SECTION 1

Communication and patient safety

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CHAPTER 1

THE RELATIONSHIP BETWEEN COMMUNICATION AND PATIENT SAFETY

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LEARNING OUTCOMES

This chapter will enable you to:

- discuss the relationship between communication and patient safety
- describe the impact of effective/ineffective communication on patient care
- use critical conversations to promote patient-safe communication
- reflect on your own level of communication competence and identify appropriate learning strategies for ongoing improvement.

KEY CONCEPTS

augmentative and alternative communication (AAC) | communication impairment | communication partner | complex communication needs | Mindful Dialogues Model | severe communication impairment

> The greatest problem with communication is the illusion that it has been accomplished.
>
> (George Bernard Shaw)

INTRODUCTION

When seeking healthcare, people trust that their health-related problems will be appropriately managed and their care will be safe and effective. However, despite the best intentions of healthcare professionals, clinical errors are the third leading cause of death in developed countries and up to 17 per cent of patients are harmed while receiving healthcare (Makary & Daniel, 2016). These errors can result in distress, hospital re-admissions, permanent injury, increased length of hospital stay, and death.

Although the reasons for adverse patient outcomes are diverse, studies indicate that ineffective **communication** is the root cause for nearly 66 per cent of all healthcare errors (Institute for Healthcare Communication, 2018). Deficiencies in communication continue to feature in many coroners' reports and quality improvement investigations, and there have been repeated calls for improvement.

The opportunity to improve the current situation through increased attention to the teaching of communication skills has been advocated as the most promising way forward and a pragmatic strategy for reducing healthcare errors (Australian Commission on Safety and Quality in Health Care, 2020). Skilled communication is a core requirement across all healthcare disciplines; this includes effective interprofessional communication (between healthcare professionals from different disciplines), intraprofessional communication (between healthcare professionals from the same discipline) and therapeutic communication (between healthcare professionals and patients).

Many students, graduates, educators and clinicians assume that communication skills are either inherent or acquired almost serendipitously through repeated exposure to clinical practice. However, becoming a skilled and safe communicator requires active engagement in deliberate learning activities, determination and repeated practice; it also requires reflection, particularly on activities designed to improve performance. This chapter, and the ones that follow, provide the foundation for these types of learning activities. We illustrate the link between **patient safety** and communication from a wide range of disciplinary perspectives. The real-life patient stories include profile authentic and sometimes challenging situations that will cause you to re-examine many taken-for-granted assumptions as you

reflect on your personal beliefs and professional understandings. Importantly, this text will enhance your communication competence and ability to practise in a way that promotes patient safety and wellbeing.

VANESSA'S STORY

Vanessa Anderson was 16 years old at the time of her death. She enjoyed good health; her only known medical conditions were asthma and migraine headaches; she did not drink or smoke. While competing in a golf tournament, Vanessa was struck on the right side of her head by a golf ball. She was taken to hospital, vomiting several times en route. A CT scan was performed and Vanessa was subsequently transferred to another, larger hospital where she was diagnosed as having a closed depressed right temporal skull fracture with temporal brain contusions. On the basis of her Glasgow Coma Score (GCS), the neurosurgical fellow classified Vanessa's head injury as mild. He then telephoned the on-call consultant neurosurgeon to advise him of Vanessa's condition and told him that she would be transferred to the local children's hospital. He did not subsequently advise the consultant that Vanessa wasn't transferred but had been admitted to an adult ward instead.

The next day, a senior medical resident, an intern on her first day in the neurosurgical unit and a nurse practitioner, conducted a ward round. During the round the resident changed Vanessa's analgesic regime from Tramadol to Codeine Phosphate. The intern was responsible for making notes in Vanessa's medical records but the notes she made were inadequate and did not include the author of the notes, the results of the physical examination or the ward-round attendees.

At approximately midday, the consultant neurosurgeon visited the ward and was told that Vanessa had been admitted under his care. He discussed the CT results and formed the view that she most likely had dural lacerations with bone fragments. He expressed concern about the poor communication which meant that he had only just become aware of Vanessa's admission and, because of this, her surgery could not be scheduled until the following day.

