REDUCING BARRIERS OF COMMUNICATION IN CANCER CARE AND PALLIATIVE CARE SETTINGS FOR PATIENTS REQUIRING INTERPRETERS

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KEYWORDS

Medical interpreter, end-of-life discussions, culturally and linguistically diverse, palliative care, cancer care

EXECUTIVE SUMMARY

Using interpreters adds complexity to challenging palliative care and cancer care conversations. Literature demonstrates the value of pre-briefing interpreters, though no formalised pre-briefing practices exist. We aimed to increase interpreter pre-briefing in palliative and cancer care settings from 26% to 50% in six months, using evidence-based QI strategies. Interventions included multidisciplinary education, clinician reminder systems and mandatory pre-briefing fields at booking. By project's end, palliative care appointments achieved 100% pre-briefing consistency, though other cancer settings did not meet the primary aim. Future work includes enlisting champions of optimal interpreter engagement within cancer and other healthcare settings and monitoring interpreter feedback.

INTRODUCTION

Census data shows that 52.7% of residents in the South Western Sydney Local Health District (SWSLHD), in Sydney, Australia, are born overseas, with a significant proportion of this population coming from a non-English speaking background. These communities have shown to experience significantly poorer access to palliative care and support services, and thus experience poorer end-of-life outcomes in comparison to the wider population. While professional health interpreters address some of the typical barriers such as language and communication affecting accessibility for people from non-English speaking backgrounds, interpreters have indicated interpreting end-of-life conversations to be especially challenging. Challenges reported by interpreters include a lack of awareness from health staff of an interpreter's role, interpreters not feeling valued and a lack of integration within the care team. Interpreters, along with several literature papers, have identified the value of pre-briefing in addressing such challenges, including its ability to clarify appointment goals, identify potential issues and improve overall communication and emotional readiness. Despite this, no formal processes have been implemented to integrate pre-briefing practices to support the delivery of effective interpreter interactions with clinicians and patients/families, resulting in poorer quality palliative care and end-of-life outcomes for people and families requiring an interpreter.

As a result, the SWSLHD Palliative Care Service aimed to increase the percentage of pre-briefing sessions occurring with interpreters in palliative care and cancer care settings from a measured baseline of 26% to 50% over a 6-month period.

HIGHLIGHTS

- 100% consistent pre-briefing achieved for all interpreted palliative care appointments.
- Increased pre-briefing from 26% to 39.4% in palliative care *and* cancer care settings.
- Interpreter satisfaction of the appointment improved when pre-briefing occurred.
- Post-interventions, interpreters reported greater empowerment to self-request pre-briefing

METHODOLOGY/ PROCESS

This initiative followed an evidence-based QI framework to achieve its aim of increasing pre-appointment briefing from 26% to 50% in cancer care and palliative care settings for patients requiring interpreters. A multi-step approach was utilised:

Forming a team: A multidisciplinary and diverse team was formed including representatives from the SWSLHD Health Interpreter Service, Multicultural Health Service, District Palliative Care Service and Clinical Governance. The team included an interpreter who represented the consumer in this project.

Identifying a problem: The project sought to develop a holistic understanding of the problem by consulting stakeholders (interpreters, cancer services staff and others), reviewing available data (census data, incident data) and reviewing interpreter survey responses.

Investigating potential issues: QI diagnostic tools were utilised to help understand key issues. These included a fish bone analysis and a prioritisation matrix.

Implementing change ideas: Extensive workshopping helped determine the conditions required to facilitate change. Through this, several interventions were identified and tested. These interventions centred around targeted education, general awareness and embedding processes, including IT changes and clinic reminders, to help facilitate pre-briefing to occur.

Assessing impact and improvement: The primary outcome was monitored via surveys from the Interpreter Service which were requested to be completed each time an interpreter interpreted in a palliative care and/or cancer care setting. Several PDSA cycles were commenced to test change ideas and regularly reviewed for appropriateness and impact.

