Communication

Cross cutting theme for patient safety

Sign up to Safety

Creating the conditions for; a safety culture, a just culture, a learning culture and locally led, self directed safety improvement; and building a safer care movement to reduce avoidable harm by half and save 6000 lives.

Bringing to life the five values and behaviours [our pledges]

- put safety first
- continually learn
- be honest
- collaborate
- be supportive

Helping all in the NHS (in England) address five cross cutting system and human factors

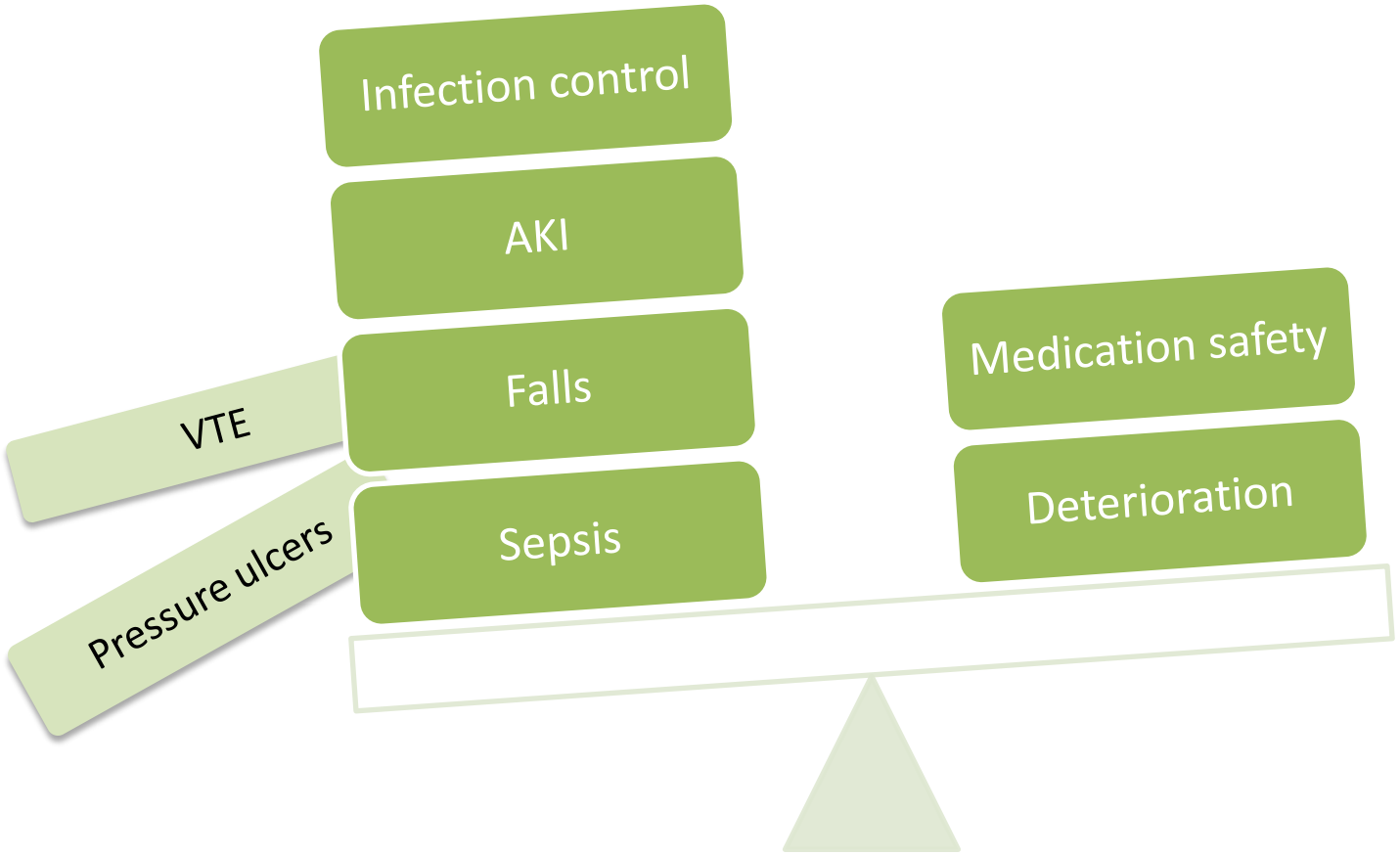
- Communication failures
- Availability and design of the right equipment
- Individual factors; well-being, experience, stress, attitudes and relationships
- Observation failures
- Information failures

