Royal College of Physicians

Setting higher standards

# Improving teams in healthcare

## Resource 3: Team communication

Developed with support from

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# Background

In December 2016, the Royal College of Physicians (RCP) published *Being a junior doctor: Experiences from the front line of the NHS*.[1] This report identified the breakdown of the medical team as a central factor contributing to the low morale and disengagement felt by physician trainees. This is also reflected in previous RCP reports.[2] The benefits of high-quality team work in healthcare are well recognised. Effective team working has been shown to reduce medical errors,[3] increase patient safety[4] and improve patient mortality rates.[5] It also leads to better staff outcomes including reduced stress[6] and improved job satisfaction.[7] The RCP has produced a compendium of reports aiming to promote high-functioning team working in the medical setting.

In this resource we focus on team communication. Breakdown in communication has been identified as a leading factor in adverse patient events[8] and was cited by the Francis report as a major cause of inadequacies in healthcare delivery.[9] Unfortunately, in medicine, effective communication and teamwork is often assumed and training in this area not prioritised. This resource aims to:

- highlight the importance of effective communication in healthcare
- identify potential barriers to good communication
- explore what good communication looks like and tools to help achieve this.

# What is good team communication?

*'Good communication is the accurate and unbroken transmission of information that results in understanding'.*[10]

In one journey, a patient will receive care from multiple individuals from different teams across different healthcare sectors. Effective communication is essential both within an individual team and between teams to ensure co-operation and coordination of care.[11]

The World Health Organization (WHO) describes ineffective communication as a leading cause of inadvertent patient harm.[8] In an analysis of 2,455 sentinel events reported to the Joint Commission for Hospital Accreditation, communication failure was the root cause in over 70% of events.[12] Furthermore, ineffective team communication leads to duplication of tests[13] and delays identification[14] and treatment[15] of deteriorating patients. Communication deficits are especially common at the interface between primary and secondary care. They can culminate in adverse events, including an increase in preventable hospital admissions.[16,17]

The benefits of good communication are not limited to patients. Effective communication improves job satisfaction, increases staff retention and facilitates a culture of support and trust.[18] When individuals have confidence that their opinions will be heard, they are more likely to speak up. This maximises use of the team's internal resource to solve issues and improve performance.

## What are the barriers to effective communication in healthcare?

Healthcare is becoming increasingly challenging and complex, with multiple recognised barriers to effective communication. A key step in facilitating effective communication is recognition of these barriers; teams are then well placed to deploy strategies that overcome them.

### Barrier 1: Interprofessional communication

Professional groups have historically been trained to communicate in different ways, for example, doctors have traditionally had a more succinct approach to communication with an emphasis on facts, while nurses have had a more holistic focus.[11] This can lead to misunderstanding and misinterpretation of the communicated message. Tools like SBAR (Situation, Background, Assessment, Recommendation – see page 5) have been developed to bridge these differences. Interprofessional education (where different healthcare professionals learn and train together) is another helpful approach to help overcome these barriers.[19]

### Barrier 2: Fear of failure

There is a culture embedded within healthcare, where mistakes are too often viewed as a personal failure. An incorrect expectation of error-free clinical practice, leads to individuals being reluctant to communicate errors.[20] This can be overcome by enabling a team culture where professionals are able to raise concerns and admit errors in a safe environment, where blame is not attributed. When an individual is able to discuss their mistakes in a supportive environment both the patient and team will benefit. Further guidance on changing team culture can be found in *Resource 2: Team culture*.

### Barrier 3: Human factors, stress and fatigue

Healthcare professionals operate in times of increasing stress and workload. Inherent limitations of human memory, and the impact of stress and fatigue, influence our ability to communicate effectively.[21] This is further influenced by the environment in which we work, including distractions and interruptions. Everyone, no matter how skilled or experienced, can make mistakes and may communicate poorly during stressful times. Given this, it is all the more important that there are communication structure mechanisms, eg checklists, with failsafe mechanisms to reduce the chance of error.

