

Creating communicatively accessible healthcare environments

Creating communicatively accessible healthcare environments: Perceptions of speech-language pathologists

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Abstract

There is a growing body of research that indicates that a person with a communication disability communicates and participates more effectively given a communicatively accessible environment. If this research is to be translated into practice then we need to determine who will take on the role of creating communicatively accessible environments.

This research adopted a qualitative methodology to explore the perceptions of speech-language pathologists about working to create communicatively accessible healthcare settings.

Fifteen speech-language pathologists in three focus groups participated in this research. The focus group discussions were transcribed and analysed thematically. Thematic analysis indicated that speech-language pathologists believe there are four main benefits in creating communicatively accessible healthcare environments. These are Benefits for all people:

Access for all, Benefits for healthcare administrators, Benefits for those wanting to improve communication with patients and Benefits to our capacity to provide communicatively accessible environments. However, they believe these benefits can only be achieved if; The communication resources are available, Skilled, knowledgeable and supportive healthcare providers are available and Systems are in place to support a whole of hospital approach. This research supports the development of a new role to improve the communicative accessibility of healthcare settings.

Introduction

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) states that “disability results from the interaction between persons with impairments and the attitudinal and environmental barriers that hinder their full participation in society on an equal basis with others” (World Health Organization, 2006, p. 1). This definition identifies two separate but interacting causes of disability; a person’s impairment and their environment. A person with any type of impairment that impacts on their ability to communicate such as hearing, vision, speech, language and/or cognitive impairment may experience a communication disability. However, the CRPD indicates that the extent of the person’s communication disability will depend on the interaction between the communication-related impairment and the communicative environment. That is, a person with a mild communication related impairment, such as mild dysarthria may experience a severe communication disability in one environment where there are many environmental barriers, such as communicating with an unfamiliar communication partner in high levels of background noise. However, the same person may experience no communication disability where there are no environmental barriers, for example where the person is communicating with a familiar communication partner with no background noise.

Given that the communicative environment can profoundly influence the extent of a person’s communication disability, understanding the nature of the communicative environment and the ways in which the environment can be modified is very important. The World Health Organization defines the environment as the factors that “make up the physical, social and attitudinal environment in which people live and conduct their lives” (World Health Organization, 2001, p. 16). Environmental factors exist at an individual and a societal level. For people who experience communication disability, environmental factors at the individual level include the presence or absence of a communication board, the level of background

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noise, the language complexity of written information or the skills and attitudes of the communication partner. Environmental factors at the societal level include all the formal and informal social structures, services and systems that indirectly impact on people, such as public transport services, local government services and the legal system (World Health Organization, 2001). Environmental factors that enable or enhance functioning are described as facilitators whereas environmental factors that restrict or prevent optimal functioning are described as barriers (World Health Organization, 2001).

How the environment facilitates or creates barriers for people with communication-related impairment has been explored in a variety of ways. For example, research has described how public transport systems, arts venues and community services can be modified so people with aphasia can access them more easily (Ashton et al., 2008; Duchan, Jennings, Barrett, & Butler, 2006; Howe, Worrall, & Hickson, 2008). A recent systematic review of the literature also provides support for the education and training of communication partners to improve the communication and participation of people with aphasia (Simmons-Mackie, Raymer, Armstrong, Holland, & Cherney, 2010). Researchers have also explored how the school environment can be modified to enable children with significant disabilities to gain greater access to the school curriculum (McSheehan, Sonnenmeier, Jorgensen, & Turner, 2006) and how legal services can be adjusted to enhance access for people with traumatic brain injury and for people with complex communication needs (Togher, Balandin, Young, Given, & Canty, 2006).

The ways in which healthcare environments enable and/or restrict a person's ability to communicate about and participate in their healthcare has been a particular focus of research for the last 15 years. This is because many people with different types of communication-

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related impairment report difficulty communicating about their healthcare (Balandin, Hemsley, Sigafoos, & Green, 2007; O'Day, Killeen, & Iezzoni, 2004) and because the consequences of ineffective healthcare communication can be dire. Hospital inpatients with communication disabilities describe being unable to communicate with healthcare providers about very basic needs such as being hungry, thirsty and needing to go to the toilet (Iacono & Davis, 2003). They describe feeling ignored, confused and frightened (Mencap, 2004) and are at significantly greater risk of experiencing a preventable adverse event (Bartlett, Blais, Tamblyn, Clermont, & MacGibbon, 2008). People with communication disabilities are also significantly less satisfied with their healthcare (Hoffman et al., 2005). Adverse events and dissatisfaction with care may mean that people are less trusting of treatment recommendations, less willing to adhere to these recommendations and more reluctant to seek further healthcare, resulting in further restrictions to healthcare in the future (Street, Makoul, Arora, & Epstein, 2009).

There are many different environmental factors in healthcare settings that either enhance or restrict a person with communication-related impairment to communicate effectively (O'Halloran, Grohn, & Worrall, 2012). Interventions to enhance the healthcare environment for people with communication-related impairment have been conducted such as; providing education and training to doctors (Legg, Young, & Bryer, 2005), providing support people (Foster, 2005), modifying written healthcare information (Rose, Worrall, Hickson, & Hoffmann, 2011) and modifying healthcare systems, services and policies (Simmons-Mackie et al., 2007). Work has also commenced to enhance the knowledge, skills and attitudes of the next generation of healthcare providers through tertiary education programs (Burns, Baylor, Morris, McNalley, & Yorkston, 2012).

