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THE ROLE OF EFFECTIVE COMMUNICATION BETWEEN DEPARTMENTS IN IMPROVING HEALTH SERVICES

A cross-sectional survey of healthcare professionals in Saudi Arabia

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Abstract

Background. Reliable communication between hospital departments underpins safe, timely and coordinated care, yet in Saudi Arabia it has largely been studied as one domain of broader safety-culture surveys. Few studies ask a multi-professional workforce how well departments communicate with one another and how that perception relates to perceived service quality.

Objective. To describe how healthcare professionals rate the effectiveness of communication between hospital departments and to examine its association with perceived health service quality.

Methods. Cross-sectional, descriptive–correlational online survey of 313 healthcare professionals (doctors, nurses, pharmacists, administrative staff, technicians and others) working in governmental and private hospitals in Saudi Arabia, using a questionnaire approved by the King Saud University research ethics committees (reference KSU-HE-26-0359). Sixteen statements covered communication effectiveness (speed, credibility, flexibility) and health service quality (tangibles, reliability, responsiveness) on a five-point Likert scale coded 1 = strongly agree to 5 = strongly disagree. Data were analysed with descriptive statistics, Pearson correlation and simple linear regression.

Results. Mean subscale scores ranged from 1.81 to 2.12, indicating general agreement with all positively worded statements; the least favourable item concerned information flowing without barriers (mean 2.36). All five composite dimensions correlated positively ($r = 0.30–0.49$, $p < 0.01$). The service-quality score accounted for 53.6% of the variance in the communication-effectiveness score ($R^2 = 0.536$; $B = 0.761$, 95% CI 0.682–0.840; $\beta = 0.732$; $F(1, 311) = 359.74$, $p < 0.001$).

Conclusions. Professionals who rated communication between departments favourably also rated service quality favourably. Because the data are self-reported, cross-sectional and drawn from a convenience sample, the association should not be read as causal. The findings support testing structured handover and relational-coordination practices locally, with objective safety and efficiency outcomes alongside staff perceptions.

Keywords: interdepartmental communication; health service quality; patient safety; hospital coordination; Saudi Arabia

Key Points

◆ Staff across professions agreed that communication between departments is timely, credible and flexible (subscale means 2.07–2.12; 1 = strongly agree).

◆ Agreement was strongest for statements linking communication to reliability and responsiveness of care (means 1.82 and 1.81).

◆ Communication and service-quality scores were strongly associated (r = 0.732); the design supports association, not causation.

◆ Saudi safety-culture surveys that flag handoffs and communication openness as weak points suggest that general agreement may coexist with specific failures at transitions.

1 Introduction

Hospital care is delivered by interdependent departments — emergency, laboratory, pharmacy, radiology, nursing and administration — and each depends on information that originates elsewhere. When that information arrives late, incomplete or unclear, the cost is borne by patients. Miscommunication is a leading cause of serious medical errors, and in a prospective study across nine hospitals (10,740 admissions) a standardised handoff programme was associated with a 23% fall in medical errors and a 30% fall in preventable adverse events (Starmer et al., 2014). Implementation of the same programme across 32 community and academic hospitals was followed by a 47% decrease in reported handoff-related adverse events (Starmer et al., 2023). More broadly, ineffective care coordination and suboptimal teamwork have been described as a public health issue that demands collaboration across organisational and disciplinary boundaries (Rosen et al., 2018).

Communication quality is also linked to how care is experienced. Relational coordination — timely, frequent, accurate and problem-solving communication supported by shared goals and mutual respect — was associated with lower nurse-reported rates of hospital-acquired infection and medication error among 747 registered nurses (Havens et al., 2010), and with higher staff engagement and patient satisfaction in 11 outpatient surgical clinics (Gittell et al., 2020).

In Saudi Arabia, communication has mainly been examined as one domain of patient-safety-culture surveys. A systematic review of 14 studies identified poor communication, a blame culture and inadequate staffing as the main factors hindering safety culture, with good teamwork within units as a recurring strength (Albalawi et al., 2020). A national study of 366 hospitals reported teamwork within units as the highest-scoring domain (80.65% positive) and found that “communication and information” was among the contributory factors most often linked to reported sentinel events; higher scores for teamwork, communication openness and handoffs were associated with fewer such events (Binkheder et al., 2023). Surveys of nurses point the same way: handoffs and transitions and communication openness were rated as weaknesses among 351 nurses in three hospitals (Alquwez et al., 2018), and openness in communication was a priority for improvement in primary care centres in the Eastern Province (Aljaffary et al., 2022). Among 402 nurses in Jazan, perceived patient-safety grade correlated with communication about errors (r = 0.424) (Al Muharraq et al., 2024).