RESULTS/ OUTCOMES

Through data collected via surveys completed by interpreters after each occasion of service in a palliative care or cancer care setting:

(i) The primary outcome of increasing pre-briefings in cancer care and palliative care settings increased from 26% to 39.4%. While 50% was not achieved, an improvement in the number of pre-briefings was seen across both palliative care and cancer settings. However, differences in pre-briefing uptake was noted between interpreters attending palliative care settings or cancer care settings.

- In palliative care settings, 100% of surveys reported receiving pre-appointment briefing by the project's end, with this consistency sustained over 10 weeks. This result demonstrates 100% compliance with policy directives and reflects sustained changes in integrating interpreters within the care team in palliative care settings, ultimately ensuring safety and quality care for patients requiring interpreters.
- In cancer care settings, uptake of pre-briefing varied across weeks, and averaged below 50%. This demonstrates interventions were not similarly impactful across the two settings. Differences in outcomes could include the difference in cohort size, with supervision and encouragement for pre-briefing more easily enforced in the palliative care setting compared to the larger cancer care setting.

(ii) A secondary outcome was also noted in the surveys, with interpreters reporting improved satisfaction in palliative care and cancer care settings when pre-briefing occurred. This was corroborated by written feedback indicating key themes that highlighted patients received improved care, a more satisfied interpreter workforce and better integration into patient care teams.

(iii) Informative case studies to be used for future education and awareness initiatives were also identified through written feedback from interpreters on the negative impacts of utilising family members as interpreters, not engaging in pre-briefing and cases of sub-optimal patient care.

CONCLUSION

This project has addressed a critical gap in all SWSLHD clinical care settings by specifically targeting the pre-briefing process for interpreters, a component often overlooked in healthcare protocols. By integrating education, visual reminders, and technological enhancements into the workflow, it proactively tackled challenges faced by interpreters, ultimately enhancing communication between patients, families and

clinicians, and thus improving quality end-of-life care and health outcomes for the SWSLHD diverse population. There is now a need to further develop this work within cancer care settings and expanding to other hospital departments, with an immediate focus on delivering hospital-wide Junior Medical Officer and registrar education about optimal interpreter engagement. Addressing the other challenges that were later identified through the feedback surveys and diagnostic and root cause analysis phase should also be considered in future projects to ensure the continued, appropriate use and integration of interpreters.

Figure 1 outlines the QI diagnostic tools utilised to understand the key issues that contributed to the challenges interpreters experienced when interpreting end-of-life conversations.

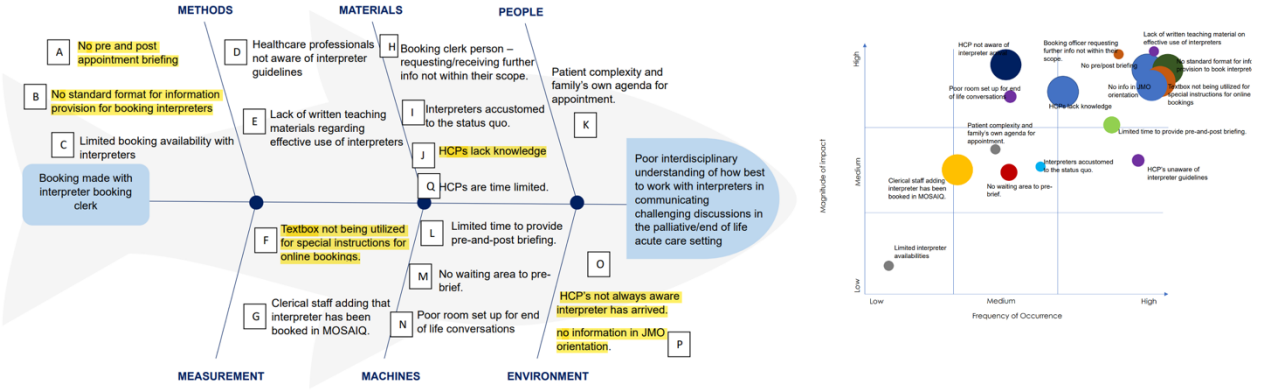


Figure 1: Fish bone analysis & prioritisation matrix

Figure 2 highlights the key drivers that were identified upon engaging with the QI tools. These key drivers helped determine the interventions to be used.