As the evidence base grows about interventions directed at the environment to enhance the ability of people with communication disabilities to communicate and participate in their

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healthcare, so will the expectation that this research evidence is implemented in practice. However, it is not clear who should do this. Some interventions, such as providing education and training to communication partners of people with aphasia (e.g., Simmons-Mackie et al., 2010) are well within the remit of practicing SLPs. However, other interventions such as creating communicatively accessible services (Anderson, 2010; Kagan & LeBlanc, 2002) may require different knowledge, skills and abilities (Simmons Mackie, 2013). This broadening of practice from the assessment and intervention of individuals with communication disabilities and their communication partners to the assessment and intervention of systems and services prompted Wylie and colleagues (Wylie, McAllister, Davidson, & Marshall, 2013, p. 11) to ask recently: “Are we ready and indeed are we able to do this as a profession?” Another related question is “should SLPs take on this role?” Many people including those from culturally and linguistically diverse backgrounds, those with low literacy, those with different sexual orientations, as well as people with communication-related impairment have difficulty communicating about their healthcare with healthcare providers and experience lower quality healthcare as a result (The Joint Commission, 2010). These people have been described as communicatively vulnerable in the healthcare setting (The Joint Commission, 2010). Patient advocacy groups and other health professions including medicine, nursing, audiology, and social work are also interested in improving communication between patients/ clients and healthcare providers. This calls into question what the role of the SLP should be in relation to these other potential client/ patient groups, advocacy groups and healthcare professional groups.

In summary, despite emerging research evidence that supports modifying the healthcare environment at both the individual and systems level to enhance the communication and participation of people with communication-related impairment in their healthcare, there has been no research to date about SLPs’ perceptions about working in this area. If this research

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evidence is going to be implemented into practice there is a need to understand if SLPs feel willing and able to broaden their practice in this way.

The opportunity to explore the perceptions of SLPs about their role in the development of communicatively accessible healthcare environments became available whilst preparing to conduct a research project on the perceptions of SLPs on the development of an audit tool to measure the communicative accessibility of the hospital setting. Preparations for the initial research project on the development of an audit tool were modified so that the role of SLPs in the creation of communicatively accessible healthcare environments could also be explored. The research on SLPs perceptions on the development of an audit tool to measure the communicative accessibility of the hospital setting has been reported elsewhere (Lee, 2011). This paper reports on SLPs perspectives on their role in the development of communicatively accessible healthcare settings.

Method

Qualitative research provides a way to “document the world from the point of view of the people studied” (Hammersley, 1992, p. 45). This approach is essential when little is known about the topic under investigation (Liamputtong, 2013). Therefore, in this study, qualitative research methods were employed to document the perceptions of SLPs about their role in the development of communicatively accessible healthcare environments. Methodologically, this research was framed within a symbolic interactionist theoretical framework because this framework purports that we act towards things on the basis of the meaning that these things have for us, and that we continue to derive new meanings and modify meanings through social interaction (Crotty, 1998). This theoretical framework suggests that SLPs will act (or not) towards creating accessible healthcare environments on the basis of the meaning that this

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has for them as SLPs. This framework also proposes that what ‘creating accessible environments’ means to them will continue to be shaped through social interactions with others. Similarly, as researchers we wanted to develop new meanings about the profession’s role in creating accessible healthcare environments through social interactions with SLPs. Ethics approval from La Trobe University Faculty of Health Sciences was granted before this research commenced.

Participants

SLPs working in Victoria, Australia with experience working in the hospital setting were invited to participate in this research. SLPs across private and public healthcare settings and from rural, regional and metropolitan healthcare networks were invited to participate to canvas a wide range of perspectives. A total of 19 SLPs expressed interest in participating in a focus group about this research. These SLPs were sent participant information and consent forms. Two SLPs working in rural settings were unable to attend a focus group and efforts to enable them to participate via phone or internet were unsuccessful. The remaining 17 agreed to participate in one of three focus groups and 15 attended. The details of those participants who attended are provided in Table 1.

Table 1 about here

Data Collection

In order to generate discussion about the role of SLPs in creating communicatively accessible healthcare environments SLPs were asked: “Do you think working to create a communicatively accessible healthcare environment is a useful thing to do?” and “If so, who is best placed in the healthcare setting to address this?” These questions were added to the set of research questions already planned to investigate SLPs’ perceptions of the development of

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an audit tool, as described earlier. Given participants were required to respond to several questions, three semi-structured rolling focus groups were conducted. Focus groups were conducted because they provide a means of gaining an understanding of a wide range of views that people have on a specific issue (Liamputtong, 2011). In rolling focus groups, a verbal summary of the data gained from the previous focus group is presented to the next focus group for comment, refutation and expansion (Toomey, Nicholson, & Carswell, 1995). This allows each focus group to cover a greater number of issues related to the topic. Three rolling focus groups were conducted over a period of three months. The focus groups were recorded on a digital camcorder and a digital audio recorder as back up and later transcribed.

Data Analysis

A thematic analysis as described by Braun and Clarke (2006) was used to provide a descriptive analysis of the data. This analysis consists of six phases.

Phase 1: Familiarising yourself with the data

The first and second author conducted all three focus group interviews together so they already had initial impressions of the data. Both authors read through all three transcripts to check for accuracy and to re-familiarise themselves with the discussions.

Phase 2: Generating initial codes

In the second phase the first and second authors independently went through each focus group transcript and highlighted text that related to SLPs' perceptions on the development of communicatively accessible healthcare environments. They discussed differences of opinion until they reached agreement. Text excluded at this stage was not subject to further analysis. The selected text was then reviewed and an initial list of potential codes was generated.

Phase 3: Searching for themes

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During phase 3 all the initial codes were grouped into potential themes. Each piece of selected text with its corresponding initial code was spread out across a large table and sorted into potential themes. This process allowed potential themes and subthemes to be positioned spatially according to how closely related they appeared to be. It also provided an immediate sense of the number of pieces of text informing each potential theme and the emerging dominance of potential themes. If only one or a few pieces of text described a qualitatively distinct idea then it was still identified as a separate potential theme.