Aligning and encouraging the use of five different theories and methods

- Improvement science
- Implementation Science
- Movement methods
- Campaign methods
- Evidence based guidance, standards, targets and incentives

Not assuming we know what works - exploring and questioning current thinking – to do things differently

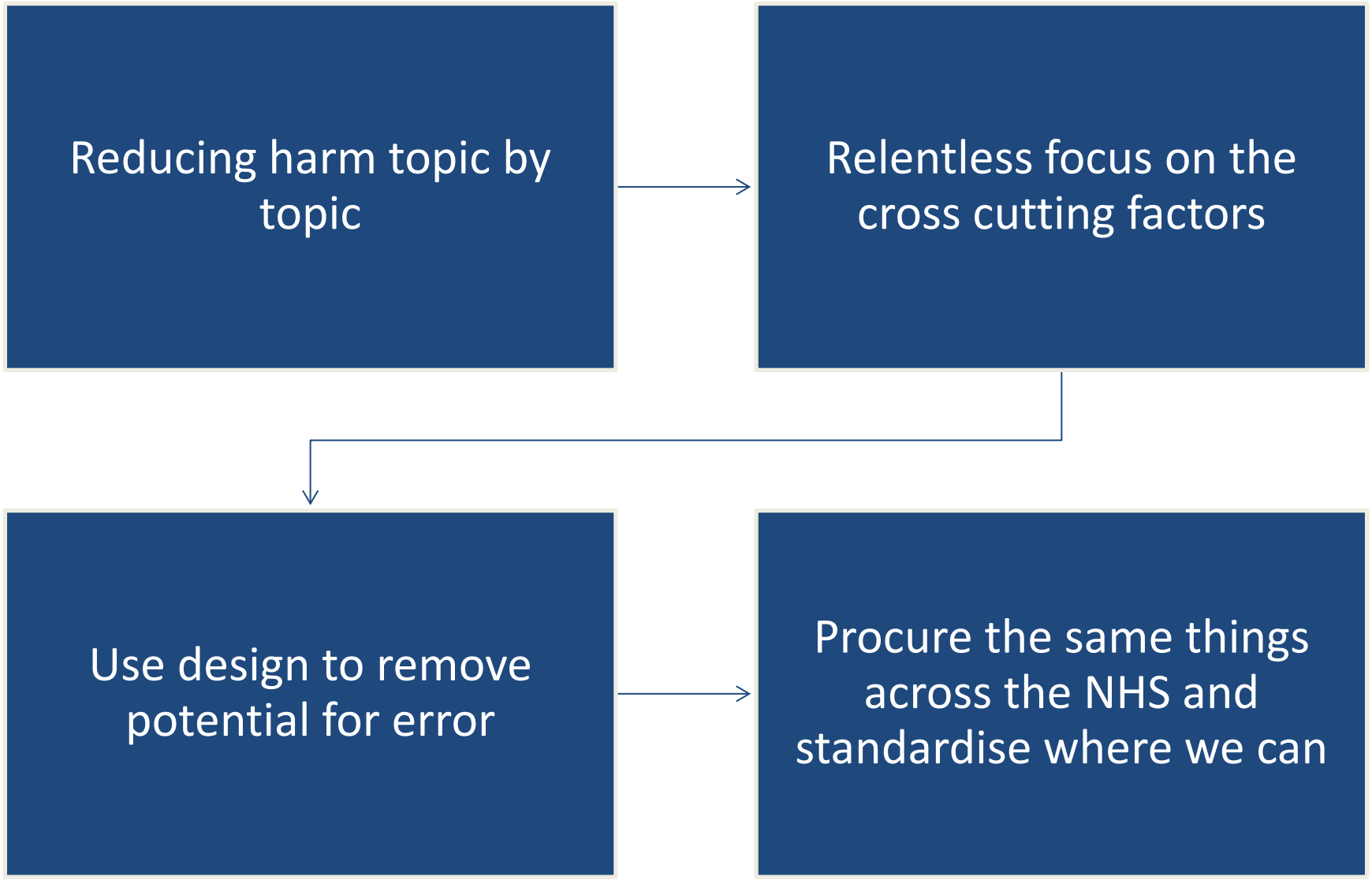
Competing priorities



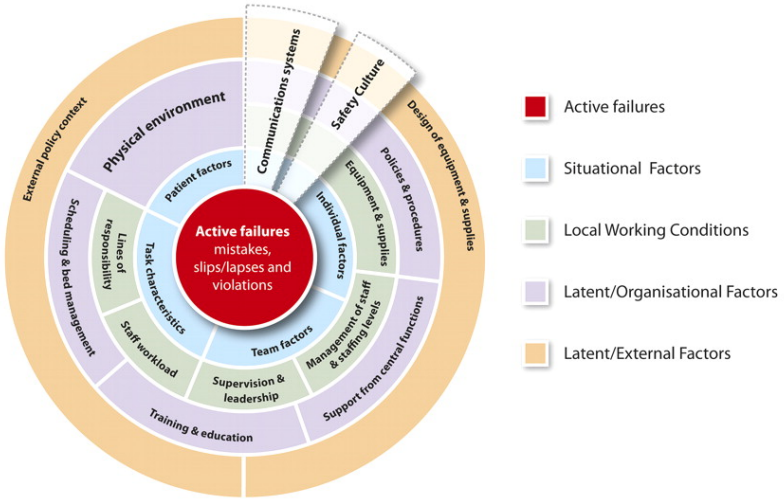
Human factors

Mental workload	Fatigue	Boredom	Scheduling
Barriers	Rules	Distractions	The physical environment
Physical demands	Device/product design	Teamwork	Process design
	Abbreviations	Assessment	

