Health professionals often assume they are skilled at communicating with colleagues, patients and families. However, many patient safety incidents, complaints and negligence claims incriminate communication failures and/or poor teamwork. Good teamwork requires effective communication, leadership, situational awareness and mutual support. Simple tools and techniques, such as those used in the TeamSTEPPS training method, can help improve communication and teamwork, which can in turn decrease the risk of harm to patients. This article describes what can go wrong in communication between team members and how to go about fixing it.

Key points

1. Health professionals tend to overestimate the quality of their communication skills
2. High-quality patient care relies on teams collaborating and communicating effectively
3. Key elements of teamwork are communication, situational awareness, leadership and mutual support
4. The US TeamSTEPPS training method uses tools such as closed-loop communication, safety checklists and debriefs
5. Good teamwork and effective communication increase staff satisfaction as well as patient safety

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Abstract
Although health professionals tend to think they are good at communicating, many patient safety incidents, complaints and negligence claims incriminate communication failures and/or poor teamwork. Good teamwork requires effective communication, leadership, situational awareness and mutual support. Simple tools and techniques, such as those used in the TeamSTEPPS training method, can help improve communication and teamwork, which can in turn decrease the risk of harm to patients. This article describes what can go wrong in communication between team members and how to go about fixing it.

Citation
These form the basis of TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety), a training programme from the US that has been shown to improve team effectiveness and patient safety (Neily et al, 2010). Many US hospitals use the programme to train their staff and some hospitals in the UK are beginning to follow suit. This article explores how communication and teamwork sometimes go wrong and describes some of the TeamSTEPPS tools and techniques.

### Communication

One likely cause of errors is when a health professional communicates with a colleague but does not check whether that colleague has correctly received the message, and/or when the colleague does not check that they have understood it. How many times have you witnessed communication breaking down and heard a colleague saying, “Oh, I thought you meant X, not Y”. In other areas of life, checking that the message has been received to avoid misunderstandings is standard practice. For example, when I order a takeaway over the phone, the person taking my order reads it back to me; they also check my address so there is less chance of errors or delays in the delivery.

Ironically, in healthcare settings, messages that are far more important are passed between team members or between staff and patients or their relatives without checks. The receiver may nod or say “OK”, and the sender may assume the message has been effectively transmitted, but this may not be the case, which can lead to errors and patient harm. Checking that the messages we send or receive are understood is vital, particularly when working with staff we do not know, such as agency nurses.

### Situational awareness and shared mental models

Situational awareness is defined as an “accurate awareness or understanding of the situation in which the team is functioning” (Alonso and Dunleavy, 2013). In simple terms, it is knowing what is going on around us. One would assume that health professionals do this all the time, but the truth is they sometimes lose situational awareness. If you are driving on the motorway, you are constantly monitoring what is happening around you and using that information to predict what may happen next, taking action if necessary. If you start searching for a different radio station, you lose focus and may well make an error. This can happen at work.

We maintain our situational awareness by scanning our environment for clues about what is happening. For example, are any patients deteriorating? Is the workload increasing too quickly in relation to the available staff? How are staff coping? This is essential to avoid untoward events, so all members of the team need to remain constantly aware of the situation. However, no one is able to look inside other people’s heads, so it is also essential that we share our observations with team members. Again, this seems obvious, but a frequent source of errors is when staff have different perceptions of the situation; that is, different shared mental models.

Shared mental models are “shared cognitive representations of tasks, situation/environments, teams or other factors that enable team members to anticipate one another’s actions” (Weaver et al, 2013). A key to teamwork is sharing one’s perceptions (mental models) with colleagues regularly throughout a shift. This is akin to thinking out loud, making simple observations about patients, workload, resources, threats to the plan for the day and more.

### Leadership

Sometimes errors happen because staff are not comfortable raising concerns or clarifying ambiguous messages or situations. If you are a team leader, you can create a positive culture by telling your team you want them to raise any concerns and ask any questions they may have, however trivial, without fear.

Errors can also occur because the team leader has not made roles and responsibilities clear to everyone. This can lead to tasks not being carried out because no one knows whose job it is (for example, a patient’s urinary catheter not being removed, when it should have been) or tasks being done twice because two team members think it is their responsibility (for example, a patient receiving two different appointments for an outpatient clinic). Clarifying each person’s role and responsibilities helps the team work more effectively and safely. At handover, it is the team leader’s job to ensure all staff understand who is responsible for doing what during the shift.