This analysis became problematic during phase 3 because the participants would often describe why they thought creating a communicatively accessible healthcare environment would be useful but would then qualify their comments by saying “but only if...” To capture this complexity, the data was analysed in two ways. First, SLPs’ perceptions of the benefits of creating communicatively accessible healthcare environments were identified. Then SLPs’ perceptions about how to realise those benefits, including their role in this were identified. Each of these analyses was conducted concurrently.

Phase 4: Reviewing themes

In phase 4 all the text and codes that informed each potential theme were reviewed in order to achieve internal homogeneity, so that the data within each theme cohered meaningfully and to achieve external heterogeneity, so that there was a clear difference between each identified theme. During this phase texts and codes were relocated and themes were split, recombined and new themes were created. This analysis was reviewed independently by the second author resulting in further changes.

Phase 5: Defining and naming themes

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In phase 5, the scope and content of each theme and sub theme was defined. Main themes and sub themes with working titles up were given titles that captured the essence of the theme. This summary was sent to each focus group participant for member checking. Four focus group participants provided additional comments which were included as data and further minor changes were made.

Phase 6: Producing the report

The final phase involved writing a report of the analysis. Quotes used in this report have been given fictitious names to maintain participant confidentiality.

Results

An exploration of SLPs' perspectives regarding their role in the development of communicatively accessible healthcare settings resulted in two separate but complimentary analyses. The first analysis concerned SLPs' beliefs regarding the benefits of creating communicatively accessible healthcare environments. Twelve subthemes were identified and these were grouped into four main themes. The second analysis focussed on SLPs' perceptions about how to create communicatively accessible healthcare environments, including their role in this. Eight subthemes were identified and these were grouped into three main themes. Each analysis is described separately below.

SLPs' perceptions of the benefits of creating communicatively accessible healthcare settings

These SLPs perceived that there were benefits in developing communicatively accessible healthcare environments for four different stakeholder groups. These were; people accessing healthcare services, healthcare administrators, healthcare providers and healthcare providers

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interested in creating communicatively accessible healthcare settings. Four main themes and subthemes were identified around each of these stakeholder groups. These themes are summarised in Table 2 and described in further detail below.

Insert Table 2 about here

Benefits all people: Access for all

The most dominant theme, indicated by the number of pieces of text supporting each theme was that creating communicatively accessible healthcare settings would benefit all people needing to access healthcare services. Participants perceived people would benefit in three different ways, as it would improve access to i) individualised patient care ii) healthcare services and iii) healthcare buildings.

Improved access would lead to individualised patient care

These SLPs perceived that all people needing healthcare, described here as patients, would benefit from a communicatively accessible healthcare setting because all patients would be able to communicate as effectively as possible with all their healthcare providers and that this would lead to individualised patient care.

When describing these patients, participants included patients from non dominant cultural and/or linguistic backgrounds, those with low literacy and those with communication-related impairment. They believed “no one should slip through” (Jenny). “Because in communication we’re talking more than just...a speech pathology point of view... It’s much broader.” (Belinda). In a communicatively accessible environment patients would be able to communicate effectively with their healthcare providers regardless of the time of their admission. Healthcare providers would be skilled in communicating with people with communication difficulties and they would have the resources at hand to enable them to do

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this. Healthcare providers would be able to communicate effectively with patients “as quickly as possible” (Lucy). Healthcare providers would give the “same information but in different ways on multiple occasions” (Belinda) when this was required and family members would also receive education and support to enable them to communicate successfully with the patient. These SLPs suggested that a communicatively accessible healthcare setting that facilitated effective communication throughout the patient’s admission might also enhance or maintain the patient’s independence in hospital and facilitate a more successful hospital discharge, as patients would be more able to understand healthcare procedures, their individual goals and how they are working towards their goals and participate in a more informed way in decision making about their healthcare.

Participants perceived that the development of a communicatively accessible healthcare setting and consequently more effective communication between patients and their healthcare providers would lead to a greater focus on patients’ individual needs. These SLPs believed that more effective patient-provider communication would enable healthcare providers to identify the patient’s individual needs and concerns. In the following quote Pam describes how she has failed to do this in the past:

The amount of times that I have ... provided education about texture modifications ... discussed all these things and the patient has said... [shakes head] “can I have water or not?” You know like ... they don’t really care, they don’t really... it’s not necessarily about being able to understand ... (it’s about) “I don’t need all the mumble jumble, what’s my bottom line?” It’s so individual (Pam).

These SLPs perceived that a communicatively accessible healthcare environment would mean that healthcare providers would communicate more effectively with individual patients,

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become more aware of the assumptions they were making and begin to tailor their healthcare to the patient's individual needs.

Improved access to healthcare services

These SLPs perceived that all people needing to access healthcare services would benefit from a communicatively accessible healthcare setting because healthcare information and services would be easier to access. Staff working in the healthcare system including volunteers, those at information desks, ward clerks, as well as healthcare providers would have the skills to communicate with people with different communication abilities:

You ... meet people in front of the hospital and direct them places, and you get people walking around the corridors. And also people at information... ward clerks, frontline first contact people. Yeah, they should be involved (Jenny).

All information systems would be easier for people with different levels of communication ability to access as well:

It is more than the staff at this point. It needs to include any interaction from the moment a person is referred or looks up the website of the organisation. That includes appointment letters/cards, posters, phone calls to arrange/cancel appointments. (member checking comment)

Improved access to healthcare buildings

Finally, participants believed that all people would benefit from a communicatively accessible healthcare setting because this would mean that buildings would be easier to

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navigate around. “It must be so confusing when you’ve got signs up, you know one sign saying this is ... acute, and another sign directing you a different way ... it’s just very confusing” (Virginia). In a communicatively accessible healthcare setting people would be able to navigate their way around buildings because there would be clear, easy to read, well located maps available. Internal and external signage would be clear and unambiguous and include nationally and internationally recognised symbols.

Although the majority of the discussions centred on the benefits for patients and others accessing healthcare services, participants identified benefits for other stakeholder groups in the development of communicatively accessible healthcare services and these are described below.