RE(think) solutions



The Yorkshire contributory factors framework

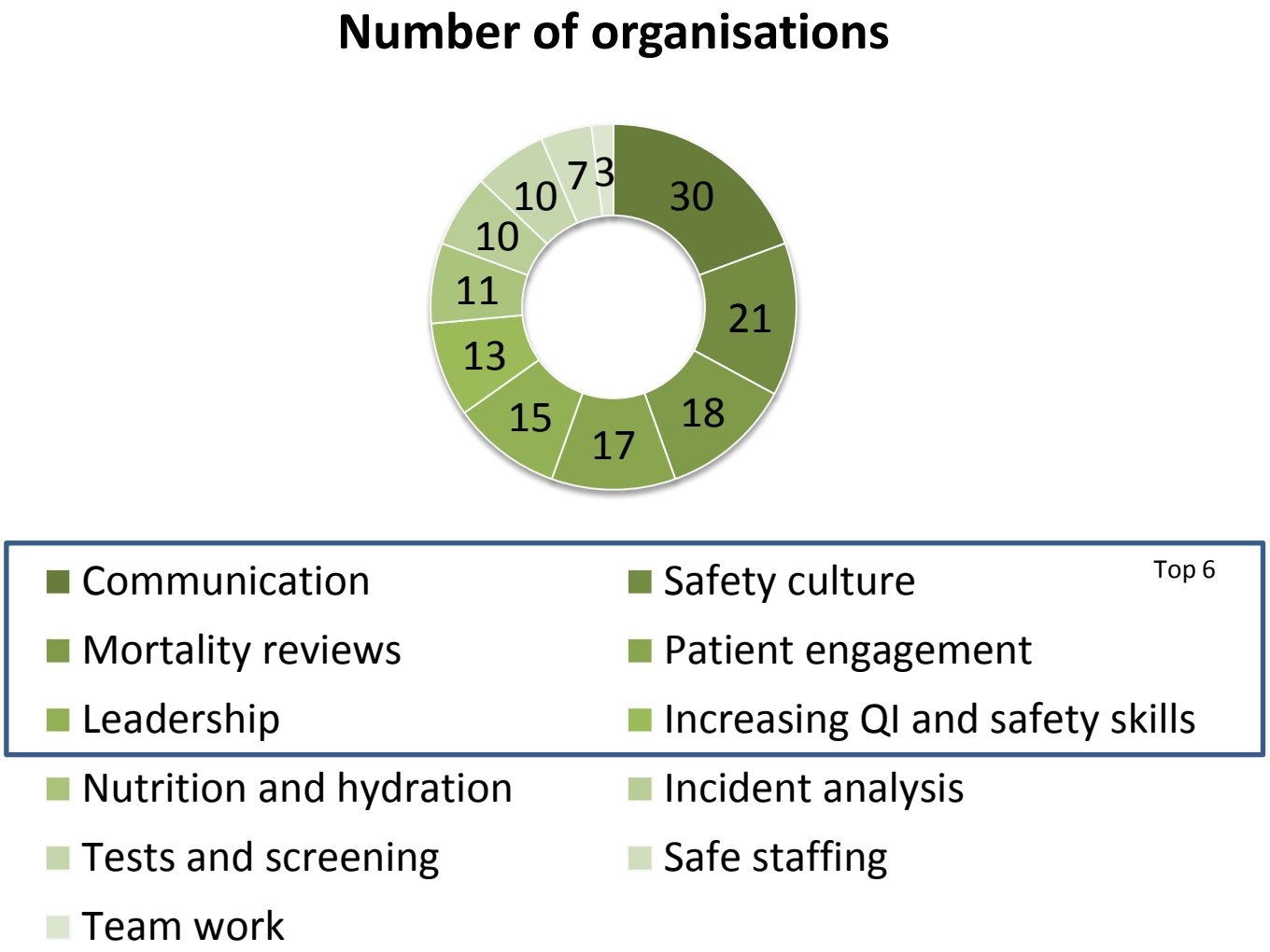


Factor	Definition
Active failures	Any failure in performance or behaviour (eg, error, mistake, violation) of the person at the 'sharp-end' (the health professional)
Communication systems	Effectiveness of the processes and systems in place for the exchange and sharing of information between staff, patients, groups, departments and services. This includes both written (eg, documentation) and verbal (eg, handover) communication systems
Equipment and supplies	Availability and functioning of equipment and supplies
External policy context	Nationally driven policies / directives that impact on the level and quality of resources available to hospitals
Design of equipment and supplies	The design of equipment and supplies to overcome physical and performance limitations
Individual factors	Characteristics of the person delivering care that may contribute in some way to active failures. Examples of such factors include inexperience, stress, personality, attitudes.
Lines of responsibility	Existence of clear lines of responsibility clarifying accountability of staff members and delineating the job role
Management of staff and staffing levels	The appropriate management and allocation of staff to ensure adequate skill mix and staffing levels for the volume of work
Patient factors	Those features of the patient that make caring for them more difficult and therefore more prone to error. These might include abnormal physiology, language difficulties, personality characteristics (eg, aggressive attitude).
Physical environment	Features of the physical environment that help or hinder safe practice. This refers to the layout of the unit, the fixtures and fittings and the level of noise, lighting, temperature etc.
Policy and procedures	The existence of formal and written guidance for the appropriate conduct of work tasks and processes. This can also include situations where procedures are available but contradictory, incomprehensible or of otherwise poor quality
Safety culture	Organisational values, beliefs, and practices surrounding the management of safety and learning from error
Scheduling and bed management	Adequate scheduling to manage patient throughput minimising delays and excessive workload
Staff workload	Level of activity and pressures on time during a shift
Supervision and leadership	The availability and quality of direct and local supervision and leadership
Support from central functions	Availability and adequacy of central services in support the functioning of wards/ units. This might include support from Information Technology and Human Resources, portering services, estates or clinically related services such as radiology, phlebotomy, pharmacy.
Task characteristics	Factors related to specific patient related tasks which may make individuals vulnerable to error
Team factors	Any factor related to the working of different professionals within a group which they may be able to change to improve patient safety
Training and education	Access to correct, timely and appropriate training both specific (eg, Task related) and general (eg, Organisation related)