Early in the afternoon of the same day, in response to Vanessa's severe pain, the resident prescribed the analgesics Panadeine Forte (2 tablets, four times a day) and Endone (5 mg, six times a day, PRN). Between 4:30 pm and 5:30 pm, an anaesthetic registrar conducted a pre-operative consultation and, in response to Vanessa's ongoing pain, she increased the dose and frequency of the Endone to 5–10 mg, three-hourly. She did not record a maximum dose. She misread the medication chart and thought that Vanessa had been prescribed Panadeine, not Panadeine Forte (Panadeine contains 8 mg of codeine and Panadeine Forte 30 mg). The anaesthetic registrar did not discuss her course of action with the nurses or the neurosurgical team.

That evening Vanessa was given two Panadeine Forte tablets at 7 pm and 12 am. She was also given 10 mg of Endone at 8 pm and 11 pm. At 1 am on Tuesday morning, Vanessa buzzed for assistance. The nurse who responded observed that Vanessa could not move and sounded distressed. She lifted Vanessa's arm and it fell down limply on the bed. The nurse took some observations and noted that Vanessa's breathing was normal, that she was warm to touch and of normal colour, and that she had no shaking or stiffness. The nurse did not check Vanessa's lower limb movement or her GCS. Had she done so, Vanessa's GCS would have scored below 5, signalling that urgent medical review was necessary. However, the nurse did not believe that Vanessa was in immediate danger and, thinking that Vanessa was probably having a bad dream, did not escalate her concerns. Later, she returned to Vanessa and performed a set of neurological observations, including calling her name, asking if she was okay (to which she responded 'yes') and requesting her to lift her arms and push her feet against the nurse's hands. Vanessa could do all these things and the nurse felt that the earlier event was not clinically significant, and that her initial view that Vanessa was simply having a bad dream was correct. The nurse did not document the events or her observations in Vanessa's chart, nor did she consult the registrar or the consultant.

At 2 am, Vanessa went to the toilet and was given a further 10 mg of Endone. The nurse later admitted that the dose of 5–10 mg Endone three-hourly struck her as unusual and that it was rare for this order to be charted in conjunction with regular Panadeine Forte. However, she felt that this was what the doctors wanted so she did not express her concerns to the anaesthetic registrar or the consultant.

Vanessa's observations were due again at 4 am; however, the nurse decided not to do these observations because Vanessa had been neurologically unchanged when she conducted the observations at around 2 am.

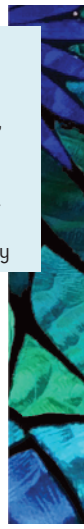
Vanessa's father arrived on the ward at around 3:45 am and sat in Vanessa's darkened room, then fell asleep. At around 5:30 am the nurse entered Vanessa's room and found her unresponsive. An emergency was called and CPR administered. Vanessa was pronounced dead at 6:35 am. The formal finding from a later coroner's inquest was that Vanessa died from a respiratory arrest due to the depressant effect of opiate medication.

Although Vanessa's death undoubtedly resulted from a series of system and human errors, any one of the healthcare professionals involved may have prevented this tragic outcome had they communicated in an effective and timely manner. The NSW Deputy State Coroner, Magistrate Milovanovich, made the following statement in relation to the findings of the coronial inquest:

> ***The death of Vanessa Anderson at the very young age of 16 years was tragic and avoidable. Vanessa's case should be used as a precedent to highlight how individual errors of judgment, failure to communicate, failure to record accurately and poor management of staff resources, cumulatively led to the worst possible outcome for Vanessa and her family.***

Source: Inquest into the death of Vanessa Anderson, Coroner's Court, Westmead, Sydney, 24 January 2008. (Tracy Levett-Jones was given permission by Vanessa's family to use her story in teaching students and healthcare professionals about patient safety from the perspective of patients and their families.)