Benefits for healthcare administrators

Participants perceived that healthcare administrators would also benefit from communicatively accessible healthcare environments. These benefits were grouped into four subthemes; i) enhanced person centred care, ii) a reduction in preventable adverse events, iii) improved patient satisfaction with care, and iv) a reduction in patient complaints.

Improved person centred care

As described above, some SLPs suggested that a communicatively accessible healthcare setting would benefit patients because it would improve patient-provider communication and that this would result in more individualised patient care. However, they also described how

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they believed communicatively accessible healthcare settings would facilitate person centred care:

I think the key to that is person centred care, it's finding out what that person wants ... I agree that you know, people, typically older people... (say) "please just tell me what to do" ... but ... is this that type of person?, or is this a person who wants to know their goals and wants to read that through? ... I don't think we ask that question (Virginia)

Person centred care or consumer centred care as it is described by the Australian Commission on Safety and Quality in Healthcare is a key component of the Australian Safety and Quality Framework for Health Care (Australian Commission on Safety and Quality in Health Care, 2010). The phrasing of this comment suggested to the researchers that these SLPs were also considering how creating communicatively accessible healthcare settings would meet a key objective of healthcare administrators.

A reduction in preventable adverse events and patient complaints and improved patient satisfaction with care

SLPs also described how communicatively accessible healthcare environments could reduce preventable adverse events in hospital as "communication is one of the options that you can tick as a reason that might have contributed to the incident" (Belinda). They also described how they believed creating communicatively accessible environments would lead healthcare providers to enquire about the experiences of patients and their families with healthcare. This would raise the awareness of healthcare providers about areas where patients and families

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were not satisfied with care and might make complaints. One SLP described being involved in focus groups with patients and their families. She described how:

...a whole lot of issues came up, that you know, that they're not happy or happy about treatment during their stay. And...one of them was... they didn't know who (the) medical (staff) were, um, they didn't know what they were going to be doing...(Liz).

Other patients “felt very strongly that they were not cared for, abandoned” (Michaela).

Participants associated enhanced communication between patients, their families and healthcare providers with improved patient centred care and a reduction in the situations that result in communication related adverse events, patient complaints and patient dissatisfaction.

Benefits for healthcare providers wanting to improve communication with patients

Participants also described how communicatively accessible healthcare environments would benefit all healthcare staff interested in improving communication with patients. These benefits were grouped into three subthemes; benefits for i) healthcare providers communicating with patients, ii) speech-language pathologists and iii) other healthcare providers interested in creating communicatively accessible healthcare settings

Benefits for all healthcare providers communicating with patients

These SLPs believed all healthcare providers who wanted to improve their ability to communicate with patients would benefit because they would be given the education and

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training they needed to communicate more effectively with patients: “it’s only going to ... benefit their ability to communicate with the patient” (Peter).

Benefits for speech-language pathologists and other health professionals interested in creating communicatively accessible healthcare environments

SLPs also perceived that they and other healthcare providers would benefit because the development of communicatively accessible healthcare settings would enhance them professionally. SLPs perceived this as “a beautiful opportunity, for really establishing ourselves as communication experts” (Susan). They also recognised that creating communicatively accessible healthcare settings was integral to the interests of others, for example: “I think the cultural diversity department they are also interested in promoting communication” (Justine). “We’re not alone in wanting to achieve this” (Justine).

Benefit our capacity to provide communicatively accessible environments

Finally participants also identified a smaller but qualitatively different benefit of creating communicatively accessible healthcare environments. This benefit was that it would facilitate the ongoing development of knowledge in this area. Two subthemes informed this theme. These were i) increasing the capacity to create communicatively accessible healthcare environments and ii) increasing the capacity to create communicatively accessible environments in the wider community.

Increasing the capacity to create communicatively accessible healthcare environments

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SLPs perceived that a focus on creating communicatively accessible healthcare settings would provide them with the impetus to develop resources. These resources could be made available to wards, departments and other organisations. For example, having guidelines on how to create communicatively accessible written information meant the SLPs could share this information: “say ‘look, there are some guidelines...it says this font, this colour, this size – it’s a good start” (Virginia). They also perceived that collaboration could occur across different organisations as well. We could “partner up with (other organisations)” (Simone) and “all contribute to a common knowledge base” (Pam).

Increasing the capacity to create communicatively accessible environments

Efforts to create communicatively accessible healthcare services would also mean “taking it through the hospital and out into the community as well” (Belinda). This would enable healthcare providers to let people know about communicatively accessible services in the community.

How to create communicatively accessible healthcare environments

As SLPs discussed the benefits of creating communicatively accessible healthcare environments they also described how this could be achieved. These comments were analysed into three main themes; having the communication resources available, having skilled, knowledgeable and supportive healthcare providers and having the systems in place. These themes and corresponding sub themes are summarized in Table 3 and described in detail below.

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Table 3 about here

Having the communication resources available

Participants believed that in order to create a communicatively accessible environment communication resources need to be readily available on the ward so that any healthcare provider or family member can use these resources to communicate with the patient. These SLPs said, there:

...needs to be something... that is there all ready to go if there's an afterhours or weekend admission... a tool kit on the ward with some general information that can be used (Anne).

Other SLPs said: "having communication boards easily available, pencils and paper easily available, things that, uh the environment is sort of set up as friendly as possible for them" (Jenny).

SLPs identified the need for a communication toolkit and accessible written information to be readily available so that healthcare providers and family members could communicate with patients without needing to wait on the SLP. However, as SLPs discussed what should be included in a communication tool kit for a ward or department they raised concerns that a generic resource might not meet the needs of patients with different communication abilities and different communication needs. These concerns were reflected in the following comments about communication boards:

If they're too general, they become not useful and nobody would use it. So, you know, if you've got a generic communication board, is it 4 pictures in a page? Or is it 15

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pictures in a page? ...Or is it only used for people with cognition difficulties? ...how many groups of communication boards do you have? How many pictures for each page? for different sorts of patients? It ... becomes quite difficult (Belinda).