Rebecca Lawton et al. BMJ Qual Saf 2012;21:369-380

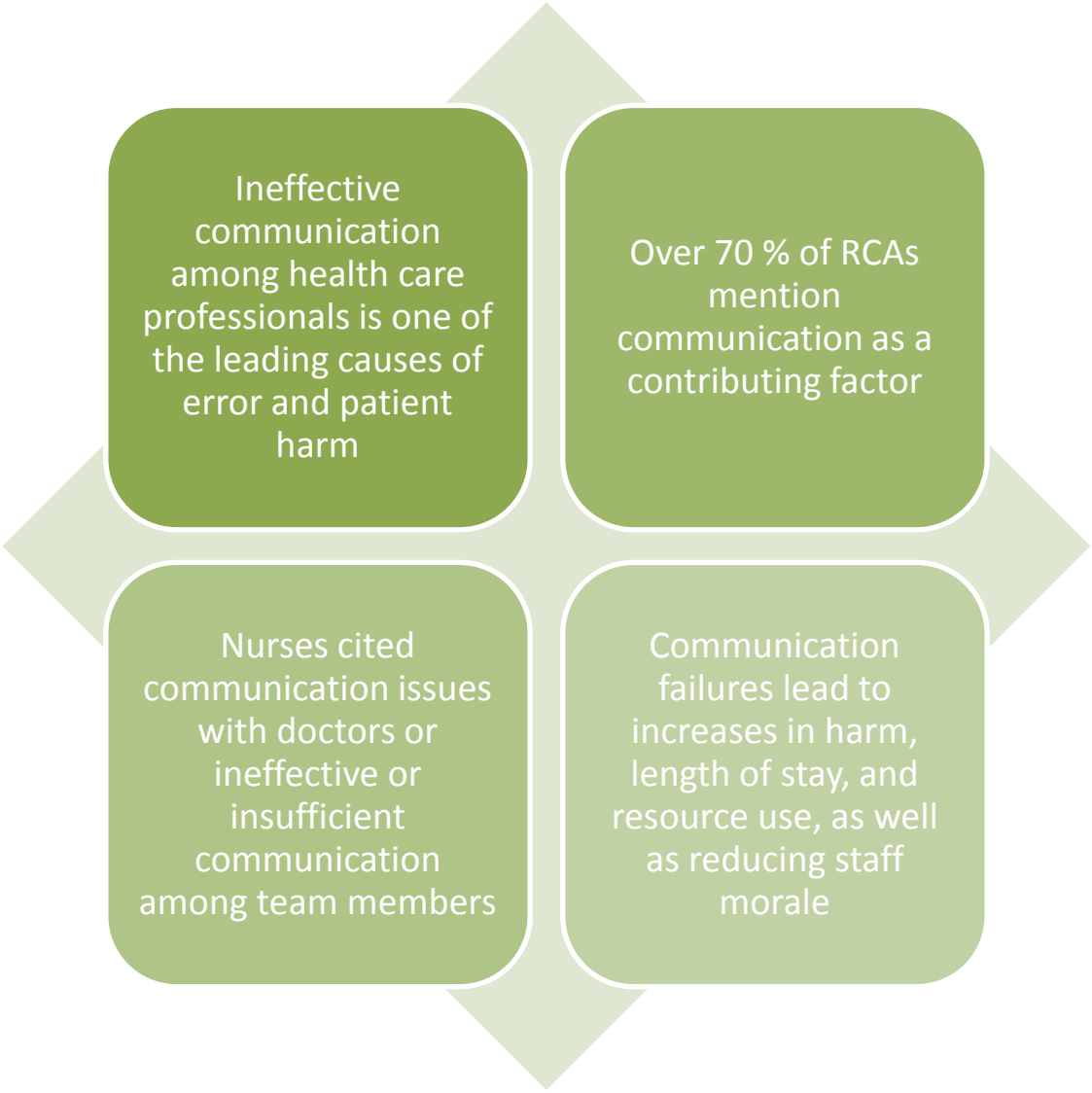
BMJ Quality & Safety

Focus on cross cutting factors



Communication

The evidence



Four categories

(1) Delay in communications so that they were too late to be effective

(2) Failure to communicate with all the relevant individuals on the team

(3) Content that was not consistently complete and accurate

(4) Failure to achieve the purpose of the communications – i.e. issues were left unresolved until the point of urgency

The Team

Health care is complex and unpredictable, with professionals from a variety of disciplines involved in providing care at various times throughout the day, often dispersed over several locations

Different professions often have their own view of what the patient needs, with each person prioritising the activities in which he or she acts independently

Health care has historically had a hierarchical organisational structure, with significant power distances between doctors and other health care professionals. This frequently leads to a culture of inhibition and restraint in communication, rather than a sense of open, safe communication (psychological safety)

Education and Training

Differences in education and training among professions often result in different communication styles and methods that further complicate the scenario and render communications ineffective

