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Pouryahya Pourya[124], Leong Esther[4], Lim Andy[234], Meyer Alastair[124]

1 Casey hospital, Emergency Department, Program of Emergency Medicine, Monash Health, Victoria
2 Monash Emergency Research Collaborative, School of Clinical Sciences, Monash Health, Monash University, Victoria
3 Monash Medical Centre, Emergency Department, Program of Emergency Medicine, Monash Health, Victoria
4 Faculty of Medicine, Nursing and Health Sciences, Monash University, Victoria

Corresponding / Main Author:
A.Prof Pourya Pouryahya
Casey hospital, 62 Kangan drive, Berwick, Victoria 3806, Australia
email: Pourya.Pouryahya@monashhealth.org
Pourya.Pouryahya@monash.edu

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ABSTRACT

Objective
This is an observational study using phone survey data to describe Consultant in Charge (CIC) phone introductions at major Australian hospital Emergency Departments (EDs).

Methods
Twenty-nine principal referral hospitals were surveyed by phone using a predetermined script. The primary outcome measure was the number of receivers who identified their name, role, and department. A 'success' was recorded if this was unprompted. A 'partial success' was recorded if prompting was required. An 'inadequate' outcome was the failure of the first two steps.

Results
Twenty-nine principal referral hospitals were contacted. The primary outcome results were 10.3% [95% CI 3.58, 26.38] success, 48.3% [95% CI 31.4, 65.6] partial success, and 41.4% [95% CI 25.5, 59.3] inadequate. Name, role, and hospital/department were provided without prompting in 86.2% [95% CI 68.3, 96.1], 27.6% [95% CI 12.7, 47.2], and 72.4% [95% CI 52.8, 87.3] respectively.

Conclusions
Major referral centers have potential to improve communication at the front line.

Keywords: Communication, Emergency Services, Emergency Department

Background and Rationale

Effective communication is increasingly being recognised as key to good and safe patient care. Standardised communication strategies are recommended by the Medical Board of Australia (2014), World Health Organisation (Leotsakos et al., 2014) and The Institute of Healthcare Improvement (2018) to promote good patient care. At the very outset of any communication is the introduction. A proper introduction sets the tone for the conversation to follow. Participants in one study expressed how the nature of their exchanges was "in part by whether they knew or what they knew of the person to whom they were speaking" (Alrich et al., 2009). Recently, the change from the SBAR protocol to ISBAR has encouraged healthcare staff to properly and accurately Identify themselves while participating in the handover.There has also been a movement encouraging doctors to introduce themselves to patients, but it is less common for doctors to introduce themselves properly to other healthcare staff. Studies have been done about the structure or content of phone calls (Kessler et al., 2015) and

how doctors introduce themselves in real life (Gillen et al., 2018), but few have addressed how doctors introduce themselves over the phone. Informal observational data have suggested that healthcare staff often do not know whom they spoke with over the phone, which can become problematic when there is a need to follow up on information exchanged during the interaction. Joint Commission Centre for Transforming Healthcare identified "Inability of sender to follow up with receiver if additional information needs to be shared" as one of the root causes of communication failure in patient handovers. (2014) This complaints-driven study aims to observe the practices of the Consultant in Charge (CICs) of Emergency Departments (EDs) with respect to answering an unknown external phone call. CIC often receive phone calls from GPs or other medical practitioners for advice relating to emergency patient management or to make a referral. The objectives were two-fold: first, to measure the rates of a comprehensive introduction of the CICs in an ED setting, and second, to find out what CICs deem important in an introduction.

Name	State
Austin Hospital	Vic
Canberra Hospital & Health Services	ACT
Concord	NSW
Flinders Medical Centre	SA
Geelong Hospital	Vic
Gold Coast Hospital	Qld
John Hunter	NSW
Liverpool	NSW
Monash Medical Centre [Clayton]	Vic
Nepean	NSW
Prince of Wales	NSW
Princess Alexandra Hospital	Qld
Royal Adelaide Hospital	SA
Royal Brisbane & Women's Hospital	Qld
Royal Darwin Hospital	NT
Royal Hobart Hospital	Tas
Royal Melbourne Hospital [Parkville]	Vic
Royal North Shore	NSW
Royal Perth Hospital Wellington Street Campus	WA
Royal Prince Alfred	NSW
Sir Charles Gairdner Hospital	WA
St George	NSW
St Vincent's Darlinghurst	NSW
St Vincent's Hospital [Fitzroy]	Vic
The Alfred	Vic
The Prince Charles Hospital	Qld
The Townsville Hospital	Qld
Westmead	NSW
Wollongong	NSW

Table 1. Demographics of the study population.

Methodology

An assessment was undertaken for major principal referral hospitals across all 6 states (Victoria, Western Australia, New South Wales, South Australia, Queensland, Tasmania) and 2 territories (Australian Capital Territory, Northern Territory). These hospitals are public acute hospitals with highly specialised and broad range of services and large patient volumes. All but 4 hospitals have a 24-hour ED (Table 1).

Phone calls were during business hours and placed directly to the CICs of the shift through the hospital switchboard. Calls were mainly made at the time of morning and afternoon shift overlapping to minimize interruption and similar script were used for all contacts (Figure 1).