Having skilled, knowledgeable and supportive healthcare providers

The second theme identified to create a communicatively accessible healthcare environment was skilled, knowledgeable and supportive staff. This theme was divided into three subthemes; i) staff with the skills and knowledge to communicate with all patients, ii) staff who saw this as relevant to them and iii) staff who were supportive of it. Each of these subthemes is described in detail below.

Having the skills and knowledge to communicate with all patients

These SLPs identified that staff need specialised knowledge and skills to support patients with communication difficulties. These included being aware of those patients who are having communication difficulties and knowing how to use the resources that are available. SLPs also believed that staff needed the skills and knowledge to feel empowered to engage with patients who have communication difficulties “(it) enables nursing staff and the patient to have some empowerment around the process of communication” (Anne). Staff would have the knowledge and skills to provide the “same information but in different ways on multiple occasions” (Liz) and “the nurses (then give) that education to the family” (Jenny).

Interestingly, SLPs also described a qualitatively different type of knowledge that healthcare providers need to successfully communicate with patients. This was the knowledge that sometimes achieving optimal communication with the patient may not be possible and that

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creating a communicatively accessible environment was about being realistic, doing the best you can in often difficult circumstances. This was indicated by:

You know [the recommendation to] minimise distractions, well you've got 4 people in the room, and it's all very... lovely, and that's individualised for that patient, but ...it may not well, be as practical in an acute setting (Pam).

This sentiment was confirmed later when the moderator asked: "So ...is it something about flexibility? like "hearing aids are great, but (what are the) alternatives if they haven't got hearing aids?" and the participant agreed.

Seeing it as relevant

These SLPs also felt that healthcare staff need to believe that being able to communicate effectively with all patients is relevant to them and that they may need additional skills and knowledge to do this, as indicated by the following comments. "Another speech pathologist is currently doing a project on ... training ... people that work with people with communication disorders, and across the whole institution ... a simple survey (suggests) they think they don't need it" (Virginia) and "if nobody else thinks that there's a need, they're not going to do the training, they're not going to... value it" (Virginia).

The need to be supportive of it

SLPs also believe that healthcare providers may be reluctant to invest the time and effort that is needed to support patients with communication difficulties because this may create

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additional work when they are already under considerable workload pressures. One SLP described how developing a communication board for one ward was unsuccessful because: “They (the staff) didn’t want home, and phone on the board because they hear them the most, (they said) it would upset the patient if they kept asking, so they didn’t want it on the board” (Jenny).

Similarly, SLPs thought staff might be reluctant to spend extra time to communicate with patients. SLPs were concerned that creating a communicatively accessible environment might mean nurses would be required to “spend time having a chat whereas ‘[they might think] I just want to walk in and check if you’ve finished eating and then remove the tray. And then get on to everything else I need to do” (Pam). Lauren expressed concern that healthcare providers would not be supportive of a communicatively accessible healthcare environment if it meant tasks took longer:

Even if it’s just basic needs like waiting for someone to spell out “I need to go to the toilet” on an alphabet board, versus a nurse who just lifts up the blanket and checks their incontinence pad, like which one is going to be quicker? (Lauren).

SLPs also described that working to create a communicatively accessible healthcare environment also has implications on their own workload. Simone described the situation in her workplace, where they offered communication training for staff members. Multiple training sessions were required to cover all the staff and this resulted in significant increases in referrals to speech-language pathology:

There are 2 or 3 (training) sessions every 8 weeks to catch up with the whole shift. And then you renew it again the following 8 weeks across 15 months. The percentage of referrals has ... almost tripled (Simone).

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Having the systems in place

The third essential element to creating a communicatively accessible healthcare setting identified was having the necessary systems in place to support it. These systems were grouped into four subthemes, systems to ; i) support a multidisciplinary team to work on this issue, ii) support healthcare providers communicate with patients and their families; iii) support healthcare providers communicate with each other and iv) ensure standards were evaluated.

Systems to support a multidisciplinary team working on this

Participants believed that executive support to establish a multidisciplinary team to address the issue was critical to its success as indicated by the following comment:

All the good intention could be there, but you do need that executive buy in, and that local buy in as well...for one discipline to do it as a unilateral type thing I think... has the potential to be detrimental (Susan).

Systems to support healthcare providers and patients / family communicate

SLPs also described the need for standards of practice that supported staff to provide clear consistent information to patients and their families. For example, Lauren described a system of documenting the patient's rehabilitation goals so that all staff provided consistent information:

...we would have goal setting signs above every single patient's bed with all the patient centred treatment goals. So... all you have to do is just look above the bed, "oh you can't go home, we're still working on this" (Lauren)

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These SLPs also described the value of having formal systems in place to standardise the information patients and their families are given as “... it’s about having uniformity, so it does absolutely have value” [nods] (Anne)

Systems to support inter professional communication

Participants also believed that formal systems help support inter-professional communication, which in turn enables better communication with patients. Having formal systems in place enables the SLP to engage other health professionals in conversations about communication. For example, one SLP described how:

...you can say “oh um...did you have a chance to catch up with Mr Smith’s wife? ... I’m the key liaison person and I didn’t notice the sticky label (in the patient’s notes)” ... it’s part of the process, you can ask that...without it being a big issue (Jenny).

Systems to evaluate implementation of the standards

Finally SLPs perceived the need for systems to be in place to monitor the effectiveness of these strategies such as accessible complaints systems and audit tools. Healthcare settings need to have an accessible way for patients who have communication difficulties to give comments and make complaints, as “most of the people don’t complain if they’re communicatively unable to access something, they usually can’t communicate the complaint” (Michael).

SLPs also believed that systems to monitor the implementation of strategies need to be enforceable, as indicated by the following.