These studies largely assess communication within units or as a safety-culture domain, and mostly from nurses. Among the sources we retrieved, none asked a multi-professional hospital workforce

how effectively departments communicate with one another and how that rating relates to perceived service quality. This study addresses that gap with three objectives: (1) to describe perceived effectiveness of interdepartmental communication; (2) to examine how its dimensions relate to one another and to perceived service-quality dimensions; and (3) to quantify the association between the communication-effectiveness and service-quality scores. We hypothesised a positive association.

2 Methods

2.1 Design and setting

We conducted a quantitative, cross-sectional, descriptive–correlational survey of healthcare professionals working in governmental and private hospitals in Saudi Arabia. The design measures communication and service-quality perceptions at one point in time without manipulating either; it is suited to estimating associations but not to establishing their direction.

2.2 Participants and sampling

Eligible participants were healthcare professionals currently working in a hospital with at least one year of experience, directly involved in communication or coordination between departments, and willing to complete the questionnaire voluntarily. Newly hired staff (< 1 year), staff on temporary leave, those not involved in interdepartmental communication and those who returned incomplete questionnaires were excluded. Participants were recruited by convenience sampling according to availability and willingness, which was practical given clinical workloads across departments. The final sample comprised 313 respondents; one did not report a profession (valid n = 312 for that item).

2.3 Instrument

The structured questionnaire, developed from the healthcare-communication literature, had two sections. Section 1 collected gender, age group, profession and years of experience. Section 2 contained 16 statements in two dimensions: **Dimension 1, communication effectiveness** — speed (3 items), credibility (3) and flexibility (3); and **Dimension 2, health service quality** — tangibles (2), reliability (3) and responsiveness (2). The statements are listed in Figure 2. Items were rated on a five-point Likert scale and analysed with the coding 1 = strongly agree, 2 = agree, 3 = neutral, 4 = disagree, 5 = strongly disagree, so that **lower scores indicate stronger agreement**. Content validity was established by expert review in healthcare management and academic research. In a pilot study before data collection, internal consistency (Cronbach's α) was 0.91 for communication effectiveness and 0.93 for health service quality. This report covers these two dimensions only.

2.4 Procedure

The questionnaire was administered online to healthcare professionals in the participating hospitals. Respondents were told the purpose of the study, that participation was voluntary, and that responses were anonymous and confidential, before they began; reminders were sent to encourage completion, and no personal identifiers were collected.

2.5 Statistical analysis

Data were analysed in SPSS. Categorical variables are summarised as frequencies and percentages and Likert items as means and standard deviations. Pearson correlation coefficients were computed among five composite dimension scores (D1–D5, labelled as in the analysis file). A simple linear regression was fitted with the communication-effectiveness composite as the outcome and the health-service-quality composite as the predictor, as specified in the analysis output. Because of the inverse coding, a positive coefficient means that the two scores move together: agreement with one goes with agreement with the other. In a bivariate model R^2 equals r^2 and does not depend on

which variable is the outcome. Tests were two-tailed with $\alpha = 0.05$. The 95% confidence intervals for the regression coefficients and for r (Fisher transformation) were derived from the reported estimates, standard errors and n.

2.6 Ethical approval

The study protocol and questionnaire were reviewed by the Standing Sub-Committee on Human and Social Research Ethics (30th session, 7 April 2026; 19/10/1447 AH) and approved by the Standing Committee on Scientific Research Ethics of King Saud University at its 27th meeting on 12 April 2026 (24/10/1447 AH). The approval letter, reference **KSU-HE-26-0359**, dated 16 April 2026 (28/10/1447 AH), records the study as "Approved" with the questionnaire as the approved instrument (Appendix A). Participation was voluntary and anonymous, no personal identifiers were collected, and data are used for research purposes only.

3 Results

3.1 Participant characteristics

Table 1 and Figure 1 describe the 313 respondents. Women made up 56.9% of the sample (n = 178). The largest age group was 35–44 years (43.5%), and 62.0% had more than 10 years of experience. Nurses were the largest professional group (34.0%), followed by doctors (26.3%), administrative staff (18.3%), technicians (9.0%) and pharmacists (3.5%); 9.0% reported another role.