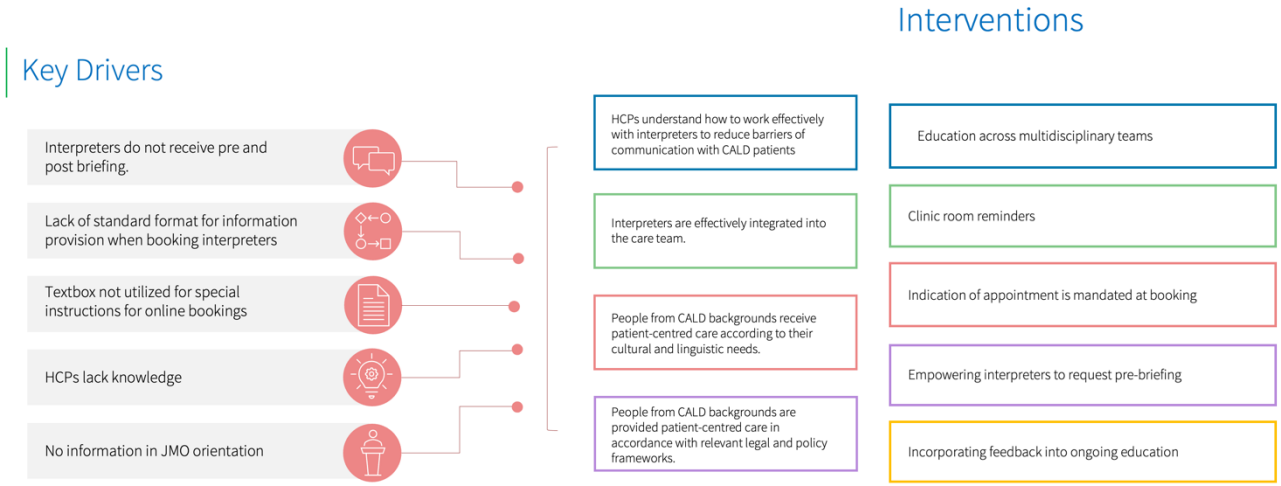


Figure 2: Key drivers and interventions

Figure 3 reflects the number of pre-briefing sessions occurring with interpreters interpreting in cancer care and palliative care settings, over a period of six months.