### Barrier 4: Team instability

Team stability (where the same individuals come together to work on collaborative tasks) has been shown to improve communication by building effective relationships and understanding of colleagues. Shift work, and the changing delivery of healthcare, results in dynamic teams with constantly changing members and therefore a lack of stability. Shift work also means that there is more handover of care than ever before, with poor communication

recognised as a cause of increased patient mortality.[13] Toolkits and guidance on effective handover are helpful in ensuring the safest possible transfer of care (see below).

### Barrier 5: Inconsistent technology

Technology can be used to enhance communication. However, within the NHS we have not reached consistency in the use of technology between healthcare teams, which can present a challenge. An increased focus on shared technology systems, including patient record sharing between primary and secondary care, should enhance communication between teams.

### Barrier 6: Hierarchy

Hierarchy within healthcare remains a substantial barrier to the free flow of information. This is discussed elsewhere in this series, in *Resource 2: Team culture*. In summary, where team members feel intimidated, they are prevented from speaking up and challenging seniors, even in critical situations. This can occur within professional groups (eg foundation doctors and consultants) and between them (eg nurses and doctors). There are national drives to promote a culture of speaking up, including the Freedom to Speak Up Guardians.[22] These guardians work with trust leadership teams to foster a culture of empowerment, allowing workers to speak up to protect patient safety.

## How to achieve effective communication

Effective communication is not something that occurs by chance. It requires active development and prioritisation from organisations, team leaders and individuals. Here are some simple steps to consider for all interactions:

- Introduce yourself and clarify your role
- Listen attentively and allow people to complete their thoughts
- Ask questions for clarification
- Check for understanding of what has been said
- Invite opinions from those who have not spoken
- Be aware of communication barriers, eg hierarchy
- Use objective not subjective language
- Show mutual respect
- Consider setting: right place, adequate time, no distractions
- Be aware of body language, both given and received: facial expressions, eye contact, posture.[23]

TeamSTEPPS is one example of a strategy employed by healthcare organisations to improve communication. Developed jointly by the US Department of Defence and the Agency of Healthcare Research and Quality, it has demonstrated improvements in institutional communication relating to patient safety.[24]

Organisation-wide training programmes are beneficial, but often difficult to implement. Conversely, there are multiple tools used by teams within the NHS that greatly improve communication and require less training and expense to adopt.

### Example 1: Team brief and debrief

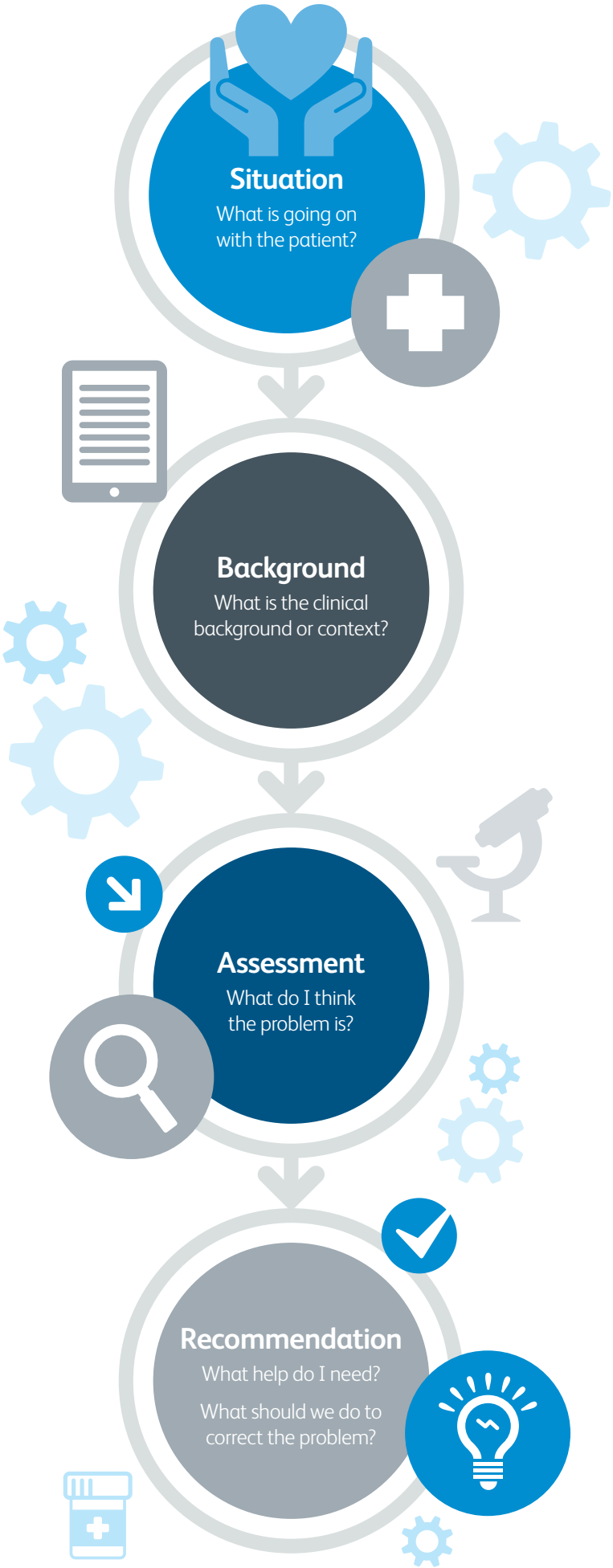
A team brief is a short session, at the start of a shift or clinical activity, that enables the team to come together to discuss objectives, outcomes, roles, responsibilities and safety issues. Effective team briefs lead to better patient safety outcomes. The following questions are recommended by TeamSTEPSS to structure a team brief:

- Who is on the team?
- Do all members understand and agree goals?
- Are roles and responsibilities understood?
- What is our plan of care?
- What is the availability of staff during the shift?
- How will workload be shared?
- What resources are available?[25]

Debriefings allow the team to come together after a shift, procedure or difficult situation to reflect on what went well, what went wrong and how things can be improved. They provide a structured mechanism for members of the team to speak up in a blame-free, supportive environment and are designed to improve team performance via reflection. They can also reinforce positive behaviours. Debriefs are discussed further in *Resource 4: Team development*.

### Example 2: SBAR

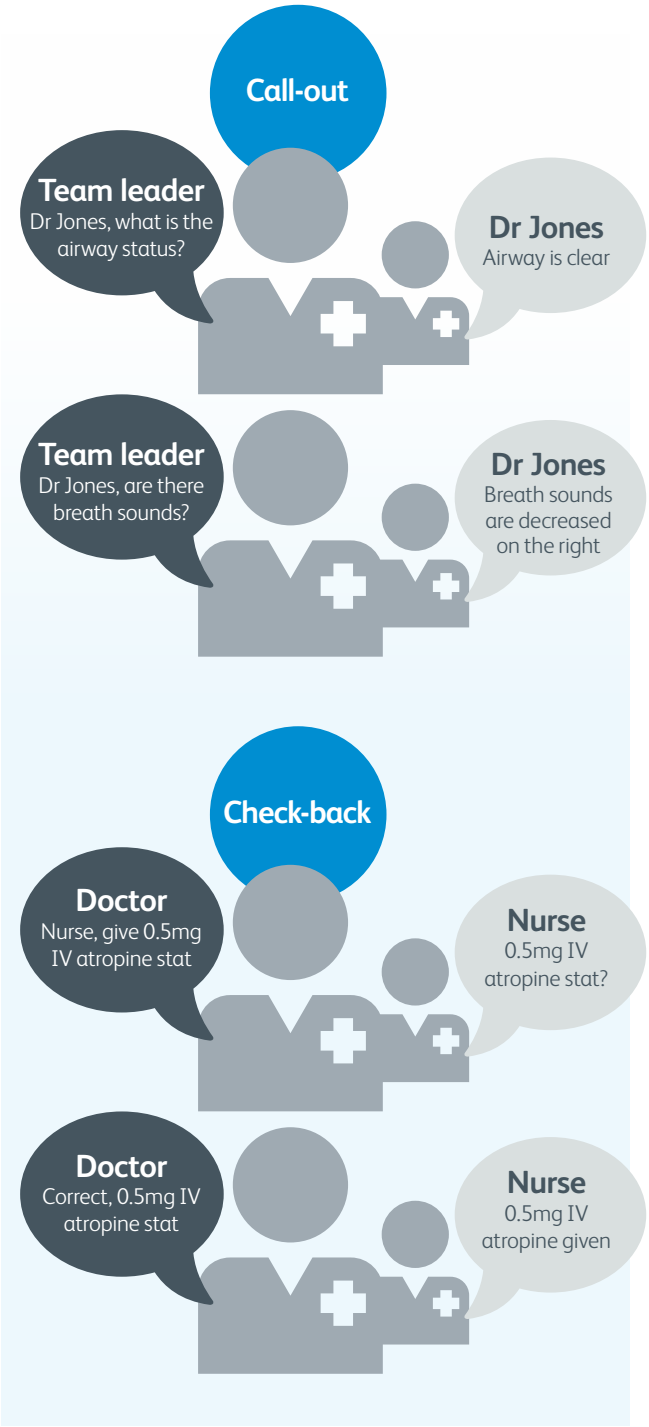
Adapted from the US Navy, SBAR is an effective tool that provides a commonality in communication structure and can be used in almost any clinical setting.[26] The tool allows staff to share concise and focused information, empowering professionals to communicate assertively and effectively. It also helps users to anticipate the information needed by colleagues, encouraging critical thinking. The fact the tool is focused on data decreases the likelihood of misunderstanding, which can occur with more implicit styles of communication.




