Communication – The vital link in best practice organisations

Case study: The Princess Alexandra Hospital Best Practice Communication Project

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Abstract

The critical issue of communication has been addressed by the Princess Alexandra Hospital in Brisbane. The hospital commissioned a communications audit, benchmarked outside the health sector in the service industry, and designed and piloted communication strategies at an organisational level and in selected clinical settings. The communications models developed have emphasised the importance of planning, evaluation and flexibility to enable the modification of communication strategies to continually improve communication in the organisation. It is envisaged that regular communication assessments will be conducted with the use of audit tools which have been developed to compare results over time.

Introduction

In any discussion on change in the workplace, communication is identified as a crucial element in success or failure. This leads to the question of why communication is considered to be a key to change.

Management texts tell us that effective communication is critical in managing organisations and employees, with links to productivity, culture and human resource management. In the real world it is common sense that people will do a better job, and feel happier in their work, if they know what is required of them and if they have the knowledge and tools to do the job (Hutton 1994, p 235).

If this is all such common sense, why is communication consistently identified by organisations as one of the major problems they face? When asked what factors contribute to a good workplace, communication is consistently rated as important by staff and as one of the factors most in need of improvement.

Such was the case for the Best Practice Communication Project which took place at Princess Alexandra Hospital. The Hospital and District Health Service obtained funding from the Commonwealth's Best Practice in the Health Sector Program to develop a best practice model for hospital communication which could be used by any health care facility.

The approach – how the project used the best practice framework

The project relied heavily on the best practice framework to guide its development.

One of the difficulties in a project focusing on communication is that it can become a magnet, attracting a wide array of organisational problems. At times it was difficult to separate communication issues from management issues. It was also a challenge for the project to remain in a facilitation role without adopting the problem – thus reducing responsibility and ownership. The best practice framework enabled the project to give issues an order of priority and limit the scope of the project to a manageable size.

In the early stages of our project, Queensland Health developed a corporate approach to best practice. This model supported the project objectives and was a useful reference for staff. Queensland Health's enterprise bargaining agreement was also underpinned by the best practice framework. It was important to link the project to these corporate initiatives to minimise confusion about enterprise bargaining, best practice and quality improvement and to harness potential synergy between the initiatives.

The project was conducted over 18 months and comprised four major phases:

* information gathering and analysis, including the conduct of a comprehensive communication audit

* benchmarking by comparing communication strategies employed by other organisations, which involved extensive site visits to service industry organisations and the development of performance indicators

* design of communication strategies and piloting of these strategies at an organisational level and in a variety of clinical settings

* evaluation and dissemination, including evaluation of strategies and repeating major components of the communication audit.

As well as a strong customer focus, three major groups were targeted in the early stages of the project – patients, staff, and external clients, specifically general practitioners.

The communication audit involved these groups in surveys, focus groups and interviews and was to be a 'snapshot picture' of communication at the Princess Alexandra Hospital. Questions were asked about the *way* information flows; *what* we need to know; *how* we like to get information; and *where* we get information.

Although the audit results were not surprising in many respects, they did highlight major areas for improvement. Involving staff in the audit also increased interest in the project and ownership of the results. The communication audit formed the basis for ongoing direction of the project.

Another success factor in the project was the cooperation and support of unions. This was achieved through the involvement of union organisers on the project's steering committee and also through participation of union delegates in the project management team. The aims of the project were consistent with improving work conditions for staff through consultation, feedback and training.

Learning from other organisations – difficulties in benchmarking

The project found that benchmarking communication was a complex process. Organisations had measured communication differently, which made comparison of results difficult.

Some organisations spoken to early in our investigations had evaluated 'tools' of communication without first asking what the key success factors were in employee communication or client communication. There is little value in starting a communication assessment by an evaluation of the staff newsletter if staff do not indicate that the newsletter is an important source of information.

In the end the project adopted a generic benchmarking approach, which is defined as comparing a key process with a similar process in other organisations in other industries. Communication processes were compared with various service organisations and hospitals, and the project learnt about problems staff and clients had faced and successful strategies that had been used to improve communication.

Another significant project principle was people involvement and employee empowerment. Staff from the pilot sites and project committees were all involved in the benchmarking phase. The exercise was extremely beneficial and a large

amount of information was gathered. The process of benchmarking also offered lessons for the organisation which were shared with staff in a seminar.

Several factors contributed to the success of this phase. Having a sound understanding of our communication issues and problems as a result of the communication audit provided the visiting team with detailed information which could be compared to the host organisation's situation.