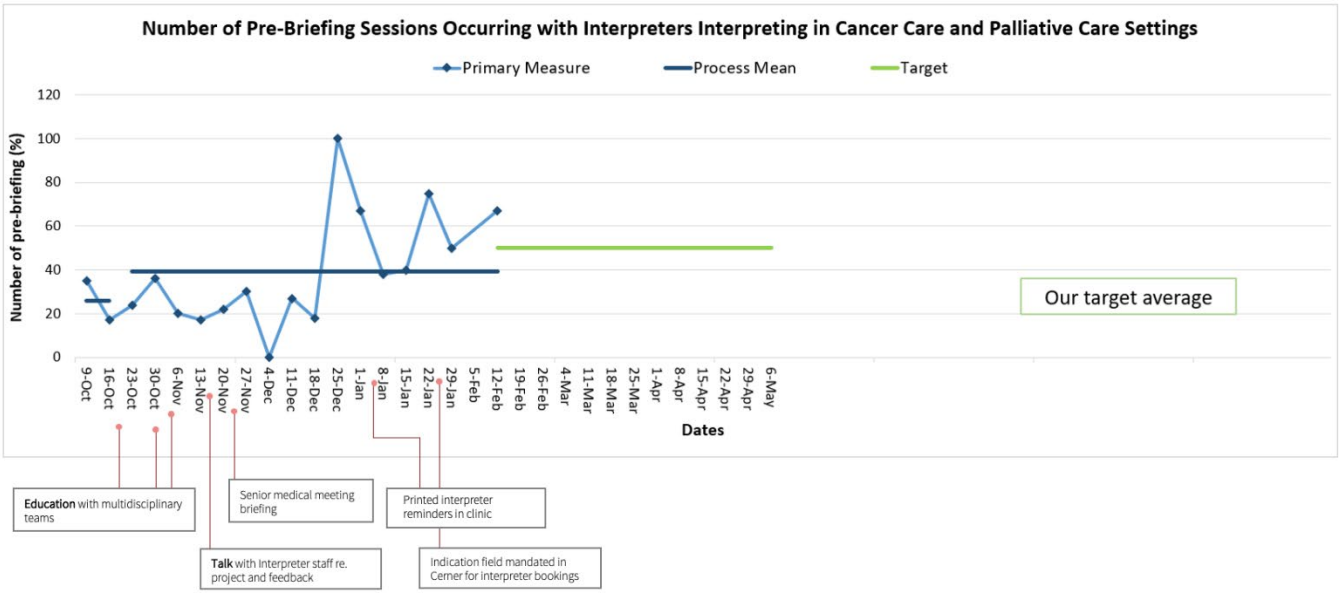


Figure 3: Number of pre-briefing sessions occurring with interpreters interpreting in cancer care and palliative care settings.

Figure 4 separates the number of pre-briefing occurring between palliative care settings and cancer care settings.