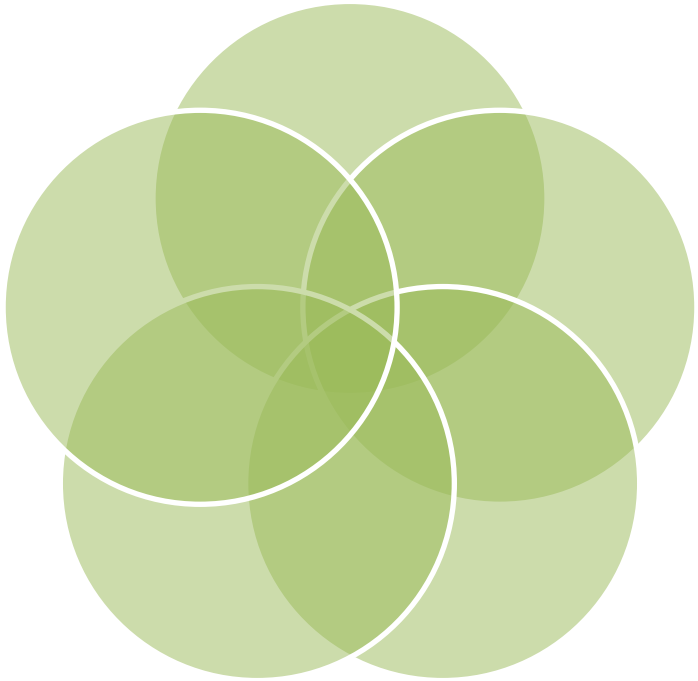
Although teamwork and effective communication are crucial for safe patient care, the educational curricula for most health care professions focus primarily on individual technical skills, neglecting teamwork and communication skills

Human factors and communication

Cognitive overload

Flawed decision making

- All contribute to errors in health care
- Failure to recognise and understand these issues can lead to a culture of unrealistic expectations and blame