Asking staff to introduce themselves also helps. Health professionals increasingly work in fluid teams that may include agency nurses, locum doctors or staff sent from other wards to cover for shortfalls. If all team members introduce themselves at handover, this makes it easier to approach colleagues during the shift in case any issues arise. This will also give the team an idea of everyone’s level of experience – otherwise they may wrongly assume that a team member is an experienced nurse or a consultant simply due to their age.

### Mutual support

Imagine a busy acute admissions ward, with four bays and one nurse allocated to each of them. The nurse in charge is band 6 and the other three are relatively newly qualified. They are all busy but reluctant to ask for help. The three staff nurses worry that it may look like they are unable to cope with their workload. The nurse in charge wants to demonstrate being in control, and offers to help the others; however, they decline for fear that it may be wrongly perceived. As a result, they are all falling behind with important tasks: observations are late for some patients and two-hourly turns are not being maintained.

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*Fig 1. Example of closed-loop communication*

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Discussion

Failure to offer, ask for or accept help leads to stress and work overload, increasing the risk of errors and harm. We must become better at these things, as patient safety may depend on them. Staff need to feel that it is acceptable to ask for help if they feel overwhelmed, that they will not be deemed ineffective or unable to manage their time. Mutual support is key in effective teams, people support each other. Everyone in the team needs to look after everyone else and watch out for signs of stress and overload in their colleagues.

Tools and techniques

Closed-loop communication

Closed-loop communication is a technique that reduces the risk of errors arising from misunderstandings and wrong assumptions. As shown in Fig 1 on p25, both the sender and receiver confirm that the information has been correctly passed and understood. It is a good idea for team leaders to use closed-loop communication in their communication with the team. This role modelling will encourage staff to adopt the same good practice.

Readback

Readback is similar to closed-loop communication. It involves reading back to the sender information they have given to you in order to check you have correctly understood it. This might be when taking over the care of a newly admitted patient, for example, or at handover of important shift coordination information. For example, the nurse taking over might say to the nurse handing over: “Can I just check with you that I’ve got everything right? This is Mr Jones, aged 47, no previous medical history, admitted via ED with chest pain, and you want me to ask the doctor to check his troponin and repeat a U&E this evening.” Readback can also help clarify who is responsible for what, as this can be unclear at handover and important interventions might thus be missed or delayed.

SBAR tool

The SBAR communication tool, used in many NHS trusts, structures communication in four stages:

S: situation – Hello, this is Peter Jones. I am a staff nurse on Ward 25. I am calling about Mr Smith.

B: background – Mr Smith is 92. He was admitted yesterday with chest pain. He has had two MIs in the past and has heart failure.

A: assessment – I have assessed him today and I am worried – he looks very unwell. His respiration rate is 34 and his oxygen saturations are 86% on 15L. His NEWS is eight.

R: recommendation – I would like you to come and see him now please.

The SBAR stages can be complemented by a readback (R) stage – it then becomes SBARR (Haig et al, 2006).

Checklists

As well as maintaining our situational awareness and sharing observations with colleagues, we need to be aware of our own vulnerability and potential for making errors. This can be done through a simple self-checking exercise using either the I’M SAFE checklist or the ‘three bucket’ model.

Box 1. TeamSTEPPS debrief checklist

The team should address the following questions during a debrief:

- Was communication clear?
- Were roles and responsibilities understood?
- Was situational awareness maintained?
- Was workload distribution equitable?
- Was task assistance requested or offered?
- Were errors made or avoided?
- Were resources available?
- What went well?
- What should improve?

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Going through the list, you ask yourself whether or not you might be affected by any of these factors. For example, if you have had too much alcohol the night before, your ability to perform certain tasks may be hampered the next morning. The more positive answers you obtain, the more likely you are to make an error.

The ‘three bucket’ model, shown in Fig 2 (NPSA, 2008), works as follows:

- The ‘self’ bucket fills if you are late, hungry, stressed, unwell, and so on;
- The ‘context’ bucket fills if your ward or department is understaffed, poorly led or lacking equipment;
- The ‘task’ bucket fills if the tasks assigned to you are unfamiliar or technically demanding.

The fuller each bucket is, the greater the likelihood of you making an error.

As a team, all staff can run through one of these two checklists at the beginning of a shift, for example. If you feel vulnerable and therefore prone to errors, you should share this with your colleagues so they can keep an eye on you.

Safety huddles

A safety huddle is a brief coming together of staff, once or more in a shift, aimed at maintaining situational awareness, sharing observations and going through risks: which patients are causing concern? Is anyone at risk of deterioration? How is staffing? How is workload? Anyone can take part or lead the safety huddle, whether they are nurses, doctors, physiotherapists, housekeepers or ward clerks.

