient-provider interactions. Realizing the link between how well a provider understands the communication process and patient satisfaction and outcomes, a growing number of health care systems are beginning to train employees in this critical skill.
The articles below suggest a wide variety of ways to overcome communication barriers and mitigate the incidence of preventable adverse events in health care settings:


The authors advise health care professionals about how to effectively assess and treat clients suffering from aphasia by enhancing natural communication strategies and using appropriate AAC technologies. The article delineates two partner-dependent strategies, three transitional strategies, and two independent strategies patients can use depending on their needs and cognitive and speech abilities. The authors encourage the use of AAC technologies in health care settings to accomplish communication goals and allow patients to effectively participate in their own rehabilitation.


This free, downloadable leaflet provides guidelines for medical and nursing staff to communicate effectively with patients who have speech, language, or communication difficulties due to injury, illness, or learning disabilities. It discusses both general and specific tips for facilitating communication with patients, including asking questions one at a time and writing words on paper while speaking. The leaflet also defines communication aids and describes how patients can use them to communicate their needs, questions, and desires.


The Americans with Disabilities Act mandates that all hospital programs and services provide effective communication for patients, family members, and visitors who are deaf or hard of hearing. The document briefly describes four communication methods used by such people, including sign language interpretation, oral interpretation, cued speech interpretation, and Computer Assisted Real-time Transcription (CART),
explaining the conditions under which each is used. The remaining portion of the brief delineates what services hospitals are required to provide people who are deaf or hard of hearing, as well as what is not required of them.

http://www.augcominc.com/index.cfm/acn.htm

This article introduces a new book, Augmentative Communication Strategies for Adults with Acute or Chronic Medical Conditions, which offers practical tools and strategies for providing AAC services to adults with medical conditions which hinder effective communication. Blackstone advocates for the use of augmentative and alternative communication (AAC) and assistive technologies (AT) for people who suffer from severe communication impairments either because of disease or injury and gives examples of people with different conditions who could benefit from AAC or AT. This issue of Augmentative Communication News then summarizes several chapters from the book, in the following articles.

http://www.augcominc.com/index.cfm/acn.htm

Chapter 2 of the Beukelman book demonstrates why intensive care units (ICUs) are ideal locations for AAC technology use, as many admitted patients cannot speak and require aid in communicating their questions and needs to caregivers. Aware that the efficacy of AAC in such emergency settings is not well documented, the authors attempt to fill this gap by providing concrete examples of how AAC is useful in the ICU. They then recommend four major areas in which AAC treatment should be considered: (1) Natural communication signals and gestures, (2) use of pre-existing sensory aids, (3) strategies to support attention and comprehension, and (4) strategies to support expression.

http://www.augcominc.com/index.cfm/acn.htm

This chapter discusses the daily communication needs of people with brainstem impairments and delineates key assessment and treatment strategies to effectively address them. The authors begin by describing four phases of treatment that medical
providers can use in multiple service delivery settings: Initial assessment, early intervention, formal assessment, and ongoing assessment. They then discuss four clinical profiles of patients with various degrees of brainstem impairment recovery, ranging from complete locked-in syndrome to functional speech. In each case, they describe what kinds of communication tools and technologies each patient uses, based on his or her condition and needs.

http://www.augcominc.com/index.cfm/acn.htm

The authors propose five treatment guidelines for people suffering from TBI: An ongoing and dynamic assessment process, use of natural motor responses, accounting for the patient’s residual strengths, periodic reassessment of the patient’s capabilities, and inclusion of family members and caregivers in AAC assessments and interventions. The article then discusses three levels of recovery (Stimulation, Structured, and Compensation) and recommends AAC treatments corresponding to each level. The authors use a case study about a man who sustained a severe TBI after a motor vehicle accident to exemplify how such patients use AAC technologies during and after recovery.

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The article argues that communication is an essential component of the recovery and rehabilitation process after a patient suffers a spinal cord injury (SCI). The authors discuss seven “principles of AAC treatment” for SCIs, such as inclusion of the patient in treatment decisions and the benefit of an interdisciplinary rehabilitation team in carrying out AAC interventions. Lastly, the article discusses three phases of AAC treatment for SCI patients, including the early, formal, and AAC solutions phases.

http://www.montereyherald.com/health/ci_11087405

This article discusses Carol Welsh’s illness, which began in early November, 1999, characterized by morning attacks of nausea and vomiting. Her doctor at the College of William and Mary student health center believed her symptoms were due to a
gastrointestinal problem and/or stress from her studies, and she was treated for those, with minimal effect. On April 19, 2000, Carol’s condition turned into a crisis and she returned to her school’s health clinic, where she was seen by a new doctor. After listening to her symptoms and examining her, the new doctor realized that she suffered from a rare brain tumor that needed to be operated on immediately. He observed that actively listening to patients is the best way to avoid misdiagnoses and provide quality care.


The author exemplifies New Jersey University Hospital’s use of communication picture boards to bridge communication barriers between health care professionals and patients. The New Jersey Department of Health and Senior Services (NJDHSS) has distributed more than 2,200 boards to facilities across the state in its efforts to ensure that every patient receives effective medical care. The article strongly advocates the use of communication boards, stating that they should become an integral part of the U.S. Department of Health and Human Services’ “Effective Communication in Hospitals” program. Although communication boards may not be an appropriate tool for diagnosing diseases or requesting consent, they are useful for everyday communication purposes.


This article discusses a study in which Japanese doctors assess the clinical impact of a home videophone system for patients receiving home respiratory care. The doctors compare two groups of patients to whom the videophone system was introduced, evaluating its impacts on the type and quality of care. The authors conclude that using this technology significantly reduces the number of house calls by physicians, unscheduled hospital visits by patients, and hospital admission days. Furthermore, both patients and health care professionals considered the videophone system to be acceptable and beneficial. The authors strongly advocate the use of this communication tool to improve the quality of pediatric home ventilatory care.