Table 1. Characteristics of the 313 participating healthcare professionals

Characteristic	n	%
Gender		
Male	135	43.1
Female	178	56.9
Age group		
< 25 years	17	5.4
25–34 years	92	29.4
35–44 years	136	43.5
45–54 years	49	15.7
≥ 55 years	19	6.1
Profession (valid n = 312)		
Doctor	82	26.3
Nurse	106	34.0
Pharmacist	11	3.5
Administrative staff	57	18.3
Technician	28	9.0
Other	28	9.0
Years of experience		
< 5 years	64	20.4
5–10 years	55	17.6
11–15 years	91	29.1
> 15 years	103	32.9

Note. Percentages use valid responses; one respondent did not report a profession.

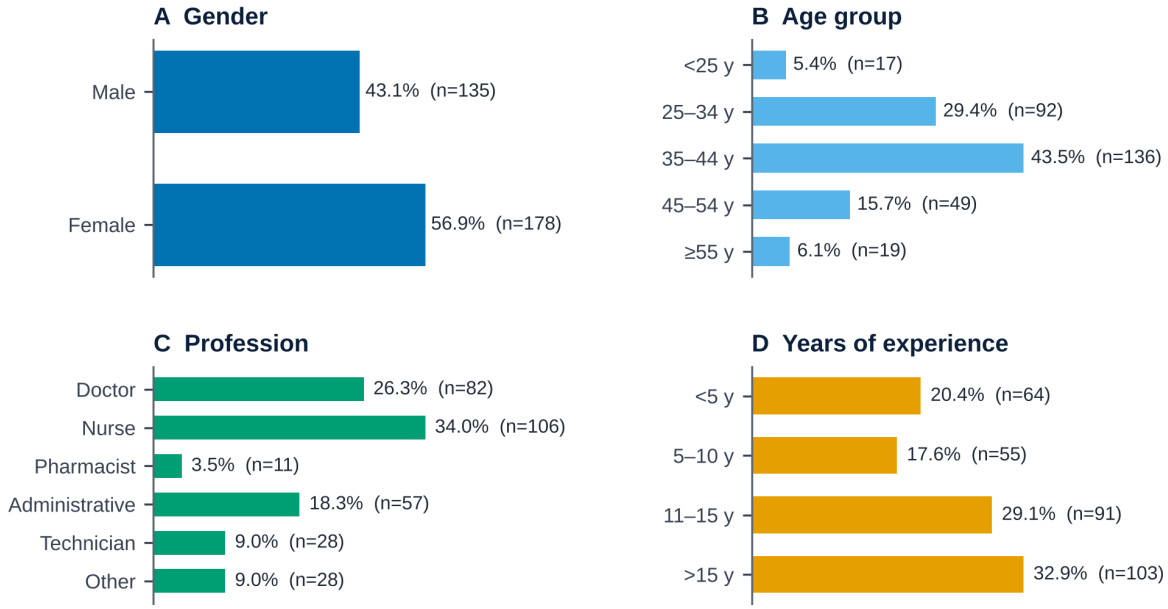


Figure 1. Profile of respondents. Horizontal bars show the share (%) and number of respondents by (A) gender, (B) age group, (C) profession (valid n = 312) and (D) years of experience. Data are from Table 1.

3.2 Perceived communication effectiveness and service quality

All six subscale means lay between 1.81 and 2.12, close to the "agree" anchor of the scale (Table 2). The communication subscales were rated slightly less favourably (speed 2.12, credibility 2.09, flexibility 2.07) than the service-quality subscales (tangibles 1.97, reliability 1.82, responsiveness 1.81). Figure 2 shows the item-level picture. The most favourable item was that communication improves timely responses to patient needs and emergencies (mean 1.73, SD 0.876), and the least favourable was that information flows smoothly between departments without unnecessary barriers (mean 2.36, SD 1.241). Item standard deviations of 0.88–1.24 show that opinion was spread around these means rather than uniform.

