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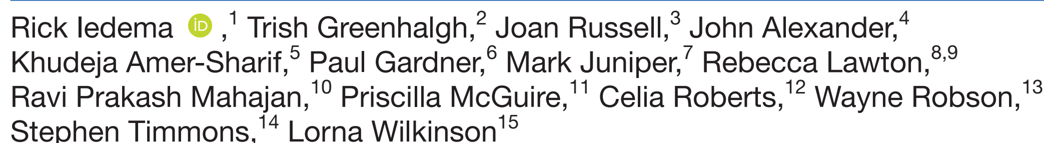
Spoken communication and patient safety: a new direction for healthcare communication policy, research, education and practice?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OVERVIEW

This report sets out the findings of a National Health Service Improvement (NHSI) working group on care communication which included clinicians, patients, patient representatives, NHSI staff and academics from different disciplines. The group's activities included running four national focus groups and discussion days, in addition to conducting national and international literature searches on healthcare communication and communication improvement. The group's conclusions are that six domains of care communication warrant attention and improvement: the care environment, information exchange, attitude and listening, aligning and responding, team communication, and communicating with unique groups. Together, these domains expand the definition of healthcare communication from communication as information transaction to communication as complex social and local dynamic. The report outlines the consequences of this expanded definition for healthcare communication improvement and improvement research.

BACKGROUND

Britain's National Health Service (NHS) has around a million patient–clinician contacts every 36 hours. These contacts produce millions more verbal exchanges among staff. Given these figures, it is hardly surprising that spoken communication goes wrong at times, and that such mishaps can have devastating effects. Indeed, incident investigations around the globe have indicated that inappropriate or ineffective communication contributes more than any other factor to unexpected care events and undesirable care outcomes.[1]

To clarify what needs to be done to improve spoken healthcare communication (staff–patient as well as staff–staff) in the interest of patients' safety, in 2017 NHS Improvement (NHSI) commissioned an external working group of policy-makers, health professionals, NHS managers, academics, patient representatives and patients to develop a conceptual map of issues and challenges. This work resulted in a report titled *More Than Words: Spoken Communication and Patient Safety in the NHS*. This report distills the report's findings and conclusions into six critical communication domains.

APPROACH

Over a period of 10 months, our working group examined existing academic and grey literature on spoken communication in healthcare settings,[2] examined routinely collected NHS data (a representative number of complaint letters and critical incident reports) and accessed online resources (eg, patient feedback websites). We supplemented these secondary sources with information obtained from four focus groups of patients and two half-day consultation events (organised by NHSI and co-facilitated by Working Group members) with a total of 100 NHS patients and staff. Data were analysed thematically and synthesised[3] into six domains that were found (following extended checking against themes dominating the contemporary healthcare communication literature) to define safety-clinical communication. The domains are presented here with single data examples.

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Critical communication domains

Communication environment

The ideal environment for spoken communication is characterised in the first instance by 'caring surroundings'. Such surroundings support communication among clinicians and with patients by contributing to care safety and patients' feeling psychologically and physiologically safe, as noted by this patient:

> I found [name hospital] a very pleasant place, lovely building on the outside and really pleasant inside, staff were all really nice, from the chap polishing the floor who gave us directions, all the way to the registrar & the consultant who explained the operation and what would happen. I didn't feel concerned about the op at all. (From: Care Opinion website)

In contrast, the environment may also render care communication less safe and effective as explained in this online comment:

> I have to mention the large generator that sits just outside the treatment rooms. Obviously this needs to be on 24/7 and because of that patient and therapist have to speak loudly to one another in order to hear one another. (From: Care Opinion website)

Ensuring the clinical environment does not limit but safeguard communication is crucial to maximising the quality and safety of care.

Information exchange

Spoken communication is effective when accurate and appropriate information is exchanged between the right people at the right time.[4] The following was recorded in an operating theatre:

> Stitch scissors please, in my right hand.[5]

This surgeon's scrub nurse is likely to be in no doubt about what is expected.