For further information about Vanessa Anderson's story, go to: https://patientsafetyfornursingstudents.org/resources/medication-safety



Patient safety and communication

Patient safety is defined as the prevention of errors and adverse effects to patients associated with healthcare (WHO, 2019). It is important to note that patient safety is not limited to physical safety but also includes psychological, emotional and cultural safety. Patient safety is an attribute of trustworthy healthcare systems that work to minimise the incidence and impact of—and maximise recovery from—adverse events (Emanuel et al., 2011). Across the world healthcare inquiries consistently identify the same recurring problems as the cause of adverse patient outcomes; these include patients, family members and concerned staff being ignored and excluded from decision making, whistle-blowers being vilified, lack of quality-monitoring processes and deficiencies in teamwork and communication systems.

Healthcare professionals need highly developed communication skills in order to manage the complexity and competing tensions that define contemporary healthcare organisations. The importance of effective communication to patient safety is emphasised in the *National Safety and Quality Health Service Standards* (Australian Commission of Safety and Quality in Health Care, 2021) where it is specified that healthcare professionals must facilitate structured and effective communication between health service organisations, within health service organisations, between clinicians, and between clinicians and consumers.

'We think we listen, but very rarely do we listen with real understanding, or true empathy. Yet listening, of this very special kind, is one of the most potent forces for change' (Carl Rogers, 1980, p. 116).

Communication is much more than the provision of information, instructions or advice. It is a two-way process involving verbal and non-verbal skills that aims to create a shared understanding. Communication is fundamental to safe healthcare. It is required for information exchange, quality decision making, creating therapeutic relationships with patients, increasing patient uptake of recommendations, enhancing patient satisfaction and improving health outcomes. Many healthcare professionals think that effective communication means giving patients clear, unambiguous information in a timely manner. This is true, but it is only part of the story. Communication involves listening as well as talking. When we listen to patients, we are less likely to jump to erroneous conclusions because we haven't seen the whole picture (this is referred to as *premature closure*).

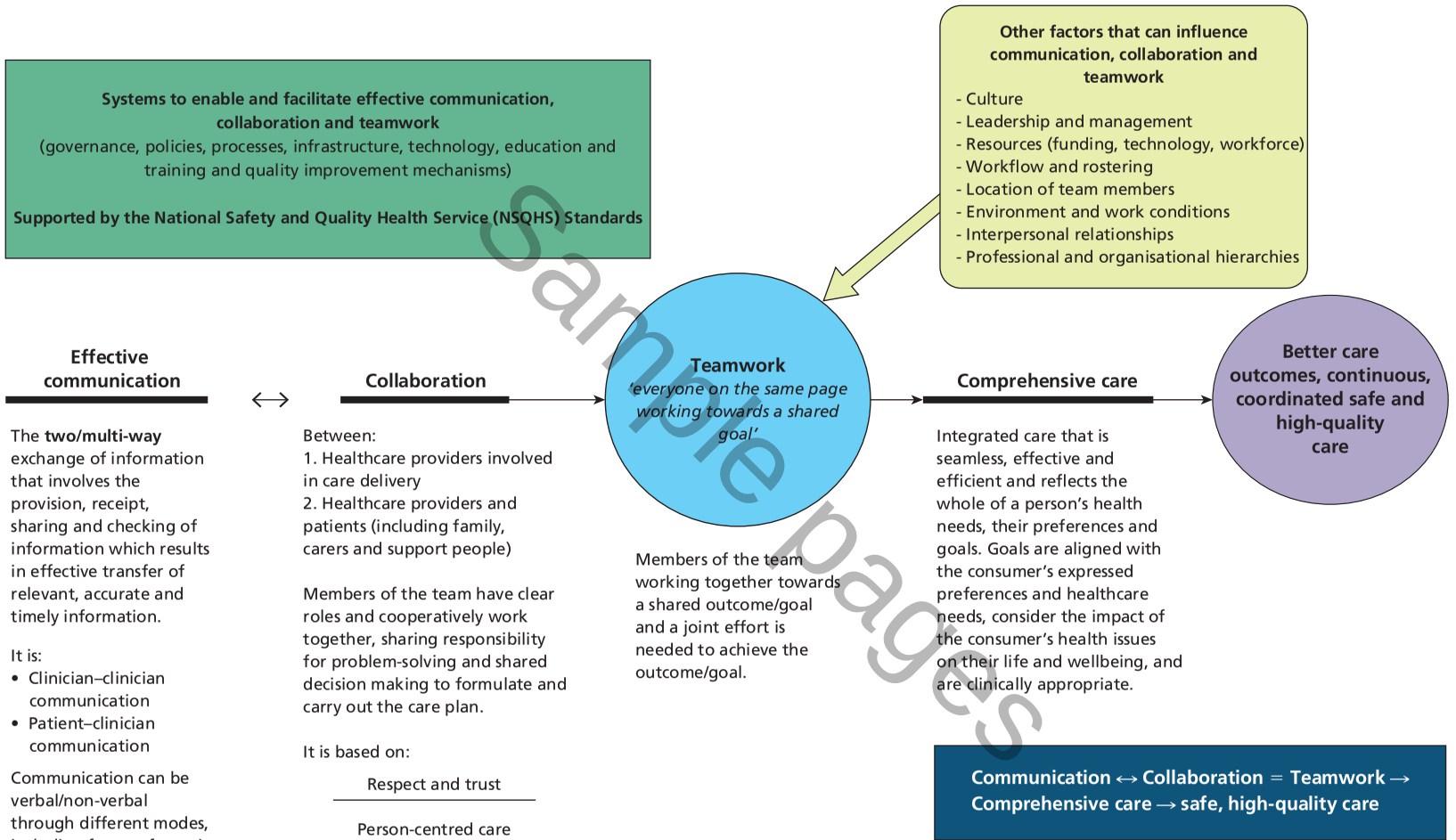
Effective communication refers to members of the care team (including the person receiving care and their significant others) collectively working together in pursuit of shared goals (Nancarrow et al., 2013). It is a process that ensures accurate information is provided in ways that are tailored, open, honest and respectful. Effective communication relies on a complex set of skills, including the ability to provide information in a structured and meaningful way, gather and synthesise relevant information, escalate concerns and deal with conflict or challenging conversations.