Information exchanged before the visit optimised contact time with each organisation. Essential steps included clearly outlining the project's goals and objectives for the site organisation and thorough preparation of the visiting team. Additionally, mutual exchange of information helped build rapport and create ongoing networks. Some of the benchmarking partners were interested in the communication audit tools and in the performance indicators that the project developed.

Site visit team members were involved in presenting information back to the Princess Alexandra hospital staff and information was also distributed to hospitals in our network group. This group was established in the early stages of the project by contacting large teaching hospitals throughout Australia to learn about existing communication projects and initiatives.

The process lessons we learnt from the benchmarking phase were:

• understand your own process well

• prepare in advance and allow adequate time

• provide as much information as possible to site organisations about your objectives

• share information in return where possible

• show appreciation for the time people spend with you

• report your findings to your organisation

• be realistic about what is possible to implement in your organisation.

The project team learnt an enormous amount and consistent themes emerged irrespective of the specific organisation's business.

The major findings from the site visits were:

• improving communication tools and mechanisms in isolation is insufficient

• communication needs to be linked at the strategic level

• communicating vision and values throughout the organisation is vital

- role modelling effective communication behaviour demonstrates the value of communication

- feedback mechanisms are essential

- managers/supervisors need to be shown how to communicate and what to communicate

- staff expect honest, open communication which is relevant to them

- customer focus in communication is vital

- all major change processes take a long time.

Strategies in best practice communication

One of the major difficulties for the project was changing the external environment and the senior management of the organisation. The project felt the impact of several changes in chief executive officer, a change in State Government, corporate health restructure, cessation of the integration of a nearby hospital (and pilot site) and revision of the hospital's internal organisational structure.

The extent of change made the ability to link the project at the strategic level very difficult. Best practice organisations focus on the communication of vision and values to staff and the translation of these into action. Constancy of purpose and the communication of direction are important best practice principles, which many of our benchmarking partners exemplified.

Our strategy focused largely on cultural issues of organisational communication. The project identified quite early that technology would not be a major focus. This is not to deny the huge role technology can play in enhancing communication, but our hospital is constrained by its size, geographical layout and resources. As an example, we do not have an effective email system at this stage, although this is now a major priority.

There are also several other groups currently examining strategic information technology needs in Queensland Health and the hospital. Although this issue was frequently raised as a weakness in the project, this formula reinforces our view:

OO + NT = EOO

Old Organisation plus New Technology equals Expensive Old Organisation

As discussed earlier, face-to-face communication is the crucial ingredient for successful employee communication. Our communication audit clearly

demonstrated a preference for face-to-face communication from the direct supervisor. It also confirmed that the supervisor is the most trusted and preferred source of information in the organisation, which is consistent with worldwide research. Our project strategy was based on these principles.

The manager/supervisor has a key role in communication, and this role should be supported. However, many managers require additional skills in the new approach to communication and in how to communicate change. Communication should be a competence against which supervisors are assessed in performance reviews.

Communication models

The process improvement model of planning, implementing, evaluating and modifying has formed the basis of our communication models. All too often we jump into the doing part of communication before we have planned the communication and, importantly, worked out how to evaluate its effectiveness.

If it is to be effective, the key success factors in communication need to be considered. These include the elements of communication relationships, information mechanisms, communication management (and linkage to organisational plans and policies), information flow, information content and the characteristics of the target audience.

Our communication strategy addressed the top 10 organisational issues identified by project committees, based on the results of the audit. Issues identified were:

- lack of vision, values, direction
- lack of meetings, or ineffective meetings
- lack of consultation
- lack of feedback
- lack of senior/middle management seen at workplace
- need for more face-to-face communication
- lack of resources, staff and equipment
- need for improvement in general practitioner information
- need for improvement in top-down/bottom-up communication
- unclear reporting lines.

At an organisational level, the strategy focused on improving top-down and bottom-up communication, consultation and feedback and on face-to-face mechanisms.

The introduction of the team brief, a structured process of information dissemination and feedback, provided a consistent message to staff. It was based on face-to-face communication with direct supervisors which allowed clarification and questioning. It was trialled in three areas of the hospital. In evaluation of the team brief process, respondents wanted it to continue and said it helped to keep them informed. The project's second audit also showed that the vertical flow of information in the hospital had improved.

The QUALEBY (Quality, Enterprise Bargaining and You) hotline allowed staff to anonymously phone or fax questions or suggestions to senior management, with answers circulated fortnightly. The hotline proved to be very popular and has contributed to notice-boards being rated more highly as a source of information.