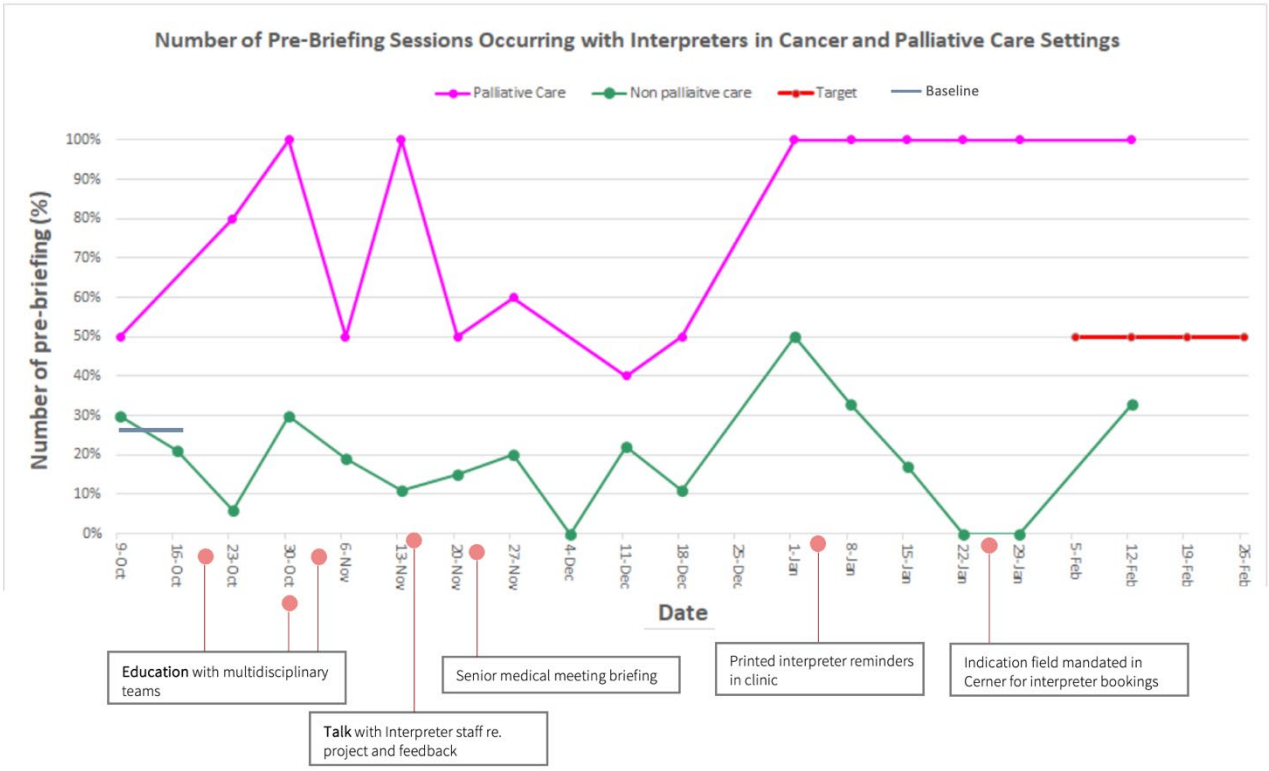


Figure 4: number of pre-briefing sessions occurring with interpreters in cancer care and palliative care settings – divided.

Figure 5 demonstrates interpreters are more likely to be satisfied with the appointment when pre-briefing is provided.

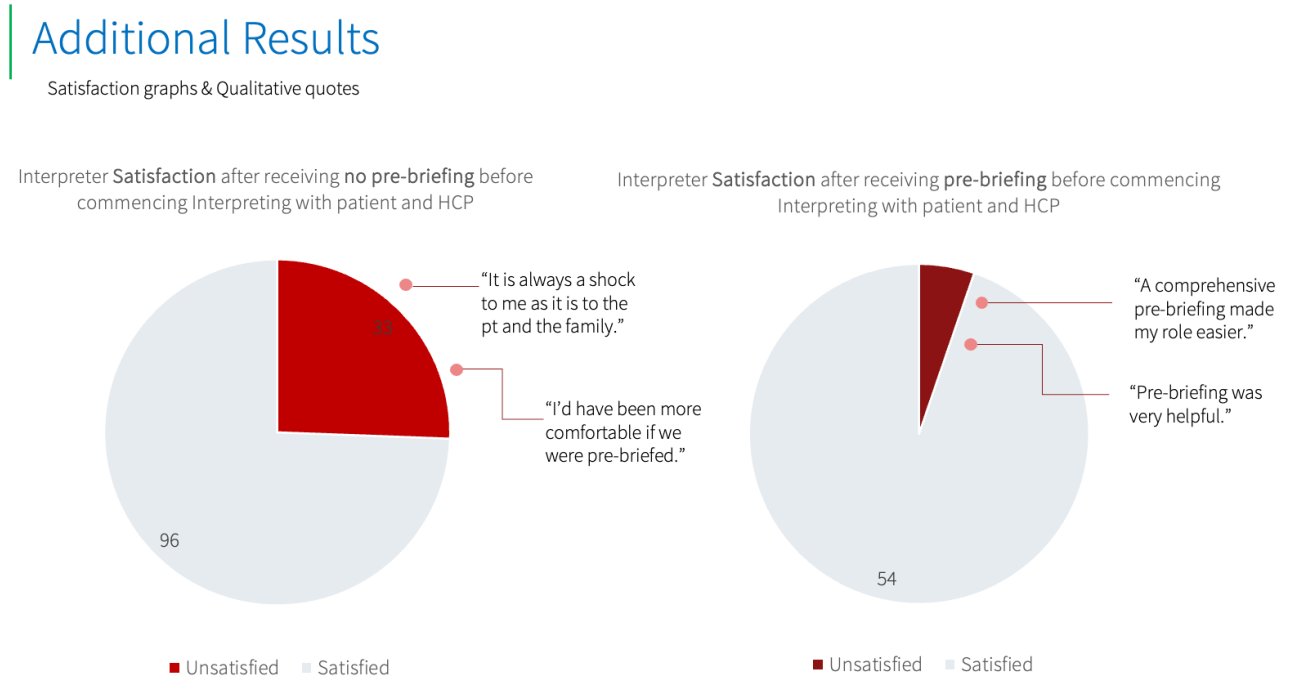


Figure 5: Satisfaction graphs and qualitative quotes