We probably need DHS (Department of Human Services) to mandate standards or have accreditation involved, so it’s something enforceable, cause the reality is, oh

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(and) a need to fund it, it will be um... probably very pragmatically be dropped down on the list of priorities (Anne).

Discussion

In conducting this research we sought to gain a greater understanding about the perceptions of SLPs regarding their role in creating communicatively accessible healthcare environments. In doing so we gained insights into these SLPs' conceptualisation of what a communicatively accessible healthcare setting is, the potential benefits they perceive in creating communicatively accessible healthcare settings and how they believe communicatively accessible healthcare settings could be developed, including their role in this. Each of these areas is discussed in further detail below.

SLPs' perceptions of a communicatively accessible healthcare environment

The participants in this study perceived a communicatively accessible healthcare environment broadly. One that includes the physical resources, such as communication aids, communication partners including healthcare providers and family members, who have the knowledge, skills and attitudes to communicate as effectively as possible and the healthcare systems that support communication. This conceptualisation of the environment aligns with the definition of Environmental Factors in the International Classification of Functioning, Disability and Health (ICF; World Health Organization, 2001).

They also perceived the potential beneficiaries of communicatively accessible healthcare environments broadly. In particular they described how people who experience difficulty communicating about their healthcare as a result of cultural or linguistic difference, low literacy or because of acquired difficulty reading, writing, understanding or speaking would

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benefit from communicatively accessible healthcare settings. Speech-language pathology literature has focussed on creating communicatively accessible healthcare environments to support people with aphasia (Kagan & LeBlanc, 2002; Parr, Pound, & Hewitt, 2006; Simmons-Mackie et al., 2007) and people with intellectual disability (Law, Bunning, Byng, Farrelly, & Heyman, 2005). The SLPs in this study conceptualised a broader remit in which healthcare environments need to be modified to support people who experience difficulty communicating for other reasons as well. However, they did not explicitly include people with low health literacy, those who are critically ill and those with a different sexual orientation as needing a communicatively accessible environment. These groups of people have also been identified in the literature as having difficulty communicating about and participating in their healthcare (Australian Commission on Safety and Quality in Health Care, 2013; The Joint Commission, 2010). Despite this, the SLPs' description supports a definition of a communicatively accessible healthcare setting as a setting that has the people, resources, systems, services and buildings that enable all people to communicate and participate in their health to the best of their ability.

The potential benefits of creating communicatively accessible healthcare services

SLPs have an expansive view of the potential benefits of communicatively accessible healthcare environments. They identified many potential benefits that have already been identified in the literature, such as improving the ability of patients to communicate about and participate in their healthcare (Simmons-Mackie et al., 2007), improving access to all healthcare services (Parr et al., 2006) and improved way finding around healthcare settings (Anderson, 2010). They also identified benefits such as improved patient centred care (The Joint Commission, 2010), enhanced patient satisfaction with care (Hoffman et al., 2005) and as a way to reduce preventable adverse events in hospital (Bartlett et al., 2008). Whilst these benefits have been mooted in the literature, further research is needed to determine if actually

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enhancing communication between patients who experience difficulty communicating in the healthcare setting leads to these desired outcomes. For example, interventions directed at healthcare providers may improve communication between patients with communication disability and their healthcare providers but it may not automatically result in more patient centred care. There may be other intermediary factors that influence these desired outcomes as well.

These SLPs identified other benefits that have not previously been mentioned in the literature as well. These included the enhancement of the SLP's role within the healthcare setting, the professional enhancement of other members of the healthcare team, increased knowledge of communicatively accessible services in the community and improved knowledge in this area. This list of benefits, provided in Table 2, could serve as a list of potential outcomes that could measure the effectiveness of interventions aimed to enhance the communicative accessibility of healthcare settings. It is likely that different kinds of interventions will lead to different outcomes that contribute to communicatively accessible healthcare environments in different ways. For example, communication partner training for healthcare providers would be expected to lead to the improved knowledge and skill of communication partners and improved patient-provider patient interaction, whereas improving signage throughout an organisation would be expected to lead to improved way finding.

Creating communicatively accessible healthcare settings in the future

Although these SLPs feel they have an important role to play in creating communicatively accessible healthcare environments, they believe that this can only be achieved through collective responsibility. These SLPs firmly believe that they cannot create communicatively accessible healthcare environments on their own and that a complex of systems, staff and resources are needed. These ideas are supported by the literature on creating

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communicatively accessible services for people with aphasia (Kagan & LeBlanc, 2002; Parr et al., 2006; Simmons Mackie, 2013).

However, this research suggests that there are potentially problematic issues at each level of resources, staff and systems that need to be addressed if communicatively accessible healthcare environments are to be realised. For example, although the need for communication aids and equipment to support communication is clear, these SLPs are uncertain about the kinds of resources that are needed. Clinical practice guidance is needed to determine the minimum number of tools needed to be able to communicate quickly and easily with patients about their healthcare needs. Generic communication aids for communicating in the emergency department (Eadie, Carlyon, Stephens, & Wilson, 2013) and in intensive care (McKinley, Poole, & White, 2010) have been developed. Tools like these may provide the basis for a communication resource kit tailored to individual wards and departments.

These SLPs described how communicatively accessible healthcare is also dependent on healthcare staff. Although many believed that all healthcare staff should see communicating effectively as part of their role, they expressed concern that there may be potential resistance amongst some staff. For example, the unwillingness of some nursing staff to have items on a communication board that might encourage unwanted communication with patients suggests that efforts to create more communicatively accessible healthcare may make significant intellectual, emotional and sometimes physical demands on healthcare staff as well as demands on their time. This research indicates that these demands need to be understood, acknowledged and addressed before staff will be in a position to implement the communication skills that communicatively vulnerable patients depend on.