This essay highlights a conference sponsored by the Bayer Institute for Health Care Communication and the Fetzer Institute. Twenty-one representatives and leaders from major medical education and professional organizations congregated to discuss the essential elements in physician–patient communication. The group collectively identified seven essential sets of communication goals for doctors and patients. These include (1) build a doctor–patient relationship; (2) facilitate open discussions; (3) gather information; (4) understand the patient’s perspective; (5) share information; (6) reach an agreement on problems and plans; and (7) provide closure. These communication goals were designed to provide a coherent framework for teaching and assessing communication skills, determining relevant knowledge and attitudes, and evaluating educational programs.


This article discusses the development of a prototype software called ICU-Talk, a device used for intubated patients in intensive care units (ICUs). The authors comment that current low-tech communication tools, such as alphabet charts and picture boards, are unsatisfactory, slow, and frustrating for both patients and nursing staff. They claim that ICU-Talk is a superior communication tool that is tailored to meet the specific needs of ICU patients and the ICU environment. ICU-Talk is a computer-based communication aid that allows patients to select a phrase or question from a pre-stored database. A computer interview function was developed to allow relatives to enter information about patients’ friends, family and personal interests into the database.

    http://www.computing.dundee.ac.uk/staff/ricketts/cv/preprints/Care%20of%20the%20Critically%20Ill.pdf
This paper describes the collaborative development of a computerized communication aid designed specifically for intubated patients in the intensive care unit (ICU). This augmentative and alternative communication (AAC) device, called ICU Talk, uses a speech synthesizer to voice phrases, sentences, or questions from a pre-stored database. It is most appropriate for ICU patients who are alert but physically limited and unable to speak. The core database has two different interfaces from which patients can choose, both consisting of eight color-coded topics and related phrases and questions. Each style supports the use of touch screens, mouse emulation, and single switch scanning. These access methods permit patients at different stages of recovery to use ICU Talk, including those with severe physical impairment.

http://books.google.com/books?id=yIHxZMRseFgC&pg=PA149&dq=aac+hospitals&source=gbs_toc_r&cad=0_0#PPA604,M1

This handbook provides a comprehensive and practical guide for people working with individuals who are incapable of vocal communication. Chapter sixteen of the handbook, entitled “AAC in the Hospital Setting,” discusses the acute care setting in relation to augmentative and alternative communication (AAC) practices. Many hospital professionals are unaware of AAC intervention techniques, and therefore, non-verbal patients are often excluded from AAC services from which they could benefit. The handbook provides a brief review of care givers who should be part of the AAC communication process, including physicians; nurses; respiratory, occupational, recreation and physical therapists; child life specialists; social workers; speech-language pathologists; and family members.


Groopman’s book discusses what goes on in a doctor’s mind when he or she treats a patient, illustrating the potential life and death significance of doctor-patient communication. The author describes the algorithms and evidence-based therapies doctors are trained to use for typical diagnoses and treatments. He indicates that while these methods can be useful for treating easily identifiable illnesses, they are less effective when doctors are unsure of the illness from which a patient suffers. Groopman believes that openly pondering and discussing how doctors think can reduce both the frequency and severity of medical mistakes by revealing to patients how their doctors think when they examine, question, diagnose and treat them. This in
turn will bridge communication barriers between patients and their caregivers.

   http://www.usafp.org/Word_PDF_Files/Effective-Pt-Provider-Communication-Tips.pdf

   This article focuses on the importance of effective patient-provider communication to improve health outcomes. Obstacles to effective communication like the vast gap between the healthcare world and that of the average patient, low health literacy, and low standard literacy rates are discussed. Tips for effective communication for health care providers like: building relationships, treating the patient as a person, and educating the patient after discovering what he already knows are also exemplified.

   http://www.informaworld.com/smpp/content~content=a714043349~db=all

   This paper describes augmentative and alternative communication (AAC) interventions for patients admitted to the intensive care unit (ICU). Costello focuses on patients who undergo surgeries that render them temporarily incapable of vocal communication. He describes both preoperative and postoperative interventions, providing viable strategies patients can use to communicate. Some of these AAC interventions include technologies such as patient-directed vocabulary selection and digital voice message banking. Costello interviews patients, family members, and medical staff, using their responses to illustrate the benefits of AAC interventions for ICU patients who are temporarily unable to speak.


   This research project demonstrates that successful communication with patients suffering from dementia is an essential component of hospital and nursing home care. The researchers interview several nurses to find out which techniques work best for them when communicating with patients. Nurses identified a variety of useful strategies, including verbal communication, body language and written messages. When there is open communication between hospital staff and family members, hospitals can obtain a detailed history about the patient that aids in providing quality
care. An understanding of the patient’s degree of cognitive deficit is vital in creating a comprehensive care plan, which takes into account such issues as sleeping patterns, activities the patient enjoys, and support that helps him/her cope with dementia.


This pilot study uses participant observation, interviews, questionnaires and clinical record review to obtain information about the use of electronic voice output communication aids (VOCAs) for patients admitted to the intensive care unit (ICU). The authors study eleven critically-ill patients who are temporarily unable to speak due to mechanical ventilation, and they find that patients attempt to communicate more frequently when VOCAs are available then when communicating with non-vocal methods. The researchers also study barriers to VOCA use, and their results show that deterioration in the patient’s condition, staff unfamiliarity with the device, time constraints, poor device positioning and complex message screens are the most significant barriers. Despite these difficulties, ICU patients who use a VOCA may be able to communicate more easily during respiratory tract intubation.

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