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Communication Risk: Preventive Measures and Proactive Value-Based Health-Oriented Tools

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ABSTRACT

This article analyses the different profiles related to communication risk, such as all errors, adverse events, that occur within the care path. In this respect, an analysis of a variety of factors shows a twofold trend. Innovation is a level that can positively influence communication risk, on the other hand, towards deospedalization towards multiple forms of taking charge at territorial level require a multi-factorial communication based on different channels. Based on this dual perspective, the article analyzes the set of organizational measures planned and implemented in a preventive and proactive key in the different dimensions of communication both and public. This analytical path is to be modulated concerning the different objectives pursued by communication in health both in ordinary times and emergency through the management of information in the different institutional and organizational levels involved.

Keywords

Communication errors, Prevention, proactive actions, territorial capillarization, Value-based health

Introduction

Role of communication in health care and the risks of communication errors

The safety of the health system implies a comparison, in improving clinical practices, through the understanding and overcoming of human errors, in latent and organizational (reason and Rasmussen) related to the occurrence of an adverse event. All this implies a dual path. The first of organizational change, in improving the communication of the informative circuit between operators, business management and users. The above implies to hinder the mechanisms at the base of the deviant action concerning the conscious will (slips and lapses), even when it depends on voluntary but wrong choice (mistakes).

The second implies to guarantee functional communication to the new assistance routes more and more oriented to the territory through the taking charge of the patient deospedalizzato. This latter context concerns normal, crisis or emergencies where communication is increasingly important in ensuring the universality of care. In the current structure characterized by increasing chronic diseases in elderly people and with different morbidities, social health care requires greater continuity of care from the health care structure to the territory and the interaction of various professionality. In this regard, it is necessary to distinguish an internal communication, with the function of guiding in spreading information and starting a dialogue between the managerial leaders and the business base. External communication aims to ensure a dialogue with users, through information on the supply of services and the provision of health services. Such communication is to be understood as interpersonal health care with the patient and between the users of the health service and the facility, but also public with the population and institutional representatives and stakeholders.

Public health communication is a specific activity regulated by law. To ensure uniformity of communication and autonomy, local and hospital health structures must have operational communication/information units by L. n. 150/2000, such as the Public Relations Office, l'Press Office, the Prevention Desk, Social Marketing, Front-Office Points [1-4].

Socio-health care cannot be separated from inter branch cooperation, the focal point of which is the continuous communicative interaction between professionals and patients and the provision of information through the appropriate dissemination of specialized data and news by sector. In this context, communication can only be flexible in adapting to the multiculturalism of the users, to the professional specificities and the organizational segments related to each care path. In these areas, staff must have a professionalism consistent with the disciplines about the structures to which they belong.

The latest organizational leverage in support of both cross-country and public communication is technological innovation applied in this area to reduce conflicts in healthcare, resulting from misunderstandings between health care professionals and users because of a lack of information. In the national health system, the case studies are extensive due to the many events related to the different care pathways. A high percentage of between 70% and 80% of professional errors are correlated to the critical issues arising from the failure or insufficient communication and errors resulting from poor health records.

In health organizations, communication errors occur in the initial phase of access within the health facility, even with serious consequences for users (63% of sentinel events are linked to communication errors). These errors result from an erroneous evaluation of the patient, for multiple reasons, attributable to a single denominator namely a lack of information and communication among the operators involved and in the lack of patient involvement, in the processes for verifying the diagnosis made, the prescribed therapies and the treatments carried out. In this context, the organization of each health care facility should cooperate in devising a set of measures and actions to prevent, reduce or eliminate the risk of errors resulting from such communication deficiencies.

The communication between the operators also affects the next phase after the discharge of the patient in the territory.

Below will be analyzed, some tools used at the company level to overcome such criticalities in the individual steps of the cure path. The analytical path will be oriented to understand how the socio-economic context and the organizational characteristics of the assistance can influence the dynamics of communication and influence the collaboration both between the different levels of care between hospital and territory of health professionals, managing effectively the complexity of communication with users.

In the dimensions outlined above, communication in health should be guided by specific objectives, both in ordinary times and emergency, in the management of the information in a functional way to prevent the risks from errors that through a set of measures of proactive nature able to overcome what happened to avoid the repetition.