Consistent with literature on creating communicatively accessible healthcare settings (Kagan & LeBlanc, 2002; Law et al., 2005; Parr et al., 2006; Simmons Mackie, 2013), these SLPs

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believed systems also need to be in place to support communicatively accessible healthcare. This research suggests that as well as systems to support education and training of healthcare providers, complimentary systems that support healthcare providers to communicate with all patients and families and systems that support inter-professional communication may also be needed. One system to support communication between healthcare providers perceived by these SLPs to be valuable is ISBAR (Identify, Situation, Background, Assessment, Request; Finnigan, Marshall, & Flanagan, 2010). Another structured communication system currently in development to support communication between healthcare providers and patients is the 'CARE' and 'CLEAR' program. This program addresses both the interactional aspects of communication (CARE: Connect, Ask, Respond and Empathise) as well as the informational aspects of communication (CLEAR: Collaborative, Lucid, Explicit, Active, Respond) (Slade, 2012). These SLPs perceived these complimentary systems as integral to creating a communicatively accessible healthcare environment.

In summary, although these SLPs recognise the great potential of communicatively accessible healthcare environments they believe it is beyond the scope of SLPs alone to implement the emerging research evidence into practice. In a recent special issue on the World Report on Disability in *The International Journal of Speech-Language Pathology*, McAllister and colleagues (2013) suggested there may be a need for a new type of professional to work in the field of communication disability, a 'public health communication professional', who would have a specialist skill set to work within communities, promote communicatively healthy families and communities and to create opportunities for people with communication disabilities to engage more effectively. This research suggests that this new type of professional could have a role in the development of communicatively accessible healthcare settings by bringing healthcare administrators, healthcare staff, patients and families together to address communicative access issues across the health service.

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Limitations and Future Directions

The SLPs who participated in these focus groups were working in Victoria, Australia and were interested enough in this topic to volunteer for this research. In these respects they may not reflect the views of other SLPs. However, they do reflect the perspectives of SLPs who are grounded in clinical practice and interested in the area, and therefore they provide valuable insights into the factors that will influence research implementation. Another limitation may be the use of focus groups. This method does provide a useful way to understand the views of a wide range of participants; however, some participants may feel pressure to concur with the views of the majority rather than express their own opinions. To counteract this potential limitation, participants were given a written summary of the discussion and the opportunity to provide feedback anonymously.

Whilst research evidence is emerging that interventions directed at the communicative environment improve the communication and participation of people who are communicatively vulnerable in the healthcare setting, further research is needed to understand the relationship between specific interventions directed at the environment, healthcare communication and health outcomes. It is likely that as our understanding of how to modify the communicative environment grows so too will the role of SLPs and other healthcare providers in the development of communicatively accessible healthcare settings.

References

- Anderson, N. (2010). Creating communicative access in Barwon Health: Dwelling in possibility. *ACQuiring Knowledge in Speech, Language and Hearing*, 12(3), 116-119.
- Ashton, C., Aziziah Aziz, N., Barwood, C., French, R., Savina, E., & Worrall, L. (2008). Communicatively accessible public transport for people with aphasia: A pilot study. *Aphasiology*, 22(3), 305-320.

- Australian Commission on Safety and Quality in Health Care. (2010). Australian Safety and Quality Framework for Health Care from <http://www.safetyandquality.gov.au/national-priorities/australian-safety-and-quality-framework-for-health-care/>
- Australian Commission on Safety and Quality in Health Care. (2013). *Consumers, the health system and health literacy: Taking action to improve safety and quality. Consultation paper.* Sydney: ACSQHC Retrieved from <http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Consumers-the-health-system-and-health-literacy-Taking-action-to-improve-safety-and-quality3.pdf>.
- Balandin, S., Hemsley, B., Sigafos, J., & Green, V. (2007). Communicating with nurses: The experiences of 10 adults with cerebral palsy and complex communication needs. *Applied Nursing Research, 20*, 56-62.
- Bartlett, G., Blais, R., Tamblyn, R., Clermont, R., & MacGibbon, B. (2008). Impact of patient communication problems on the risk of preventable adverse events in acute care settings. *Canadian Medical Association Journal, 178*(12), 1555-1562.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.
- Burns, M. I., Baylor, C. R., Morris, M. A., McNalley, T. E., & Yorkston, K. M. (2012). Training healthcare providers in patient-provider communication: What speech-language pathology and medical education can learn from one another. *Aphasiology, 26*(5), 673-688.
- Crotty, M. (1998). *The foundations of social research* London: SAGE Publications.
- Duchan, J., Jennings, M., Barrett, R., & Butler, B. (2006). Communication access to the arts. *Topics in Language Disorders, 26*(3), 210-220.
- Eadie, K., Carlyon, M. J., Stephens, J., & Wilson, M. D. (2013). Communicating in the pre-hospital emergency environment. *Australian Health Review, 37*(2), 140-146.
- Finnigan, M., Marshall, S., & Flanagan, B. (2010). ISBAR for clear communication: One hospital's experience spreading the message. *Australian Health Review, 34*, 400-404.
- Foster, J. (2005). Learning disability liaison nurses in acute hospitals: Is there evidence to support the development of this role? *Learning Disability Practice, 8*(4), 33-38.
- Hammersley, M. (1992). *What's wrong with ethnography? Methodological explorations.* London: Routledge.
- Hoffman, J., Yorkston, K., Shumway-Cook, A., Ciol, M., Dudgeon, B., & Chan, L. (2005). Effect of communication disability on satisfaction with healthcare: A survey of medicare beneficiaries. *American Journal of Speech-Language Pathology, 14*, 221-228.
- Howe, T., Worrall, L., & Hickson, L. (2008). Interviews with people with aphasia: Environmental factors that influence their community participation. *Aphasiology, 22*(10), 1092-1120.
- Iacono, T., & Davis, R. (2003). The experience of people with developmental disability in emergency departments and hospital wards. *Research in Developmental Disabilities, 24*, 247-264.
- Kagan, A., & LeBlanc, K. (2002). Motivating for infrastructure change: toward a communicatively accessible, participation-based stroke care system for all those affected by aphasia. *Journal of Communication Disorders, 35*, 153-169.
- Law, J., Bunning, K., Byng, S., Farrelly, S., & Heyman, B. (2005). Making sense in primary care: Leveling the playing field for people with communication difficulties. *Disability and Society, 20*(2), 169-184.
- Lee, Y. S. (2011). *Speech pathologists' perceptions of what makes a communicative environment audit tool clinically useful in the hospital setting.* (Honours), La Trobe University.
- Legg, C., Young, L., & Bryer, A. (2005). Training sixth-year medical students in obtaining case-history information from adults with aphasia. *Aphasiology, 19*(6), 559-575.
- Liamputtong, P. (2011). *Focus group methodology: Principles and practice.* London: SAGE.
- Liamputtong, p. (2013). *Qualitative research methods* (4th ed.). Melbourne: Oxford University Press.
- McKinley, K., Poole, S., & White, M. (2010). Improving communication access across Austin Health. *ACQuiring Knowledge in Speech, Language and Hearing, 12*(3), 112-115.