Figure 1.1 illustrates how effective healthcare communication contributes to safe, comprehensive care, along with the systems and factors that support effective communication, collaboration and teamwork.

FIGURE 1.1

How effective healthcare communication contributes to safe, comprehensive care

Source: Reproduced with permission from the Australian Commission on Safety and Quality in Health Care (2020). *Communicating for safety: Improving clinical communication, collaboration and teamwork in Australian health services*. ACSQHC: Sydney.



Patients expect to be communicated with in ways that are inclusive, accurate, timely and appropriate, and they assume that the members of their treating team will collaborate and communicate effectively. Yet the 2017–18 Patient Experience Survey (Australia Bureau of Statistics, 2021–22) identified that 17 per cent of patients who saw three or more healthcare professionals for the same condition, reported that there were significant issues caused by a lack of communication between team members. Additionally, a root cause analysis identified gaps or failures in collaborative planning for people receiving care from more than one team as the top two organisational system factors that caused or contributed to clinical errors (Clinical Excellence Commission, 2019).

The Australian Charter of Healthcare Rights (Box 1.1) outlines patients' rights in regard to healthcare and emphasises that communication and working in partnership with patients underpin safe care. Indeed, communication is considered by many people to be one of the most important aspects of quality healthcare.

BOX 1.1 The Australian Charter of Healthcare Rights

Safety—a right to safe and high-quality care

Respect—a right to be shown respect, dignity and consideration

Partnership—a right to ask questions, be involved in open and honest communication and make decisions with my healthcare provider, to the extent that I choose and am able to do so

Information—the right to clear information about my condition, possible benefits and risks of tests and treatments in order to give my informed consent and to be told if something has gone wrong during my healthcare

Privacy—a right to privacy and confidentiality of provided information

Feedback—a right to comment on care and have concerns addressed in a transparent and timely manner without it affecting the way that I am treated

Source: Reproduced with permission from The Australian Charter of Healthcare Rights, developed by the Australian Commission on Safety and Quality in Health Care (2019). ACSQHC: Sydney.