Elements

1. *Greetings (when the line connects)*
2. *Title*
3. *Name*
4. *Role*
5. *Hospital/department*

Part 1:

1. *Receiver of call correctly identifies all of title, name, role, and department immediately upon answer call (Considered 'complete')*
2. *If all elements are not said:*

a. *Introduce self-prompt with: 'may I ask what your role is?'*

2. *If all elements are said upon prompting this would be considered 'complete with prompt'*
3. *If all elements are not said following prompt this would be considered 'incomplete'*

Part 2 to commence following completion of part 1:

Caller to explain the purpose of call

"I am _____from Monash Health in Melbourne, Victoria. We are calling as part of a research project investigating how ED staff introduce themselves to callers. All information collected will be deidentified. Thank you for your time. "

Figure 1. The phone script

The recipients of the calls were assessed to see if their immediate introduction included: their name, their role, and the department/hospital reached. If all 3 identifiers were given, it would be considered a success. If not, a prompt would be given asking the recipient what their role was. If all 3 identifiers are then said upon prompting, it would be considered a partial success. If all 3 identifiers are not said upon prompting, it would be considered inadequate. The caller then explained the purpose of the call and asked the recipient for their opinion on what components should be included when answering the phone.

Data was collected in Excel. 95% confidence intervals were calculated in R Studio V1.2.5033, with base R v3.6.0 using the Clopper-Pearson method. The study was approved by the Monash Health Low Risk Human Research Ethics Committee (RES-18-00000-551L).

Results

Twenty-nine principal referral hospitals were surveyed. Of these, all 29 responded. The primary outcome results were 10.3% [95% CI 2.2, 27.4] success, 48.3% [95% CI 29.5, 67.5], partial success, and 41.4% [95% CI 23.5, 61.1] inadequate. Name, role, and hospital/department were provided without prompting in 86.2% [95% CI 68.3, 96.1], 27.6% [95% CI 12.7, 47.2], and 72.4% [95% 52.8, 87.3] respectively (Table 2 and figure 2).

			95% CI	
Primary Outcome	**Number**	**%**	**% Lower Limit**	**% Upper Limit**
Success	3	10.3	2.2	27.3
Partial success	14	48.3	29.5	67.5
Inadequate	12	41.4	23.5	61.1
Total	29	100		
Primary Components				
Name	25	86.2	68.3	96.1
Role	8	27.6	12.73	47.2
Location (Hospital/department)	21	72.4	52.8	87.3
Total	29	100		

Table 2. Primary outcome and individual components with 95% confidence intervals.

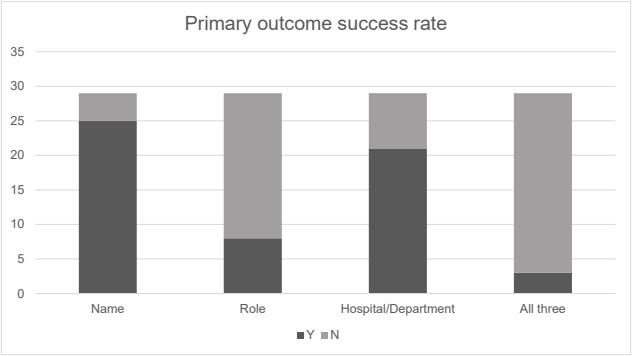

Figure 2. Primary outcome success rate.

In the partial response group, the names were identified by all 14 responders initially. In the inadequate response group, the names were the most common identifier but not all responders stated their name. There were 4 responders who initially only responded with the department/hospital reached, answering with "Emergency Department".

Seven responders were willing to answer the question on what components they felt should be included. All but one felt that their name and hospital should be stated. The one who did not state that it "depends if it's an inpatient team or an outside call". Some felt that stating their role was unnecessary because they "should not have people calling them unless they are after the CIC" and "presume that people will be calling this number if they are referring from GP or external".

Discussion

It was evident that among the CICs assessed that it was not standard practice to identify their name, role, and department upon receiving a phone call. This is problematic if there is information that needs to be followed up on. It also potentially impacts both on the nature and the content of the conversation that would take place, affecting patient care and collaboration between the hospital and outpatient services. Limitations of the study include potential confounding factors on an institutional, receiver and caller level. Institutional factors include staffing levels. In order to reduce this bias, the calls were all made on weekdays during business hours meaning there should be sufficient staffing. Other factors include whether a hospital policy on phone communication is in place. Receiver factors include fatigue or stress, patient load, experience of the CIC and variance in practice across different hospitals. Anecdotally, some CIC declined to answer upon further prompting,

wanting to know instead where the caller was from. Upon explaining that this was part of a study, many felt quite disturbed by the intrusiveness of receiving calls for data collection whilst on shift, stating that it was not appropriate to call during a "busy shift" in a "big ED".

Caller factors include the self-introduction given and inter-rater reliability. This is reduced by the use of a single data collector who followed a scripted speech for every call.

Recommendation

Major referral centers have potential to improve communication at the front line. Efficiency is prioritised in the ED but should not be at the expense of effective communication. Introductions over the phone can be simple, quick and polite yet fulfil all 3 elements. Some examples of such introductions made in the study are "It's (name), ED consultant" or "Emergency, this is (name), ED consultant". While these introductions do not include the name of the hospital, it includes all the pertinent information which the caller would like to hear.

Further studies can be done to include a bigger number of hospitals of a variety of sizes. It would also be useful to explore how healthcare staff view the importance of introduction and which elements are essential to them.

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