Access to Higher Education Unit

This unit forms part of an Access to HE Diploma. If delivering the graded version of this unit, please refer to the Provider Handbook for details on grading descriptors and the application of these across units within your programme.

Unit Title: Communication in Healthcare Practice

Graded Unit Reference Number:

Ungraded Unit Reference Number: UD33DEV40

Module: Developmental

Level: Three (3)

Credit Value: Three (3)

Minimum Guided Learning Hours: 30

Learning Outcome (The Learner will):	Assessment Criterion (The Learner can):
1. Understand the main methods and purposes of communication in healthcare	1.1 Describe the main methods of communication used in healthcare settings.
	1.2 Explain why people communicate in healthcare contexts.
2. Understand barriers to effective communication and strategies to overcome them	2.1 Identify common barriers to communication.
	2.2 Explain strategies to overcome barriers and promote effective communication.
3. Understand the importance of listening and empathy in healthcare interactions	3.1 Explain the role of empathy in building effective client–practitioner relationships.
	3.2 Analyse reasons for failure to listen empathetically in healthcare settings.
	3.3 Analyse the impact of failing to listen empathetically and suggest strategies to reduce the likelihood of this occurring.
4. Understand confidentiality and record-keeping requirements in healthcare	4.1 Explain the importance of maintaining confidentiality and its role in building trust.
	4.2 Summarise the consequences of breaching confidentiality.
	4.3 Explain circumstances when it may be appropriate to break confidentiality.

	4.4 Explain the importance of accurate and clear record-keeping in healthcare practice.

Indicative Content Learners could cover the following: (The information below is provided for guidance only and is not mandatory)	
LO1	AC1.1 **Methods of communication in healthcare:** Verbal (face-to-face, telephone, handovers), non-verbal (body language, eye contact, posture, facial expression, gestures, proxemics), written (care plans, medical notes, referral letters, discharge summaries, prescription information), electronic/digital (email, electronic patient records, clinical systems, telehealth). **Formal vs informal communication:** structured reporting (e.g., SBAR), meetings, multidisciplinary team (MDT) discussion vs ad-hoc exchanges. **One-to-one vs group communication:** patient interactions, family discussions, team briefings. **Communication aids:** interpreters, translation tools, picture boards, Makaton/sign language, assistive technology. AC1.2 **Purposes of communication:** providing information (diagnosis, treatment, medication advice), gathering information (history taking, symptoms, consent), building therapeutic relationships, reassurance and emotional support, coordinating care across services (referrals, MDT working), safeguarding and risk management, promoting independence and health education. **Importance:** reducing errors, improving patient safety, enabling informed decision-making and consent, improving treatment adherence, maintaining dignity and respect, supporting person-centred care and equality. **Professional requirements:** accountability, accurate transfer of responsibility, continuity of care.
LO2	AC2.1 **Barriers:** physical (noise, PPE masks, distance, poor environment), cognitive (memory impairment, learning disability, confusion, dementia), emotional (fear, distress, anxiety, anger), language and cultural differences (limited English, different meanings/expectations, cultural taboos), health-related barriers (hearing loss, sight loss, speech impairment, pain, fatigue), organisational barriers (time pressure, busy settings, staff shortages), professional barriers (use of jargon, assumptions, bias/discrimination), digital barriers (poor IT access, lack of skills). AC2.2 **Strategies:** active listening, asking open/closed questions appropriately, checking understanding (teach-back), adapting language level (avoid jargon), using plain English, using interpreters appropriately (not family members in sensitive contexts), use of visual aids, written information in accessible formats (large print, easy read), supportive environment (privacy, reduce noise), cultural competence and respect, trauma-informed approach, adapting to individual needs and communication preferences.

	Professional tools: SBAR handover, documentation standards, escalation pathways, reflective practice, supervision/training.
LO3	AC3.1 **Empathy in healthcare:** recognising emotions, responding appropriately, validating feelings, showing compassion while maintaining professionalism. **Benefits:** builds trust, supports disclosure, improves engagement and adherence, reduces conflict and anxiety, supports patient dignity. **Therapeutic relationship:** rapport building, person-centred communication, respecting individuality and autonomy, supporting shared decision-making. **Boundaries:** difference between empathy and sympathy; maintaining professional boundaries while showing care. AC3.2 **Reasons for failure:** compassion fatigue/burnout, stress, workload, time constraints, emotional detachment as coping, stereotyping and unconscious bias, lack of training/confidence, hierarchical cultures, frequent interruptions, difficult conversations (bereavement, safeguarding, complaints). **Impact on outcomes:** misunderstanding, reduced trust, complaints, reduced adherence, poor patient experience, increased risk of errors. **Strategies to reduce failure:** emotional resilience support, supervision, reflective practice, debriefing after difficult cases, improving workplace culture. AC3.3 **Impact on service users:** reduced trust and rapport; increased anxiety or distress; reluctance to share important information; poorer engagement with care plans; reduced satisfaction with care. **Impact on care quality:** missed cues or incomplete information leading to errors; impaired assessment or decision-making; reduced effectiveness of communication within the care team. **Impact on practitioners:** increased conflict or misunderstanding; reduced professional effectiveness; potential for complaints or deteriorating practitioner–patient relationships. **Strategies to reduce risk:** use of active listening skills (e.g., paraphrasing, open questions, attending behaviours); reducing environmental distractions; maintaining person-centred communication; awareness of personal bias; reflective practice; accessing supervision or training to develop empathetic communication skills.
LO4	AC4.1 **Confidentiality principles:** privacy, data protection, professional codes of conduct, patient autonomy. **Trust-building:** patients more likely to share personal/sensitive information, improved safeguarding and care planning.

	Practical examples: discussing patients in private, secure storage of records, not sharing passwords/logins, keeping screens locked, minimising identity exposure, appropriate use of email/telephone. **Confidentiality in different settings:** GP, hospital wards, care homes, community settings. AC4.2 **Consequences:** harm to patient (distress, stigma, safeguarding risk), breakdown of trust and therapeutic relationship, formal complaints, disciplinary action by employer, legal implications (data breaches, regulatory consequences), reputational damage to organisation, professional sanctions. **Wider impacts:** reduced willingness to disclose information, decreased engagement with healthcare services, compromised patient safety. AC4.3 **Justifiable disclosure:** safeguarding concerns (children/vulnerable adults), risk of serious harm to self or others, court orders/subpoenas, legal duty to report, public interest disclosures, serious crime prevention/detection, communicable disease/public health requirements (where applicable). **Process:** minimum necessary disclosure, record reasons, follow organisational safeguarding/escalation policies, involve appropriate professionals, discuss with patient where safe/appropriate. AC4.4 **Purpose of records:** continuity of care, legal/accountability, supporting clinical decision-making, evidence base for actions, communication between teams, audit and quality improvement. **Good practice principles:** accuracy, timeliness, clarity, factual language, professionalism, avoiding abbreviations where unclear, signed/dated entries, using accepted terminology, confidentiality and secure access. **Risks of poor records:** medication errors, miscommunication, safeguarding failures, legal disputes, reduced patient safety.