## Example 3: Call-out and check-back

*Call-out* is a technique used to communicate critical information in an emergency.[25] The clinician calls out questions and commands, ensuring that all team members are simultaneously informed of updates and can anticipate the next steps. It also allows for more accurate documentation. During the call-out the clinician should direct information to a specific individual.

*Check-back* is where confirmation is sought that information given by the sender is received and understood. It is a closed-loop communication strategy; the sender initiates a message which the receiver accepts and confirms, the sender then verifies the message.



## Example 4: Two-challenge rule

The two-challenge rule is designed to empower all team members to 'stop' an activity if they sense a safety concern. This rule is adapted from aviation where the two-challenge rule allows one crew member to automatically assume the duties of another who fails to respond to two consecutive 'challenges'.

The first challenge should be in the form of a question, the second challenge should provide some support for the team member's concern. The team member challenged must acknowledge the concerns. If this does not result in a change, then the person with the concern should take stronger action, this may be talking to a supervisor or the next person up the chain of command.


## Example 5: Critical language – CUS

A mechanism to overcome the hierarchical nature of medicine is to adopt the use of critical language, derived from the CUS programme at United Airlines. Here, there was recognition that a culture of hierarchy can lead to indirect language and uncertainty about the seriousness of a situation. CUS stands for 'I'm concerned, I'm uncomfortable, this is unsafe', and is a three-step process that provides clarity, ensures that everyone stops and listens and is alerted to the seriousness of the situation.[20] The CUS tool should be used only for serious and urgent issues, where the concern is significant. By embedding this notion of the use of critical language within healthcare, there is clarity of message that can overcome hierarchical barriers.

## Example 6: Checklists and read-back protocols

A checklist outlines the criteria for consideration in a particular process.[27] These are useful in some clinical situations; they provide a memory prompt, thereby decreasing the risk of error. Perhaps the best known of these is the WHO surgical safety checklist,[28] which is used extensively and led to a significant reduction in surgical morbidity and mortality. Checklists are commonly used in interventional procedures and briefs and debriefs. It is important to be fully attentive when using checklists as there have been instances where they have led to medical errors because of automated procedures.[29]

## Example 7: Huddles

Complementary to briefs and debriefs, huddles occur part way through a shift or team task. Team members come together to review activity, allowing re-establishment of situational awareness. They are then able to review plans and adjust as needed in response to ongoing care needs. Huddles are popular in clinical settings and there is good evidence to show that they improve information sharing and communication, increasing capacity for eliminating patient harm.[30] Huddles are also beneficial in creating a sense of a community coming together, strengthening overall commitment to the team and improving morale.