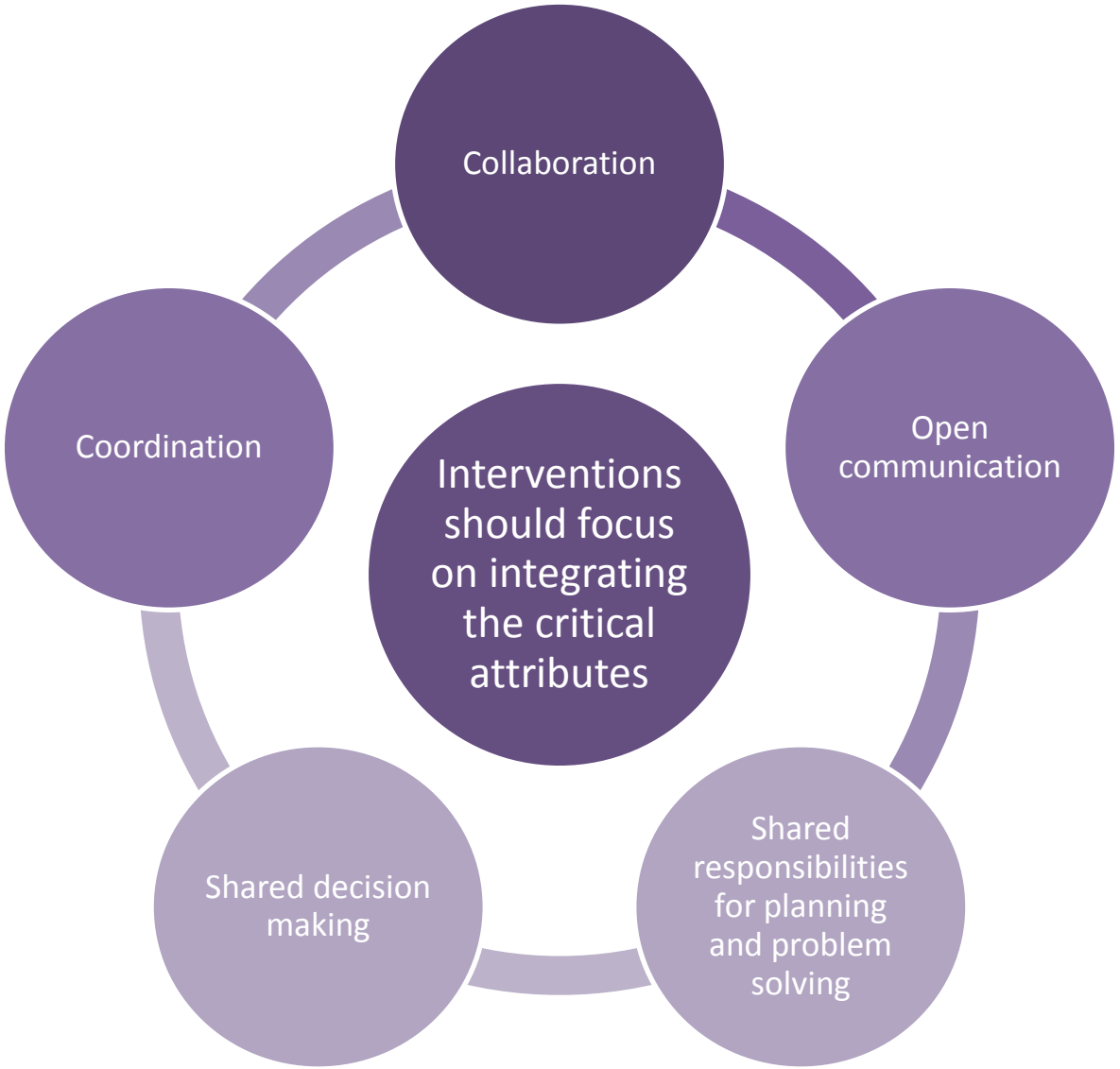


The effects of stress, fatigue, distractions and interruptions

Imperfect information processing

Poor interpersonal communications

Intervention attributes



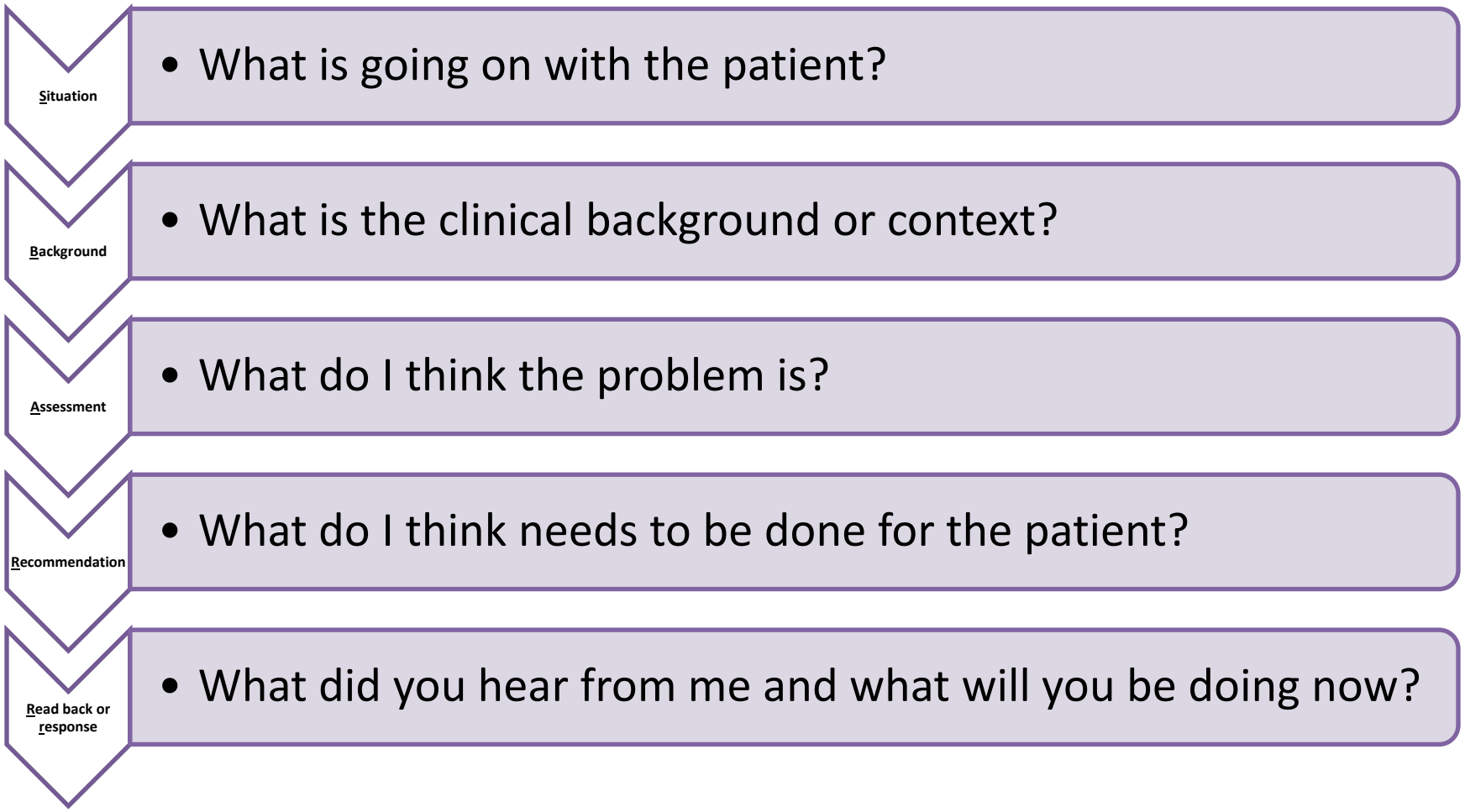
Key tip

- *Simplify messages:*
  - Making the message clear often results in a significant increase in response rates to communications
  - In particular, it's useful to identify how a complex information can be broken down into simpler, easier statements