The impact of effective/ineffective communication on patient care

Effective communication impacts on patient outcomes in multiple ways. It can enhance diagnostic accuracy, improve patient satisfaction and wellbeing, and improve treatment adherence (such as compliance with medication and rehabilitation programs) and clinical outcomes (including reduced stress and anxiety, improved pain management, self-management, mood, self-esteem, functional and psychological status) (Doyle, Lennox & Bell, 2013). Skilled communication can also enhance symptom resolution and reduce the length of hospitalisation, healthcare costs (Schmutz, Meier & Manser, 2019) and rates of post-operative complications (Vats et al., 2010). In contrast, ineffective communication can lead to hostility, anger, confusion, misunderstandings, lack of trust, poor compliance, and greatly increased risk of error, patient harm and malpractice claims (Schmutz, Meier & Manser, 2019).

Patient-safe communication is a goal-oriented activity focused on preventing adverse events and helping patients attain optimal health outcomes. It is a means by which healthcare professionals gather and share information, clarify and verify accurate interpretations of information, and establish a process for working collaboratively with both patients and other healthcare professionals to achieve common goals of safe and high-quality patient care. Every aspect of patient care depends on how well healthcare professionals communicate with each other and the patients they care for. Clinical decisions based

on incomplete or misinterpreted information are likely to be inappropriate, and may cause patient harm and distress. For healthcare professionals, unsafe communication is considered to be a breach of professional standards and a leading cause of litigation. Examples of this may include:

- inadequate or inaccurate advice on self-management
- failure to communicate in ways that the patient and their family can understand
- failure to disclose the risk of interventions and potential complications
- failure to obtain valid consent to an intervention/procedure
- failure to maintain client confidentiality
- failure to give the patient an opportunity to ask questions
- failure to respond appropriately to those questions
- failure to respect the opinion of a patient (even though the patient's opinion may be medically inaccurate, their observations are usually accurate and can be very valuable)
- failure to realise that, from the patient's point of view, there is no such thing as a 'silly question'
- failure to realise that the way we talk with patients can be just as important as the content of what we actually say to them
- failure to communicate with other relevant healthcare professionals in order to provide a reasonable standard of care
- failure to escalate concerns to supervisors/administrators when patient safety may be in jeopardy
- failure to warn authorities, when to do so would be in the public interest.

Healthcare professionals should be aware that vulnerable groups of patients are at particular risk of harm from poor communication. These include older people, children, people with mental illness, people who do not speak English, people with sensory impairment (e.g. diminished hearing or limited verbal ability) and people with cognitive changes (e.g. delirium or dementia).

The skills needed for patient-safe communication when caring for these groups are discussed in Chapters 11 and 17.

Patient-safe communication is a goal-oriented activity focused on preventing adverse events and helping patients attain optimal health outcomes.

Source: DC Studio/ Shutterstock

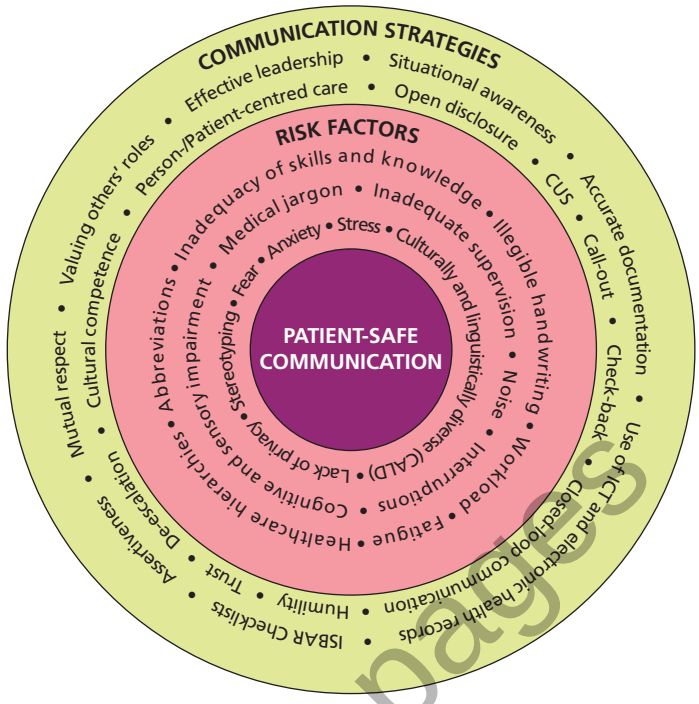


FIGURE 1.2
Patient-safe communication operates within complex clinical contexts amid myriad potential risk factors

Source: Adapted from Schuster, P. & Nykolyn, L. (2010). *Communication for Nurses. How to Prevent Harmful Events and Promote Patient Safety*. Philadelphia: E. A. Davis, p. 17.