Preventive actions geared to the personalization of care

This paragraph analyses the range of preventive measures aimed at countering the occurrence of adverse events through an approach geared to acting at the origin of communication risk. This organizational path is linked to the twofold trend not always in contrast, between personalization of care and standardization of medical practices and protocols. The common basis is identifiable in ensuring maximum awareness to the user of the path to be undertaken together with an organizational implementation of the information circuit guaranteed, through the formation of specific structures that diversification information for areas of health specialization [5-7].

The preventive value of information: informed consent

In the field of health, the person may express consent or refusal to a certain treatment through consent, the basis of which is information. The validity of informed consent by the Code of Medical Ethics constitutes not only the legal precedent, to confer lawfulness on the processing, but also a preventive instrument, ensuring maximum awareness and reducing the risk of litigation.

Similarly, information is an essential prerequisite in ensuring a conscious choice and as such qualifying consensus about each care path, through comprehensibility, clarity, completeness, and objectivity of the information provided to the individual patient.

Informed consent is a process integrated by different time segments, related to a specific welfare phase, from the information proposal to the verification of the understanding of such information up to the acquisition of the will of the Patient. The quality of the communication established at each stage has a determining role of informed consent as a result of the continuous information process. Therefore it is necessary to recognize, from the first phase of follow up the users as an integral part of a constructive dialogue through the feedback, to favor the formation of a conscious choice. The necessary cooperation and the possibility of exchanging information facilitates the quality of informed consent, through a process of co-production of knowledge through the interaction of each actor in a coordinated development of the welfare phases.

The other side of the coin of this approach is to foster territorial divergences in managing informed consent. Similarly, it is hoped that good practices will be disseminated more widely to allow continuous improvement in an organisation aimed at adapting informed consent to the evolution of socio-health addiction.

The Informed consent of L. N. 219/17: The organizational reactions

Informed consent is regulated in the Italian health system by l. 219/17, which regulates procedural aspects, through the definition of roles, the identification of obligations and the delimitation of responsibilities between the Health Service and the doctor / medical team.

The Medical Informed Consensus is defined as the process by which the Patient decides freely and autonomously after being presented with a specific set of information, made understandable to him by the physician or medical team, whether to start or continue the planned treatment.

“Acquisition of Informed Consensus” of the Patient, can be constituted by the consent (complete or partial), but born in a negative sense dissent or revocation, compared to what proposed by the Doctor, at the end of the whole information pathway started in the health facility. The completion of such acquisition can take place not only the modality of the signature of the patient but also through other modalities, to allow the expression also from patients unable to sign.

Law 219/17 identifies the 2 components of the informed Consensus in the health field, the information, and the process through which it is made comprehensible to the Patient. L. 219/17 identifies the subjects with the duty of information in the medical team, who takes care of their proposal to the patient that is the health facility.

Information aimed at acquiring the informed consent is an obligation of the health structure (L.219/17, art. 1, paragraph 9) aimed at ensuring greater understanding to the patient every question related to the path to be undertaken (III c. L.219/17) to make people understand the benefits, the risks of every path of assistance and care.

L. n.219/17 indicates that the adequacy of information concerning the informed consent to be obtained, to be diversified concerning diagnosis, to the most useful treatments, to the possible alternatives (probable prognosis, consequences of refusal/revocation, possible psychological assistance provided by art. 1 c.5). The modalities of acquisition and management of such information are regulated by the guidelines referred to in l.24/17 (L.Gelli-Bianco”), such as soft law elaborated by the Medical-Scientific Societies for each treatment/ health inspection.

The level of understanding of the information provided is at the heart of the informed consent, as provided by l.219/17, art. 1, c.2), obligation to make information understandable, to allow the patient to express his decision independently, as a specific task and responsibility of the physician / medical team. This process is the fulcrum of informed consent, as a key moment that allows both to establish a climate of trust between doctor/ health care team and the patient, both in involving him in the therapeutic path and starting the “treatment relationship” oriented to ensure the humanization of the individual treatment path.

Even in the observance of the norm the fragmentation and the temporal dilatation constitute the organizational criticalities, in how much they disperse the resources between 40% and 80% rendering ineffective such an informative process. Each health care facility has used its organizational

and management autonomy to improve customer relations through the standardization of informed consent processes [8-10].