Table 2. Subscale and item-level scores (1 = strongly agree, 5 = strongly disagree)

Subscale	Items	Item mean range	Item SD range	Subscale mean
Dimension 1 — Communication effectiveness				
Speed of communication	3	2.01–2.24	1.134–1.150	**2.12**
Credibility of communication	3	1.99–2.23	1.107–1.172	**2.09**
Flexibility of communication	3	1.90–2.36	1.019–1.241	**2.07**
Dimension 2 — Health service quality				
Tangibles	2	1.93–2.00	1.085–1.105	**1.97**
Reliability	3	1.79–1.83	0.955–0.981	**1.82**
Responsiveness	2	1.73–1.89	0.876–0.966	**1.81**

Note. Lower scores indicate stronger agreement. Item wording is shown in Figure 2.

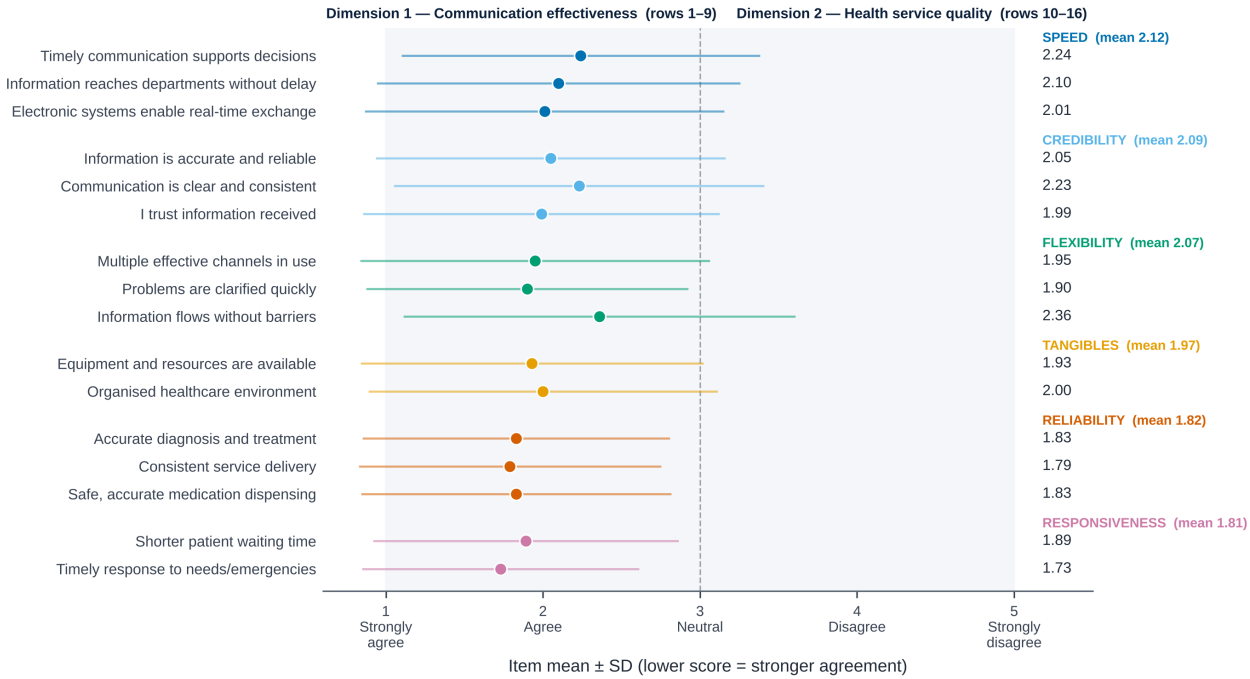


Figure 2. Item means for the 16 questionnaire statements. Dots show the item mean and lines ± 1 SD, grouped by subscale (colour) within Dimension 1 (rows 1–9) and Dimension 2 (rows 10–16). The scale is coded 1 = strongly agree to 5 = strongly disagree, so points further left indicate stronger agreement; the dashed line marks the neutral midpoint. Subscale means are given beside each group.

3.3 Associations between dimensions

All ten pairwise correlations among the five composite dimensions were positive and significant ($r = 0.30–0.49$, $p < 0.01$; Figure 3A). The strongest association was between timely and efficient communication and accuracy and reliability of information ($r = 0.49$), followed by communication channels and problem solving with operational efficiency ($r = 0.44$) and operational efficiency with patient care and safety ($r = 0.41$). The weakest was between channels and problem solving and patient care and safety ($r = 0.30$).