When many and varied healthcare professionals (including doctors, midwives, dentists, nurses, pharmacists, social workers, dieticians, physiotherapists, psychologists and others) are involved in patient care, ensuring exchange of accurate information in a timely manner can be difficult. Patient-safe communication is a complex and context-dependent process and many human and system factors influence how effectively it transpires.

Despite healthcare professionals being well intentioned, there are numerous factors that can impact on their ability to engage in patient-safe communication. Figure 1.1 illustrates some of the risk factors for communicating safely with both patients and other healthcare professionals. **Communication risk factors** have the potential to distort the clarity of the message being conveyed and impede the effectiveness of the process. This can lead to misinterpretation, time wasting, frustration and inaccurate decision making. The outer circle of Figure 1.2 depicts strategies that have been identified as preventing or overcoming risk factors, improving communication and promoting patient safety. Throughout this text, these risk factors and strategies will be defined, discussed and applied to a range of clinical stories.

Using critical conversations to promote patient-safe communication

The hierarchical nature of healthcare environments presents one of the key risk factors for effective communication. Traditional cultures can make it difficult for healthcare professionals to speak up and be assertive when they are worried about patient safety. This is exacerbated by power differentials and a lack of psychological safety. The use of critical language can create clearly agreed upon communication processes that help improve communication and avoid the tendency to speak indirectly or deferentially when feeling intimidated. The ability to get everyone to stop and listen is essential for patient-safe communication. Indeed, Vanessa's story may have ended quite differently if

the nurse who thought the prescribed analgesic regimen was unusual had escalated her concerns. Reflect on the patient story in Box 1.2 and consider how the use of **critical conversations** and graded assertiveness (see Box 1.3) may have given the healthcare professional involved the confidence to speak up (see Box 1.4).

BOX 1.2 Critical conversations and patient safety

Mr Graham Reeves was admitted to hospital for removal of a badly diseased right kidney. He had seen the surgeon a month before, who documented the need for removal of the right kidney in the patient's case notes. However, possibly due to a transcription error, the hospital admission form wrongly said 'left kidney removal'. This error was transcribed to the theatre list. One of the surgeons checked the X-ray in the operating theatre, but it was the wrong way around and he misread the diseased kidney as the one on the left. The second surgeon did not look at the X-ray. Early in the operation, a medical student looked at the X-ray and said she thought it was the right kidney that should be removed. The surgeon told her she had made a mistake and continued operating, removing the left kidney (the normal kidney). Mr Reeves died of kidney failure five weeks later.

Had there been a greater culture of openness, where junior staff were encouraged to ask questions and where their concerns were taken seriously, Mr Reeves would not have died. Training in techniques such as CUSS (see Box 1.3) would have also helped the student to be assertive and escalate her concerns in a respectful way.

BOX 1.3 Examples of graded assertiveness

CUSS

*I'm **C**oncerned*

*I'm **U**ncomfortable*

*This is not **S**afe*

***S**top what you are doing*

PACE

Probe—*I don't understand why you want to do . . .*

Alert—*I think that will cause . . .*

Challenge—*Your approach will harm . . .*

Emergency action—*STOP what you are doing! For the safety of the patient, we need to . . .*

Five-step advocacy

1. Attention getter—*Excuse me, Doctor.*
2. State your concern—*The patient is hypotensive.*
3. State the problem as you see it—*I think we need to get help now.*
4. State a solution—*I'll phone ICU to arrange transfer.*
5. Obtain an agreement—*Does that plan sound good to you?*

BOX 1.4 **Learning to speak up: Primum non tacere—first do not be silent**

- 'Speaking up' refers to a person in a non-dominant position expressing a concern or suggesting a course of action to a person in a more dominant or senior role.
- Speaking up refers to raising concerns *before* an act of commission or omission, rather than just 'hinting and hoping'.
- Healthcare professionals have a legal and ethical responsibility to advocate for patients and should never regret not having done so.
- Patients (and their loved ones) should also be encouraged to speak up.
- Speaking up requires courage and skill, but it is critical to patient safety.
- The safety and transparency of an organisational culture is demonstrated by how comfortable staff, patients and their significant others feel about speaking up.
- Speaking up requires skills in graded assertiveness.