At the level of know-how, an APP has been designed, which allows consulting the information related to a certain therapeutic path. The data for each DRG can be composed of textual and photographic contents, but also of infographics and multimedia. This tool dialogues interactively with the patient to collect information useful for consent and, through the Evaluation Engine measures the level of understanding of the disseminated content. If the patient has not understood part of the contents, these are proposed to make the consent not only informed but also aware. In this way, the direct relationship is not replaced, but the monitoring of the flow of information allows to improvement of the quality of communication progressively, through deepening's with the doctor and the team.

Another organizational tool used was the standardization of informed consent, as happened at the Policlinics of Palermo P. Giaccone, which disclosed the Guidelines "United for Safety", which practical recommendations, implemented by the Ministry of Health, disseminated through appropriate communication and distribution tools in the operating units. These guides have been tools of information for the users of the company but born of awareness for health workers.

This interaction makes it possible to go beyond mere information, as constant monitoring but also a gradual change in communication for each path can hinder the origin of the issues and concerns, as a preventive instrument for conflicts of interest and litigation.

Proactive actions at the company level

This paragraph analyses the set of organizational measures and tools implemented at the level of individual health structures to prevent and reduce the occurrence of errors related to inefficient management of information flows.

The means of identifying the patient and the means of transporting the medical documents

The correct identification of the patient is one of the priority actions promoted by the World Health Organization and the Joint Commission International, in ensuring the safety and appropriate care for the patient. The relevance of this phase of patient identification involves a variety of care processes, such as the execution of a diagnostic procedure, even out of department, surgery or invasive procedures, and non-invasive, such as taking and administering medicines or blood products.

The Recommendation n.3 of the Ministry of Health "Recommendation for the correct identification of patients, site, and procedure" provided the modalities to be applied in identifying the patient and the related responsibilities of the operators. In particular, each patient, on entering a hospital, is assigned an identification bracelet, which in addition to containing the identification data (the name, surname, and date of birth), guarantee recognition and trace the care process undertaken.

This dual function of recognition and tracing of the care path is increasingly used in Italian health facilities. Since 2010, at the Policlinics P. Giaccone in Palermo, an identification bracelet has been used for patients undergoing surgery of particular complexity. This practice aims to replace traditional identification bracelets with electronic ones with RFID technology, for the computerized compilation of the medical records and hospital discharge card, according to the regional Risk Management project. These bracelets are combined with demographic pens, used to ensure the correct identification of the surgical site. At ARNAS Garibaldi have been used identification bracelets that are part of a computer circuit, aimed at ensuring the greater customization of the care path. This instrument is part of a set of tools related to the implementation of the computerized medical record that is adapted from every Operating Unit involved in emergency medicine to the maternal-infant department, up to the oncological path. This specific method of species identification of the oncological patient allows us to follow the patient within the therapeutic circuit frequently linked to oncological treatments, European for cycles and as such require continuous monitoring [11-12].

Clinical records and operating records: management and control

The information circuit also includes adequate management and verification of health records (medical, nursing or care records, X-rays, diagnostic inquiries, therapies, reports, letters of resignation) to prevent and manage conflicts. The medical documentation has clinical and legal value and as such the management involves different organizational measures. The main instruments are medical records and surgical records. The main instruments are medical records and surgical records.

The medical record is the set of documents of forensic relevance, in which health professionals record the set of information on a patient's personal, health, environmental, legal, and individual hospitalization. In public and private establishments, medical records must be drawn up, with punctuality and diligence, following the rules of good clinical practice and contain, in addition to any information relating to the pathological condition and course, the diagnostic and therapeutic activities carried out.

In this way, clinical records can be used to manage clinical risk to prevent and manage health conflicts as a means of communication between health professionals and between patients and healthcare facilities, as well as assessing the assistance and effectiveness of cure1. Indeed, the registration of the diagnostic and therapeutic process is aimed at encouraging appropriate and timely choices, as well as reviewing the chart, as a method to identify and improve the knowledge of adverse events. Also, the chart satisfies other organizational needs through the indication of DRGs and allows them to remunerate the services and support the research funded through these attestations.