A safety huddle can also be an opportunity to review how well the department or ward is performing in specific areas, such as falls or pressure ulcers. If the aim of the safety huddle was to review falls, for example, the team would ask themselves questions such as:

- Who are we most concerned about falling today?
- For each of these patients, have we got measures in place to prevent falls?
- Does anyone have any information, suggestions or concerns they want to share with the team?

Debriefs

Debriefs are short meetings at the end of a shift aimed at reviewing how the team has performed. Box 1 features the TeamSTEPPS debrief checklist as an example of what to discuss. Staff may be reluctant to have a debrief at the end of a shift, as this might make an already long day – or night – even longer, but the debrief can be done towards the end of the shift, rather than once it has ended. Anyone can lead a debrief, but it is
Box 2. Online resources

- **TeamSTEPPS**: Resource from the Agency for Healthcare Research and Quality of the US Department of Health and Human Services and the US Department of Defense
  
  Bit.ly/TeamSTEPPSTools

- **Team building**: Resource from Team Technology, a website set up by independent consultant and researcher Steve Myers
  
  Bit.ly/TTTeamBuilding

- **‘Three bucket’ model**: Resource from the National Patient Safety Agency
  
  Bit.ly/NPSA3BucketModel

- **Safety huddles**: Resource from the improvement Academy of the Yorkshire and Humber Academic Health Science Network
  
  Bit.ly/NTSafetyHuddles

- **Human factors**: Clinical Human Factors Group (www.chfg.org) and Health and Safety Executive
  
  Bit.ly/HSEHumanFactors

Box 3. Reflective activity

- Before, during and after a shift, take note of the following:
  - When there are agency staff on the team, do they introduce themselves at handover or is it assumed that you all know each other?
  - Are you clear about who should be doing what on a shift?
  - Do staff share their perceptions of the situation throughout the shift?
  - Towards the end of a busy shift, do staff ever have a debrief?
  - Observe how patients are handed over to you: do your colleagues ever say to you, “Could you read this back to me, so I can check you have correctly understood everything?”
  - Observe how your colleagues pass information to each other: do they ever confirm that the information has been correctly transmitted using closed-loop communication? Or does the receiver simply nod or say “OK”, and the sender then assumes that they have understood everything?
  - Think about a time where poor communication or teamwork led – or nearly led – to patient harm:
    - Why did it happen?
    - Were wrong assumptions made?
    - Was there a failure to check that information had been effectively transmitted and understood?
    - Were any members of the team overloaded?
    - How could that type of incident be avoided in future?
  - Reflect on how you could use some of tools and techniques from this article in your practice
    - You could also take this article with you to work and discuss it:
      - At the next team meeting
      - With your ward or department manager
      - At your journal club if you have one

Logical for this to be done by the nurse who was in charge of the shift.

Human factors

Human factors comprise everything that affects us when we are at work. The Clinical Human Factors Group defines human factors in the work context as “the environmental, organisational and job factors, and individual characteristics which influence behaviour at work” (www.chfg.org). They include how our work is organised, how our team is set up, the design of the ward or department, the design of the medical equipment, and of course our physiological limitations – with the effects of factors such as fatigue, hunger or dehydration on nurses’ performance.

There is growing interest in human factors in healthcare, as well as in the potential benefits to the NHS of using their principles (Commission on Education and Training for Patient Safety, 2016). Some hospitals are delivering human factors education in order to improve communication and teamwork. The online resources in Box 2 include two about human factors.

The Nursing and Midwifery Council Code (2015) highlights the need for ensuring effective teamwork and communication, reducing any potential for harm, and considering the impact of human factors. In its section on preserving safety, it encourages nurses and midwives to “take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures”.

Summary

Poor teamwork and bad communication often feature in errors, complaints and negligence claims. Good teamwork and effective communication decrease the risk of harm to patients, but also increase staff engagement. They spark a virtuous circle: if you work in a good team that communicates clearly and supports you to speak up, you will most likely be happier at work. Evidence shows that greater staff satisfaction leads to better-quality care (West and Dawson, 2012).

The tools and techniques discussed in this article can improve teamwork, which can in turn enhance patient safety. Box 3 lists questions prompting you to reflect on teamwork in your setting and think about how you could use these tools and techniques in your practice. NT

References


For more on this topic go online...

- How to build effective teams in healthcare
  
  Bit.ly/NTTeamBuilding

- A strategy to maintain safety in clinical incidents
  
  Bit.ly/NTMaintainSafety