'Call-out' and 'check-back' are two other forms of critical communication that relay essential information to members of the healthcare team during emergent situations. (See Box 1.5 for examples.) The 'call-out' strategy helps team members anticipate the next steps and directs responsibility to a specific individual responsible for carrying out the task. 'Check-back' ensures that information conveyed by the sender is understood by the recipient as the sender intended. Check-back is a skill we use in our everyday lives. For example, if we give someone our telephone or credit card number over the phone, we often ask to have it read back to us so that we know it has been recorded correctly. How much more important this is when patients' lives are at risk!

BOX 1.5 **Examples of 'call-out' and 'check-back'**

Call-out

Arrest team leader: *Airway status?*
Nurse: *Airway clear.*
Arrest team leader: *Breath sounds?*
Nurse: *Breath sounds decreased on right.*
Arrest team leader: *Blood pressure?*
Nurse: *BP 96/40.*

Check-back

Doctor: *Give Adrenaline 1 milligram IV push.*
Nurse: *Adrenaline 1 milligram IV push?*
Doctor: *That's correct.*

Use of acronyms and communication tools such as CUSS, PACE, call-out and check-back are effective in streamlining the way healthcare professionals communicate and increasing patient safety. However, while acronyms can be helpful, it is important to be aware that acronyms and abbreviations can mean different things to different professionals. For example, SB can mean 'short of breath' or 'seen by'; and PID can mean 'Pelvic Inflammatory Disease' or 'Prolapsed Intervertebral Disc'. There are many similar examples and healthcare professionals need to be judicious when using abbreviations because of the risk of misunderstanding and serious communication errors, potentially leading to adverse events.

Learning to communicate in ways that promote patient safety

Although a wide body of research underpins the relationship between effective communication and positive outcomes for both patients and healthcare professionals, contemporary teaching and learning approaches do not always facilitate the development of a requisite level of communication, collaboration and teamwork skills (Australian Commission on Safety and Quality in Health Care, 2020). Indeed, a review of communication skills training by Denniston et al. (2017) identified that 55 per cent of the 168 included papers focused on medical education only. Additionally, when educational opportunities are offered they tend to focus mainly on communicating with patients and much less attention is given to communicating with other healthcare professionals. As a result, graduates and their employers consistently report that they are not well equipped to communicate and collaborate effectively as members of an interprofessional healthcare team, and consequently patient outcomes are negatively affected (Gilligan, Outram & Levett-Jones, 2014).

Both in academic settings and in clinical environments, opportunities for learning about interprofessional communication and collaboration are often overlooked. For example, in a project exploring graduates' experiences of learning about other healthcare professionals (Gilligan, Outram & Levett-Jones, 2014), the following statement was made:

> *When we were on our clinical rotations, we saw a couple of students, med students and nursing students . . . but there was no interaction. We didn't actually do any study or liaising with them about patients or anything like that; it was very much segregated into 'you are a med student, you are a pharmacy student, you are a nursing student'. You don't talk to other students or learn with them; so you don't know anything about their roles.*

Traditionally, communication skills have been taught primarily in academic settings, limited to one or two subjects and a discipline-specific manner. This is in contrast to a body of research which suggests that attention to the development of healthcare professionals' communication skills should begin early and be continued throughout each year of study and beyond. The outcomes of an integrated approach include a more permanent understanding of the importance of communication, improvement in students' confidence and competence, reduction of clinical errors, and improved patient safety (Australian Commission on Safety and Quality in Health Care, 2020). Additionally, research has demonstrated that applied interprofessional communication skills education with strong practical and experiential components are more effective than programs that are mainly theoretical. Irrespective of the educational opportunities provided, what is very clear is that students who take the initiative by actively pursuing opportunities to learn about and practise communicating with patients and other healthcare professionals, and who seek feedback and reflect on their performance, are more likely to develop patient-safe communication skills.