Each medical record shall uniquely indicate a hospitalization and shall meet the following standards. In the first place, the medical records must be complete and contain all reports, including documents relating to blood and blood transfusions, anaesthetic documentation and a copy of the surgical report. The traceability of a medical record allows tracing the activities, decisions, executors, materials, and documents, which constitute the assistance process from the initial assessment to disposal to transfer. Clarity concerns the handwriting and exposure, which can allow for readability and understanding

in the use of the medical record. Similarly, exposure must be direct and clear, without giving rise to different interpretations.

The accuracy indicates that the chart must account for what has happened in all phases of the clinical care process. In the same way, the prescribed therapies, the dosage and the method of administration of the drugs, the nutritional prescriptions, the transcription of the vital parameters, the prescribed examinations, the consultations carried out and the results of the procedures performed should be reported.

The veracity of the information contained in the health records implies that the data and events are recorded at the time of the event or in emergencies with the utmost attention to the individual modalities of communication, both verbal and written, to reduce the forms of divergence and dispersion of the same in the individual stages of the treatment. In this respect, findings can be identified in the passage of deliveries that may be deficient and disorganized, letters of transfer or resignation may present information gaps or be redundant, neglecting the relevant information. Similarly, the implementation of a standardized approach to communication is the only way to eliminate these avoidable errors. To this end, some health facilities, such as the ARNAS Garibaldi of Catania have paid maximum attention to the transport of the sanitary documents through the elaboration of business rules whose implementation is finalized to guarantee the protection of the privacy and to prevent the risks from communication for dysfunctions in the management of business documents.

Comparison organizational models oriented to value-based health

The current organizational trend is oriented to e-Health, in ensuring management able to support the interaction between professionals with the citizen and healthcare reference structure. As part of such a path towards Digital Health, the Electronic Health Issue is the main tool in the implementation of the quality of healthcare provision and efficiency, through cost containment and optimization of resources used.

The eHealth Issue constitutes a single point of aggregation of relevant information and health and social-health documents related to the citizen, generated by the actors of the SSN and regional health and social services. The Electronic Health Issue is defined by the legislation as the set of health and social-health digital data and documents generated by present and past clinical events related to an illness. The main objectives are to facilitate assistance through a health service that can help integrate the different professional skills that territorial mobility. This dossier is set up by autonomous regions and provinces, in compliance with current legislation on the protection of personal data, and pertains to activities related to the provision of health services, from prevention to the verification of the quality of care.

This Electronic tool places the health care centre of the individual user through an information bag, able to trace, consult the health path and share with health professionals every single health path undertaken. The health dossier contains in one place the health information related to the state of health of the assisted (such as laboratory examinations, therapies, medical history) inserted by the family doctor and various specialists, with the consent of the person concerned both at initiation and at the consultation. This approach avoids the repetition of unnecessary clinical investigations. All ESF information and documents shall be interoperable, facilitating consultation in the territory and not only in the region of the assisted person's residence. This increased sharing of information allows the assisted person freedom of choice of care. Also, access to the ESF by health professionals, in emergencies, makes it possible to know what is needed to intervene with a greater guarantee of results.

A standardized communication model is the SBAR, a system invented for safety within American nuclear submarines to identify critical areas, quickly and transmit this information to the commander. This communication technique SBAR, acronym of Situation, background, Assessment, recommendation/ request was introduced in the 90s in the most important accredited hospitals of the Joint Commission because it ensured compliance with the standards, based on a standardized method of communication between health care workers in teamwork, able to quickly identify the most critical settings to be placed on the operator's immediate attention in taking care of the patient.

The method of communication under consideration, applied in the areas of telephone communication in crises, in the passage of deliveries, and the transfer and discharge of the patient, has increased the level of patient safety through a simple model, that the content of communications is made to a predefined standard, for which the essential standards, the current situation of the patient, the assessment of vital signs, including the degree of severity of the disease, must be described, the clinical picture, treatment, and recommendations regarding resignation or transfer, including treatment.

A critical first phase concerns the system of collection, management, and monitoring of complaints used by Companies. It is worth noting the activity carried out by the Policlinico of Palermo, which from a paper system, has passed to a computerized system since 2011 to produce a better reporting, which will allow in addition to the paper to report, extract and collect complaints of interest. Another initiative to reduce the risks arising from incorrect communication concerns the activation of SOS Infomondo, a multilingual telephone interpreting service to facilitate communication between healthcare professionals and patients/foreign users. This service, under emergency conditions, has made it possible to prevent the risk of incorrect or late diagnosis.