### *Lessons from the ward*

*Quite a few units have introduced a safety huddle in maternity to identify current women that are of concern and review staffing. We did have a staff morale issue and staff reported not feeling 'cared for' during their shift as they rarely got breaks and no-one ever offered them a drink. Thus we introduced the 11am huddle where we produce tea/coffee/cold drinks and biscuits.*

- Midwife

## Example 8: Handover

Poor communication during handover is associated with increased patient mortality and morbidity.[13] With the introduction of more shift pattern working, communication during handover is more essential than ever. In an RCP survey in 2010, 34% of members reported no handover timetabled into working patterns and only 33% of members agreed that handover was done well.[31]

Handover between shifts should include (adapted from 1000 Lives Plus):

- adequate time without interruptions
- clear leadership throughout
- exchange of sufficient and relevant information
- discussion around clinically unstable and unwell patients, with clear and unambiguous plans
- description and assignment of uncompleted tasks[32]

Handover of a specific patient should include (adapted from 1000 Lives Plus):

- a summary of critical care stay, including diagnosis and treatment
- a monitoring and investigation plan
- a plan for ongoing treatment, including drugs and therapies
- physical and rehabilitation needs
- psychological and emotional needs
- specific communication or language needs[32]

The RCP has produced a toolkit and template to aid effective handover.[31] Other helpful resources include the TEAMSTEPSS resource[25] and 1000 Lives Matter resources.[32]

# The good and the bad: team communication

The following examples will help to put into context some of the issues raised in this resource around effective team communication. They are theoretical, but many healthcare professionals will identify with them using their own experiences, both good and bad.

### The good…

An on-call team is coming to the end of a busy night shift. When dealing with a peri-arrest patient, the registrar mistakenly instructs the nurse to prepare a medication 10 times the standard dose. The nurse asks the doctors to repeat the dose and issues a challenge. The foundation doctor also questions the dose. The registrar is receptive to the challenge, reviews the British National Formulary (BNF), and clarifies a correct dose with the nurse. The nurse calls out the dose before administration.

### The bad…

A busy day on the acute medical unit delays the opportunity for handover to the night team. Key information about Mrs Y, a deteriorating patient, is only communicated to the registrar on call and not the wider team. Later that night, the on-call foundation doctor is bleeped about Mrs Y. They do not receive an SBAR and have not had handover from the day team, so fail to appreciate the seriousness of the situation.

# Key recommendations

- Healthcare professionals must be aware that failures of communication are the most common root cause of adverse incidents.
- Hospital trusts, governing bodies and team leaders have a responsibility to nurture a culture where professionals feel able to communicate concerns and admit errors in a safe environment, where blame is not attributed.
- A team brief and debrief should be a formal part of all team activities. Of crucial importance is ensuring awareness of members' roles and responsibilities, especially in 'short-lived' teams (eg on-call teams).
- Simple techniques such as SBAR, call-out/check-back and the two-challenge rule should be adopted as standard within healthcare organisations.
- Handover should be an activity incorporated into rotas. It must target the objectives mentioned in the previous section and occur between all on-call activities as a minimum.

## Conclusion

This document explains why teamwork and effective communication is of critical importance in achieving safe patient care. Errors in team communication are a leading cause of adverse patient events and contribute to low staff morale and retention. The complex environment in which healthcare professionals work leads to barriers in effective communication. Time spent developing team communication, including supporting leaders in creating a culture of openness centred on patient safety, can help to overcome these challenges. There are some specific communication tools which can be effective in reducing adverse events and bridging differences between interprofessional communication styles. There must be a commitment from organisations and practitioners to invest in improving team working behaviours and team communication to ensure safe delivery of care for patients.

Further information on team working can be found in the accompanying resources on building effective teams, team culture and team development.

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The RCP and HEE will be working together to embed the principles of teamwork outlined in this document within the training environment, so all doctors in training programmes are supported by a team or a 'modern firm'.

For a list of references used in this resource, visit: www.rcplondon.ac.uk/improvingteams

Royal College of Physicians