Creating communicatively accessible healthcare environments

- McSheehan, M., Sonnenmeier, R., Jorgensen, C., & Turner, K. (2006). Beyond communication access: Promoting learning of the general education curriculum by students with significant disabilities. *Topics in Language Disorders, 26*(3), 266-290.
- Mencap. (2004). Treat me right! Retrieved 25/08/04, 2004, from www.mencap.org.uk
- O'Day, B., Killeen, M., & Iezzoni, L. (2004). Improving health care experiences of persons who are blind or have low vision: Suggestions from focus groups. *American Journal of Medical Quality, 19*(5), 193-200.
- O'Halloran, R., Grohn, B., & Worrall, L. (2012). Environmental factors that influence communication for patients with a communication disability in acute hospital stroke units: A qualitative metasynthesis. *Archives of Physical Medicine and Rehabilitation, 93*(Suppl 1), S77-S85.
- Parr, S., Pound, C., & Hewitt, A. (2006). Communication access to health and social services. *Topics in Language Disorders, 26*(3), 189-198.
- Rose, T., Worrall, L., Hickson, L., & Hoffmann, T. (2011). Aphasia friendly written health information: Content and design characteristics. *International Journal of Speech Language Pathology, 13*(4), 335-347.
- Simmons-Mackie, N., Kagan, A., O'Neill Christie, C., Huijbregts, M., McEwen, S., & Willems, J. (2007). Communicative access and decision making for people with aphasia: Implementing sustainable healthcare systems change. *Aphasiology, 21*(1), 39-66.
- Simmons-Mackie, N., Raymer, A., Armstrong, E., Holland, A., & Cherney, L. (2010). Communication partner training in aphasia: A systematic review. *Archives of Physical Medicine and Rehabilitation, 91*, 1814-1837.
- Simmons Mackie, N. (2013). A systems approach to training potential communication partners of people with aphasia. *Perspectives on Augmentative and Alternative Communication, 22*(1), 21-29.
- Slade, D. (2012). *Doctor-patient communication in emergency departments: Hong Kong and Australia*. Paper presented at the Communicating Health Symposium, Melbourne.
- Street, R., Makoul, G., Arora, N., & Epstein, R. (2009). How does communication heal? Pathways linking clinician-patient communication to health outcomes. *Patient Education and Counseling, 74*, 295-301.
- The Joint Commission. (2010). Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals. Oakbrook Terrace, Illinois: The Joint Commission.
- Togher, L., Balandin, S., Young, K., Given, F., & Canty, M. (2006). Development of a communication training program to improve access to legal services for people with complex communication needs. *Topics in Language Disorders, 26*(3), 199-209.
- Toomey, M., Nicholson, D., & Carswell, A. (1995). The clinical utility of the Canadian Occupational Performance Measure. *Canadian Journal of Occupational Therapy, 62*(5), 242-249.
- World Health Organization. (2001). *International classification of functioning, disability and health*. Geneva: Author.
- World Health Organization. (2006). *Convention on the Rights of Persons with Disabilities*. United Nations Retrieved from <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>.
- Wylie, K., McAllister, L., Davidson, B., & Marshall, J. (2013). Changing practice: implications of the World Report on Disability for responding to communication disability in under-served populations. *Int J Speech Lang Pathol, 15*(1), 1-13.

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Table 1: Focus group participants

Focus group	No. of participants	Years of experience Range (mean)	Current workplace setting			
			Metropolitan	Regional	Public	Private
1	7	1-25 (11.5)	6	1	7	0
2	2	<1 - 12	2	0	1	1
3	6	5-18 (8)	6	0	5	1

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Table 2: Perceived benefits of creating communicatively accessible healthcare environments:

Themes and sub themes

Theme	Sub themes
Benefits all people: Access for all	Improved individualised patient care
	Improved access to healthcare services
	Improved access to healthcare buildings
Benefits for healthcare administrators	Enhanced person centred care
	Enhanced patient satisfaction
	Reduction in adverse events
	Reduction in patient complaints
Benefits for all wanting to improve communication with patients	Healthcare providers communicate effectively with all patients
	Enhance the role of speech-language pathologists
	Enhance the role of other professions
Benefits capacity to provide communicatively accessible environments	Increasing our capacity to create accessible healthcare environments
	Increasing our capacity to create accessible environments in the wider community.

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Table 3: How communicatively accessible healthcare environments can be created. Themes and sub themes

Theme	Sub themes
Having the communication resources available	N/A
Having skilled, knowledgeable and supportive healthcare providers	Having the skills and knowledge to communicate with all patients
	Staff who see it as relevant
	Staff who are supportive of it
Having the systems in place	To support a multidisciplinary team to work on this
	To support healthcare providers and patients / family communicate
	To support inter professional communication
	To evaluate implementation of standards