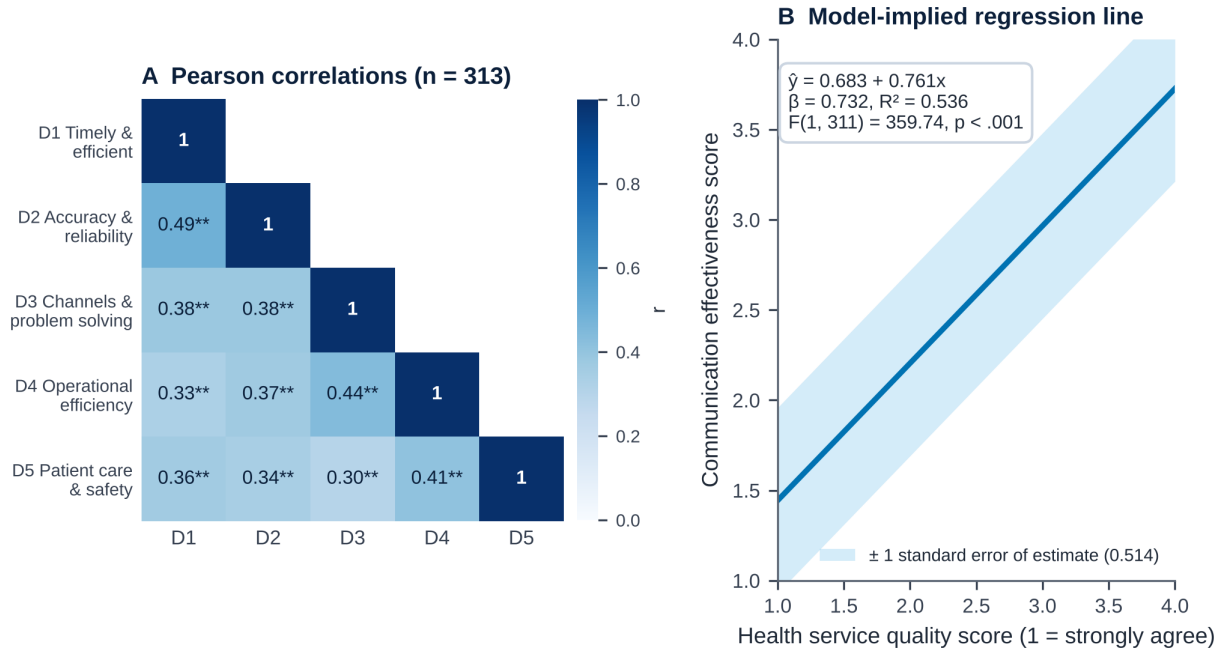


Figure 3. Associations among study dimensions. (A) Pearson correlation matrix for the five composite dimensions (n = 313); ** $p < 0.01$. (B) Line implied by the fitted regression of the communication-effectiveness score on the health-service-quality score, drawn from the published coefficients; the band marks ± 1 standard error of the estimate (0.514). No raw data are plotted. Both scores use 1 = strongly agree.

At the level of the two composite scores, the regression model was significant (Table 3). The health-service-quality score explained 53.6% of the variance in the communication-effectiveness score ($R = 0.732$, 95% CI 0.676–0.779; adjusted $R^2 = 0.535$; $F(1, 311) = 359.74$, $p < 0.001$). Each one-point shift in the service-quality score was associated with a 0.761-point shift in the communication score (95% CI 0.682–0.840; standardised $\beta = 0.732$; $t = 18.97$, $p < 0.001$). The composite-level correlation is higher than any between-dimension correlation, which is what would be expected when items are aggregated and measurement noise is averaged out.

Table 3. Simple linear regression: communication-effectiveness score on health-service-quality score

Term	B	SE	β	t	p	95% CI for B
Constant	0.683	0.080	—	8.558	< 0.001	0.526–0.840
Health service quality score	0.761	0.040	0.732	18.967	< 0.001	0.682–0.840

Note. n = 313. $R = 0.732$; $R^2 = 0.536$; adjusted $R^2 = 0.535$; standard error of the estimate = 0.514; $F(1, 311) = 359.743$, $p < 0.001$ (regression SS = 95.026, residual SS = 82.151, total SS = 177.177). Confidence intervals were derived from B, SE and df = 311. Lower scores indicate stronger agreement on both scales.