The effective realization of digital health care will be able to obtain savings through the dematerialization of the paper and to start a review of the clinical and administrative processes and the entire public health organization. In particular, the improvement of the quality of services may involve prevention, diagnosis, treatment, and rehabilitation; scientific study and research in the medical, biomedical and epidemiological fields; health planning, quality assurance and assessment of health care.

Concluding aspects

Communication paths in territorial responsibility

The health experiences gained in the Italian health system allow discussing the models of communication more effective in managing the risk. At the level of comparison, other countries have shown that communication can be seen as a resource,

not an expense, to help improve health. Communication makes it possible to measure satisfaction and to take on board the comments of the target audiences, and as such requires professional figures, able to cooperate in the information circuit and to guide the choices of users.

The picture illustrates the importance of multilevel measures and actions. At the planning level, l. n. 150/2000 allows defining the guidelines consistent with the organization of the health services, through communication offices, with human resources and means of high professionalism, under national and regional legislative requirements.

At the level of the single sanitary structure, the organizational autonomy allows adapting the communication to the own complexity of the customers, to the characteristics of the territory and the demands for the assistance of the community. Public communication in Health Enterprises plays a strategic role in facilitating access to and appropriate use of services, as well as the adoption of behaviors aimed at the protection and improvement of individual and collective health. In this process, public communication must pay attention to the most vulnerable population groups and the health effects generated by socio-economic inequalities. More efficient management of communication through websites can enable users to acquire information themselves or to make reservations directly online. The implementation of open institutional campaigns can reduce socioeconomic inequalities through adequate user segmentation and the use of integrated strategies and professionalism in such activities serving citizens.

In current digitization, information is more targeted at facilitating choices in a therapeutic path, but at the same time, it has made communication management complex with the response of services to users' needs. In the past, the organizational thirst was rooted in the territory and as such was able to guarantee an adequate assistance response in organizational terms for what was necessary to the target user. As a result of the growth in demand, the local authorities had to structure themselves to avoid the dispersion of resources, providing effective and non-bureaucratic management and control systems in which improved communication is an essential organizational lever. The last stage of this evolution is the present one, which reveals a complexity caused by a high capillarization of the assistance. In this context, the communication can be dispersed for the widening in the modalities of finding the information and for the insufficient control relative to the authoritativeness of the sources informed to the inside of sanitary structures.

Indeed, the speed of dissemination of information through current communication tools such as e-mail, social networks, texting has made communication more open and faster, but this can degenerate into a loss of control over the veracity of content, especially when corporate leaders are no longer the only ones to have access to sources and manage communication channels.

Similarly, the prospects are to manage this information in such a way as to orient it to the specific communication purposes pursued (the communication campaigns for vaccination or prevention from the Corona Virus, as well as those related to screening). In these contexts, there is a need for greater transparency in the information space, b which can indicate the purpose of communication, the content to be published and predict the possible behavior of users. The increasing spread of social media in healthcare facilities has allowed improving the level of information even if the benefits are not yet recognized in the health organization, except as indicated in Circular 2/2017 on transparency mentioning the use of such instruments. In the same way, it is felt useful to trace a national Social Media Policy and a regulatory framework of reference, able to standardize the use of social media (tone of voice, privacy, response times, off-topic, editorial plan, interactivity).

A more effective health service in responding to health needs implies a qualitative leap with a strengthening, coordination, and improvement of communication services at the territorial level. The actions promoted are to favour a correct information with appropriate contents through an adequate organization of the structures of communication to territorial level and the articulation between the Autonomous Operating Unit and structures periferiche on the mould of the model Hub and Spooke (Press Offices, URP, similar structures).

Communication in this context of territorial capilarizzazione cannot but present a high diversification of organizational management. At the organizational level, the institution of a URP in each Hospital Presidium and Health District is to be coordinated in a company "URP. Such coordination at a high level in the corporate organizational structure implies the establishment of a coordination structure ("Communication System"). This organizational structure implies professional profiles able to guarantee the uniformity of communication services, as well as the confirmation to the territory through a segmentation of the catchment area concerning the dimension of socio-sanitary care required.

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