5 practical tools

1. A standardised communication tool, such as SBARR
2. An escalation process tool to facilitate timely communication
3. Daily multidisciplinary rounds using a daily goals sheet
4. Team huddles during each shift
5. Briefing and de-briefing at the beginning of shifts, clinics or sessions

SBARR


Situation
What is going on with the patient?
Background
What is the clinical background or context?
Assessment
What do I think the problem is?
Recommendation
What do I think needs to be done for the patient?
Read back or response
What did you hear from me and what will you be doing now?

Team huddles

- A team huddle is defined as a quick meeting of a functional group to set the day/shift in motion via commentary with key personnel
- Huddles are microsystem meetings with a specific focus, based on the function of a particular unit and team
- Current literature indicates daily team huddles result in fewer interruptions during the rest of the day and immediate clarification of issues
- Team members know there is a fixed time when they will have everyone else's attention

LONDON 2012

Daily briefings have been shown to be useful for a team to:

- Quickly assess changes in clinical workload
- Identify relevant issues of the day
- Provide a means to prioritise
- So members of a team can get to meet each other and all be “on the same page” for the day or clinic or session
- Beginning of day and end of day to see what worked well and what lessons can be learnt

Guidelines for huddles and briefings

- ✓ Set a standard time each day
- ✓ Use a consistent location
- ✓ Stand up [i.e. don’t sit down]
- ✓ Make attendance mandatory [create respect]
- ✓ Limit duration to 15 minutes [keep brief]
- ✓ Begin and end on time
- ✓ Attempt to have the same structure every day
- ✓ Keep the agenda to limited items

Benefits for huddles and briefings

- Preparing new teams, staff for the shift/day/clinic
- Provides face-to-face communication
- Immediate response to questions or a way of escalating and resolving issues or concerns following the get together
- Timely response to issues or concerns when combined with debriefing at the end of the shift/day/clinic
- Efficient dissemination of information
- Improvement in teamwork and communication
- Staff involvement in decision making

How to motivate people to take part in huddles or briefings

- Make it easy
- Show that most people do it or can do it
- Share what others have done and encourages others to do the same
- Don’t inadvertently reinforce a problematic behaviour (people not turning up) by emphasising its high prevalence
- Provide mutual support, and encourage behaviours to spread peer-to-peer
- Encourage people to make a commitment to others
- Make it timely
- Reduce the hassle factor

RCT an intervention

- Test, learn, adapt
- Put your intervention into practice so its effects can be reliably measured
- Wherever possible try to use randomised controlled trials to evaluate its interventions
- Find a control group so you can understand what would have happened if you had done nothing

10 general tips on communication

- Don’t drown people in too much information
- Provide visual or physical evidence to show people the problem – if people can see or touch something they will notice more (visuals trump data)
- If you know what you want people to do then you should tell them and provide **simple instructions**; for example in a fire the objective is to get people to leave the building, not to understand why fire happens or provide a detailed theory as to why people need to leave the building
- Communications are your instrument to steer action not just about telling people – a conversation not a megaphone
- Say **one thing** – in multiple ways – but don't communication multiple issues in one go

10 general tips (2)

- When communicating consider context, audience, messenger, strategy, channel, action required, messages
- Seek individuals who have a story to tell and get them to be the voice of the change – real people, real stories
- Use iconography, metaphors, visuals to link your ideas and words to the audience
- Raising awareness can simply raise fear or concern, it has to be followed by solution and reassurance – e.g. neighbourhood watch is known to cause increased concern and fear of crime (and perceived increase of crime) rather than reassurance
- And finally, never presume that people remotely understand a single thing you are talking about – keep it simple

Resource links

- The Health Foundation
- Quality Improvement Hub Scotland
- IHI
- Being Open NPSA
- Behavioural insights