NHS Improvement

Spoken communication and patient safety in the NHS

Every 36 hours a million contacts are made between patients and healthcare staff in the NHS and each of these is likely to generate further communication between staff. Yet failings in that communication are a common finding in Serious Incident investigations and we have come to expect either direct or indirect reference to communication in most investigation reports.

Much of the research and policy analysis on communication and patient safety has focused on written communication, but safe healthcare also depends heavily on the spoken word. Good spoken communication is about passing on clear and accurate information. But it is also about expressing uncertainty, reading or 'sensing' situations, assessing others' understanding of decisions and their appreciation of responsibilities, and probing issues and concerns with the right priority.

As a starting point to identifying how to improve spoken communication across the NHS from the perspective of patient safety, we wanted to understand what constitutes good spoken communication and what leads to poor spoken communication between two (sometimes more) people – member of staff and patient, or between staff. We commissioned an external interdisciplinary group made up of policy-makers, health professionals, NHS managers, academics and patients to inform us. From reviewing the breadth of data sources and running workshops, this group sought examples of good spoken communication as well as those of poor practice that may have compromised patient safety, to identify any common themes. Here we summarise those findings; we refer those interested in fuller detail to the annex for the report prepared for the patient safety team by the external group.

What stands out from the group's findings is that spoken communication is more complex than just words and that there will be no quick fixes to people communicating better in the NHS. The examples of when it goes wrong illustrate both human failure and, in some cases, a wider culture in which ineffective, inappropriate and inattentive ways of communicating have been allowed to become the norm.

We are now considering a second phase of work, involving clinical and non-clinical NHS staff and those who train them, leaders of NHS organisations, national bodies, and patients and carers, to identify what we can do as a healthcare system to create the conditions and capability to make effective and safe spoken communication the norm throughout the NHS.

Potential areas for improvement

The group identified six key areas where it may be appropriate to focus attention:

- **The communication environment.** The ideal environment provides adequate time, privacy and comfort. Clinicians and patients are relaxed and do not feel under pressure, and there are no distractions or interruptions.
- **Information exchange.** Spoken communication is effective when accurate and appropriate information is exchanged between the right people at the right time and all parties convey they have understood what was said.
- **Attitude and listening.** Effective communication is associated with: respect, commitment, positive regard, empathy, trust, receptivity, honesty and an ongoing and collaborative focus on care. People are better listeners in situations where there is adequate time, privacy and comfort, and when clinicians sound committed to the patient's care and emotionally attuned to the needs of patients, carers and staff.
- **Aligning and responding.** Two parties who are aligned share assumptions about what is appropriate behaviour, what information needs to be exchanged and how, and what words and phrases mean. For effective communication, they both need to recognise and adapt to each other's spoken and unspoken needs and expectations. This interpersonal adaptation is not a one-off 'check' but an ongoing process that enables the conversation to flow and evolve.
- **Creating the preconditions for effective communication within a team.** A team communicates effectively when there is an open, trusting and mutually respectful ethos, as well as psychological safety – that is, anyone in the team, however junior, feels confident to raise concerns or point out problems. If these conditions are met, safety concerns are more likely to be expressed and dealt with.
- **Communicating with specific groups.** Greater care 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. These groups need extra time, along with a flexible, personalised, context-sensitive and holistic approach: one size does not fit all.

The challenges are complex: solutions will not be simple

These findings show that spoken communication should be thought of not merely as the transfer of information but as context-dependent social interaction that unfolds dynamically. It is influenced by the parties' roles, expectations and hierarchy, and by the pressure and distractions of a busy care environment. Much of it is subtle, fast-paced and situated. Thus, unsafe communication can be as much down to the wrong tone of voice, dismissive body language or a lack of interest between two people, as it can be to the omission of specific items of information or the presentation of items in a confusing order that fails to prioritise. It is also true that in the millions of encounters involving spoken communication that occur in the NHS every day, staff, using a combination of human initiative, compassion and commitment, can and often do mitigate the time pressures, practical constraints and conflicting demands of a busy and fast-moving care environment.

Structured communication tools and checklists such as SBAR, which was designed to support clear and assertive exchange of essential information in emergency situations – 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 help do I need? What should we do to correct the problem?), may help in specific circumstances but imposing an artificial structure on spoken communication may have adverse consequences.

The reviewed communication examples included problems such as excessive use of jargon and acronyms for which relatively straightforward solutions already exist or can be developed and implemented relatively quickly. But the group also identified those that are more complex and likely to be ingrained and have many causes: for example, expression of dismissive attitudes, lack of psychological safety in multidisciplinary teams, extended misunderstandings, lack of commitment to resolving complex situations, and 'tribalism' among professional groups; such problems are unlikely to be amenable to quick, simple fixes or standardised solutions.

Because of the complexity and social embeddedness of spoken communication, there will be few mechanistic or universal solutions to poor communication (in other words, good spoken communication cannot be 'scripted'). Rather, the group proposes that development of interventions to improve spoken communication takes note of the three linked tensions that emerged from its review. These are between:

- the ideal communication environment and the reality of where conversations are held in the NHS
- 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 engagement and reflection)

- a structured and standardised approach to improving communication (supported by tools, technologies and checklists) and an approach that celebrates and supports the adaptability and intuition of individuals (whose response to local challenges may rightly be unique).

Improving spoken communication across the NHS will require action from many stakeholders to establish a new paradigm, one that addresses not only the structure and format of the message but also how a person should adapt what they say and how they say it to allow the interpersonal interaction to unfold in a way that takes account of social nuances and context.

Contact us: **0300 123 2257 | enquiries@improvement.nhs.uk | improvement.nhs.uk**
@NHSImprovement
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