Inevitably however, problems arise when there is lack of clarity (eg, through the use of jargon), when information is overly scripted, too technical and insufficiently adapted to audience and context, when conflicting information is relayed, or when insufficient or no information is passed on, as in this example:

> A patient was brought up to (ward) from A&E [accident & emergency department] on BIPAP [bi-level positive airway pressure]. I had no prior warning nor was I asked if I was ready. The bed he was allocated had no oxygen tap in place and we had no spare at hand. … The remaining 3 patients who are also at risk of deterioration were put at further risk as everything had to be stopped to accommodate the unexpected arrival of the new patient. (Nurse account, National Reporting and Learning System)

As has been demonstrated by the majority of communication research studies,[6] accurate and timely information is the lifeblood of patient safety.

Attitude and listening

The literature associates effective communication with respect, commitment, positive regard, empathy, trust, receptivity, honesty and an ongoing and collaborative focus on care.[7]

> Mr X- has been nothing but kind, honest, and helpful. (from letter of appreciation sent to local Patient Advice and Liaison Service)

The patient below by contrast reports a very different experience:

> Felt unable to express anything. Being 26 with widespread inflammation and severe pain, I was struggling psychologically with the condition. The rheumatologist I saw at X- hospital, after seeing me break down in tears, not just from physical pain, responded with 'Yes, ok.' … horrendous bedside manner! (Patient's account via HealthWatch Database)

Service users' expectations and understandings are becoming more diverse and more articulate. Actively and respectfully listening out for what patients have to contribute toward their care is now critical to the quality and safety of their care.[8]

Aligning and responding

While attitude and listening are important for optimising the negotiation of information, this fourth domain, aligning and responding, is critical for nurturing the clinician–patient relationship. Such nurturing develops mutual trust, confidence and 'common ground'[9] for the discussion of sensitive and private matters. This nurturing is not a one-off 'check' but an ongoing process.[10] The elderly patient (P) speaking below has come to tell the General Practitioner (GP) (D) about her ordeals with her antibiotics:

> P I haven't been sick since then and the indigestion is gradually going as well […]
>
> D right good well done
>
> P yeah
>
> D we did think it might be a bit of a problem
>
> P If doctor P says you've got to go on more of those
>
> D you might argue with him
>
> P just let me die just let me die
>
> D right[11]

This exchange shows the GP tuning into the patient's mood and humour. By attuning her utterances to the patient's in this way, the GP nurtures their relationship, thereby enhancing the quality and safety of care.[8] Such nurturing less apparent in the following account, potentially hampering care and therefore the patient's safety:

> I had never used gas and air before and needed guidance from the nurse whilst in the procedure room. I tried to 'suck and blow' on the gas and air

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> tube but could not get it to work correctly. The nurse tried to tell me how I needed to blow on the tube and told me that I was not blowing 'right.' I didn't have a clue as to how to get it right. With some exasperation, she said that I needed to 'make a sound like Darth Vader.' I … have absolutely no idea what Darth Vader sounds like. … with the tube stuck in my mouth I couldn't really explain that I didn't know what she was talking about. (Patient's account relayed via Patient Representative)

Building relationships is paramount in circumstances where trust requires mutual understanding and openness. This is particularly true now that illnesses and treatments are becoming more long-term, complex and subject to uncertainty.[12]

Creating the preconditions for effective team communication

A team communicates effectively when it realises the previous four kinds of communication: a caring atmosphere, appropriate information, attitude and listening, and aligning and responding. These add up to team members feeling 'psychologically safe',[13] and feeling valued and sufficiently confident to raise concerns or point out problems, as exemplified in this account:

> Dr X was the consultant overnight, he was available at the end of the phone and took time to explain very clearly to the registrar overnight the child's condition, and what treatment was needed whilst also explaining in great detail what this treatment would do. At the start of the shift he also took the time to explain it to myself and also at the end of the shift he said thank you before I went home for my efforts overnight. (reported to the Learning for Excellence Initiative)

The consultant in this report takes time to explain a complex treatment regimen at handover. The inexperienced clinician feels able to admit ignorance or uncertainty and contact the consultant for further advice.