Conclusion

Without doubt, effective communication leads to better outcomes for patients. It also reduces health service expenditure as there are fewer complications. Effective communication is an integral part of quality healthcare. It can take extra time but it is time saved in the long run. However, patient-safe communication can be complex and challenging, and there are many personal, contextual and organisational factors that undermine effective communication between healthcare professionals and between healthcare professionals and the people they care for. Learning to communicate in ways that promote patient safety takes personal insight, determination and an openness to change practices and habits that may have become second nature. Just as importantly, learning to communicate effectively requires active engagement in learning activities and thoughtful reflection on practice. This chapter and the ones that follow will provide students, graduates, educators and clinicians with understandings, knowledge and practical strategies that will equip them to improve their communication skills and promote patient safety.

Critical thinking activities

The following excerpt is taken from a study that explored graduates' experiences of working within a healthcare team. While the scenario portrayed focuses on the interactions between a junior medical officer and a registered nurse, similar communication issues arise for all healthcare professionals irrespective of their discipline or context of work. As you read this excerpt, reflect on similar situations that you have been involved in; consider the implications for the healthcare professionals involved and the potential impact on the patients.

> *Sometimes you're fumbling your way through and you look to the nurses for a bit of a clue of what to do. I had a situation when there was a patient that I couldn't get a cannula into; he was dehydrated, but he was taking in fluids, and his diarrhoea had stopped. I tried a couple of times, went away and came back, and then decided that we were just going to go with oral fluids. And the nurse sort of made this face, but she didn't say anything. I said to her, 'You don't look very happy with that. What do you think? What's the problem?' And so she sort of exploded then and said she thought it was really a bad idea, and that 'we really have to get a line into this patient', and that 'he was going to go downhill if we don't'. So after she said that it sort of felt like quite an easy decision… I'd been sitting on the fence and didn't really know what to do. But I wished that she'd said something, and not just sat there and made a face, because if I hadn't seen it, what would have happened to that patient?*

1. Imagine that you were the nurse in this scenario and concerned about the junior medical officer's clinical decision. Using one of the graded assertiveness skills provided earlier in this chapter, outline how you would respond in a way that promotes both patient safety and effective interprofessional teamwork.
2. Imagine yourself as the junior medical officer in the scenario. What would you say to the nurse to promote improved communication and collaboration in order to prevent this type of situation from occurring again?
3. Reflect on a recent clinical conversation with a patient or a colleague that did not go as well as you had expected. Identify from Figure 1.2 the contextual and interpersonal factors that may have influenced your conversation. Then consider the strategies you could use to promote patient-safe communication in the future.

Teaching and learning activity

This activity can be used to help students gain a deeper appreciation of the roles and responsibilities of the members of the healthcare team. Begin by sharing the following quote from a graduate who participated in the previously mentioned study:

> *It's almost like a tradesman having a toolbox that they've never opened, and every now and again somebody tells them that there's a tool that could be useful, might make a certain job easier… but if you don't know about it, you can't use it.*

Explain to students that they cannot communicate and collaborate effectively with other members of the healthcare team unless they understand, respect and value their roles.

For this activity, students should be instructed to create a table with two columns. In the left-hand column, students list the members of the healthcare team (remind students this refers to the broader team, not just the 'nursing team on ward 6' or the 'orthopaedic team', for example). In the right-hand column, students are to provide a brief description of the roles and functions of the team members, according to their current understanding.

Students should then be asked to test their knowledge about the roles and functions of the team members by seeking opportunities to observe and communicate with members of the team about their roles, what they value and how they work. The table should expand as students identify and add members of the healthcare team and as they gain a more comprehensive understanding of their roles. It will be an invaluable resource that will help students to communicate more effectively and work collaboratively to promote patient safety and wellbeing.