Several senior managers visited different areas of the hospital to increase understanding of work issues at the coalface, in response to staff wishing to see managers more and to be able to talk to them about their work.

During the restructuring of Queensland Health, managers and supervisors were provided with information kits to help disseminate information about the restructure to staff. This recognised their role as key communicators in the organisation. Information included plain English summaries of messages about 'what this means for us'.

Interpersonal communication amongst staff members was developed through training. Staff from the pilot sites were targeted using a scenario-based approach.

Communication plans for new projects or developments which incorporated the identification of stakeholders and their communication needs, communication mechanisms, time lines and responsibilities were encouraged.

Chief executive officer forums were already being run at our hospital but we trialled several ways of improving the forums and facilitating interaction by staff.

The hospital newsletter, *WhisPAH*, reports on happenings in the organisation. The newsletter ranked tenth as a preferred source of information by staff. Various areas in the hospital also have their own newsletters.

A communication directory was created which included pager numbers and email addresses for hospital and community health services in Brisbane south.

The human resource development group facilitated the formation of a project managers' network group which shares information and resources amongst groups involved in services improvement.

In summary, all the key factors of communication need to be considered, not only the tools of communication. Most messages need to be reinforced and should use a range of mechanisms.

In the pilot sites a process improvement model was used to enhance communication for patients and staff, again based on information gathered in the communication audit.

Trials included:

- introducing communication facilitators (supporting manager's role)
- improving information exchange (for example, nursing hand-over)
- refining multidisciplinary meetings
- writing guides for patients
- increasing the awareness of interpreter services
- increasing the awareness of the use of plain English, and producing a plain English guide
- asking patients for suggestions in the formulation of patient-targeted information
- improving information exchange between the emergency department and general practitioners (referral forms, advising of patient progress, general practitioner database, referring doctor's file on the mainframe, increasing collaboration with divisions of general practice)
- introducing a ward/emergency department nursing liaison group
- training in interpersonal communication skills
- streamlining the patient message system.

The project also role modelled communication itself by designing a communication strategy, and launching the project with a display rotated around the hospital. A pamphlet was developed on the project and a logo designed; the project's progress was presented at regular staff meetings; articles were contributed to *WhisPAH*; committee members were involved in information dissemination; the project collaborated with other projects wherever possible; and took part in the project managers' network. Information about the project was also presented at various seminars and displays.

Conclusion

This project has demonstrated the application of best practice principles in the hospital, including people involvement, utilisation of information and analysis, process improvement and client focus. The project has served as a model for other groups, which has contributed to the strong commitment to continuous improvement within the organisation.

Some of the impacts of the project are difficult to assess due to the intangible nature of communication. Additionally, some of the benefits will not be evident in the short term. The project has focused largely on cultural issues of communication which are slow to change, as are perceptions of these changes.

The communication models developed for the project have emphasised the role of planning, evaluating and modifying communication strategies to continually improve communication in the organisation. The models have also provided a framework to analyse communication by identifying key aspects of communication relationships, communication management, information flow, mechanisms, content and target audience. By considering these, staff can focus on the range of factors needed to develop communication strategies and not on mechanisms alone.

The project has raised the profile of communication as a key factor in the organisation and this has been demonstrated by the inclusion of communication strategies in business plans, increased communication planning for projects and organisational changes and further assessment of communication needs in some areas of the hospital. It is also envisaged that some form of communication assessment will be conducted on a regular basis. Audit tools have been developed which can be used to compare results over time.

Existing networks have been strengthened by the project's work, such as collaboration with the Divisions of General Practice. Continuing work with the divisions, which aims to improve the continuity of patient care, has developed from the project.

The momentum of the project will be continued through the commitment of senior managers in the organisation and will be supported by the many staff who have displayed enthusiasm and advocacy for the activities of the project. The Local Consultative Forum is examining the role it can play in overseeing the implementation of communication strategies, such as employee consultation, participative decision-making and quality improvement. Key departments, including Media and Communications Service, Human Resource Management, Quality Assurance Unit and Health Information Management, and Human

Resources Development, have incorporated many of the strategies and initiatives in their departmental activities.

Success factors in the pilot sites are being implemented in other areas of the hospital and continued dissemination of information will further assist the project. Several of the successful communication strategies such as team brief and QUALEBY will also help the process.

In the next five years the hospital has the opportunity in planning for a new facility to involve staff in consultation, teamwork, and decision-making and to develop the cultural and physical environment to improve communication for the benefit of staff and, importantly, their patients.

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