By contrast, the next example describes several short-comings:

> A patient was in theatre for a Caesarian section. The patient was awake and her partner was also present. The surgeon began to close the wound despite the nurse stating that the swab count was wrong. No other staff member challenged the surgeon. Other than rugby tackling him, what could they do? (Example shared at consultation workshop with NHS staff)

It is clear that team communication must bear out respect for the knowledge, feelings, and insights of all members of the team.

Communicating with unique groups

Greater care than normal needs to be taken when communicating with groups such as children and young people, people with problems understanding spoken English (eg, limited-English speakers, people with a hearing impairment, learning disabilities or cognitive impairment) and people who are distressed or have mental health conditions.[14] These groups need extra time, along with a flexible, personalised, context-sensitive and holistic approach: one size does not fit all. To optimise their communication with such unique groups, many hospitals have proposed the use of a 'hospital passport'. Mid Yorkshire Hospitals describe their initiative as follows:

> The 'hospital passport' lists basic details about the patient such as name, ethnicity and religion as well as a section where patients or their carers can list 'things I like to do and talk about.' The passport also contains a section on 'how I communicate' describing techniques that can be used to help them understand, for example, photos, point board, easy-read documents.

The importance of the 'passport' solution is highlighted by the next example:

> A woman with autism was admitted to hospital after a fall at home. Because of her autism and the stressful experience, she was unable to speak to her clinicians. However, she was able to use WhatsApp for communicating with family members. The clinicians did not realise that the woman had a specific condition; they assumed that she was being rude by not talking to them. (Example shared at NHS staff consultation workshop)

CONCLUSION: THE CHALLENGES ARE COMPLEX, SO SOLUTIONS WILL NOT BE SIMPLE

Taken together, these domains confirm some better-known dimensions of safe communication as well as expanding our understanding of healthcare communication beyond information exchange, to include also the quality of the general care surroundings, people's listening acumen, and relational dynamics in pursuit of interpersonal alignment. They further highlight the multidimensional nature of team communication, and the distinctive characteristics of communication with unique groups of patients. They confirm that spoken communication involves much more than exchanging words: it is about taking time to set the context for open and honest communication; to listen; to connect emotionally; to nurture relationships; to take account of local practicalities and contingencies, and to acknowledge and address diverse needs.

Acknowledging the critical role of organisational leadership in creating appropriate conditions, our further work to develop interventions to improve safety-critical spoken communication will need to address and further staff familiarity with each of the above domains. In practice, this will involve resolving three types of tensions: (1) between a narrow definition of good communication (exchange of precise, accurate and relevant information) and a broader definition (a social, emotional and cultural act requiring situational awareness, emotional

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engagement and reflection); (2) between idealising visions of communication (calm, private and uninterrupted) and the *actual* and often suboptimal situations in which spoken communication happens in the NHS, and (3) between a structured, scripted and standardised approach supported by tools, technologies and checklists, and an approach that celebrates and supports the adaptiveness, creativity and commitment of individual clinicians to working amidst complex circumstances.

Framed thus, the challenge of improving spoken communication is not going to be simple. At minimum, such improvement will require behavioural interventions that help strengthen professionals' capacity for learning and reflexivity to manage rising levels of care complexity.[15] NHSI, who commissioned this work, is now committed to working with NHS organisations and front-line staff to identify what practical techniques and approaches can be deployed to make effective and safe communication happen throughout the NHS. For now, these domains set new parameters for communication improvement throughout the NHS. They also make a critical contribution to the rapidly expanding international patient safety agenda[16] around optimising healthcare communication at a time of rising immigration, diversity, uncertainty and complexity.

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