4 Discussion

4.1 Principal findings

Healthcare professionals in this sample generally agreed that communication between departments is timely, credible and flexible, and that it supports the reliability and responsiveness of care. The scores for the two dimensions were strongly associated ($r = 0.732$), with more than half of the variance shared, and the dimensions were positively inter-correlated throughout. The weakest point

was whether information flows without unnecessary barriers, which received the least favourable item mean (2.36) and the widest spread of responses.

4.2 Comparison with Saudi and international evidence

Table 4 sets these results against the sources discussed in the Introduction. Internationally, communication quality has been tied to fewer adverse events and to better staff and patient experience (Havens et al., 2010; Gittell et al., 2020), and structured handoff programmes have cut errors in multicentre trials (Starmer et al., 2014; Starmer et al., 2023). Our positive association between communication and service-quality ratings points in the same direction. The magnitude cannot be compared directly, because those studies used different constructs and, in several cases, objective or nurse-reported safety outcomes rather than agreement with statements about communication.

Table 4. Benchmarking against published Saudi and international evidence

Source	Setting	Design and sample	Finding relevant to this study
Albalawi et al. (2020)	Saudi Arabia	Systematic review, 14 studies	Poor communication, blame culture and inadequate staffing hinder safety culture; teamwork within units is a strength.
Binkheder et al. (2023)	Saudi Arabia	National descriptive study, 366 hospitals	Teamwork within units 80.65% positive; "communication and information" a leading contributory factor in sentinel events (63.20%, 103 hospitals); better handoff, openness and teamwork scores linked to fewer events.
Alquwez et al. (2018)	Saudi Arabia	Cross-sectional, 351 nurses, 3 hospitals	Teamwork within units a strength; handoffs and transitions and communication openness weaknesses.
Al Muharraq et al. (2024)	Saudi Arabia	Cross-sectional, 402 nurses, Jazan	Teamwork 77.8% positive; communication about errors correlated with safety grade (r = 0.424).
Aljaffary et al. (2022)	Saudi Arabia	Cross-sectional, 310 staff, primary care	Overall positive response 43.5%; openness in communication flagged for improvement.
Starmer et al. (2014)	International	Prospective, 9 hospitals, 10,740 admissions	Handoff programme: medical errors down 23%, preventable adverse events down 30%.
Starmer et al. (2023)	International	Multicentre, 32 hospitals	Reported handoff-related adverse events down 47% after implementation.
Havens et al. (2010)	International	Survey, 747 registered nurses	Higher relational coordination linked to better care quality and fewer infections and medication errors.
Gittell et al. (2020)	International	Cross-sectional, 11 outpatient surgical clinics	Relational coordination linked to staff outcomes and patient satisfaction.
Rosen et al. (2018)	International	Review of teamwork evidence	Suboptimal teamwork and coordination framed as a public health issue.

Note. Findings are paraphrased from the cited abstracts; full references are listed below.

Within Saudi Arabia the picture is more nuanced. Our respondents rated timeliness, credibility and channels favourably, whereas safety-culture surveys have flagged handoffs and communication openness as weaknesses (Alquwez et al., 2018; Aljaffary et al., 2022) and linked communication failures to sentinel events (Binkheder et al., 2023). These findings are not necessarily in conflict. Our statements ask about communication between departments in general, and all were worded positively; safety-culture instruments probe specific behaviours such as handoffs and speaking up. General agreement can coexist with failures at particular transitions, and the least favourable item here — information flowing without barriers — is consistent with that reading. The strong teamwork ratings reported across Saudi surveys (Binkheder et al., 2023; Al Muharraq et al., 2024) also suggest that within-unit cohesion may be a resource on which cross-department communication can build.

4.3 Implications for practice

The evidence assembled here does not show that improving communication will raise service quality in these hospitals, but it identifies practices worth testing. Structured handoff tools have a multicentre evidence base (Starmer et al., 2014; Starmer et al., 2023). Relational-coordination approaches — shared goals, shared knowledge and mutual respect — have been associated with better staff and patient outcomes, and clinical leaders can act on them (Gittell et al., 2020). Hospitals could pair a brief perception survey like this one with objective indicators such as handover-related incidents, turnaround times and waiting times, so that agreement is checked against measured performance.

4.4 Strengths and limitations

Strengths include a sizeable multi-professional sample (n = 313), an instrument reviewed by experts and piloted for reliability, and formal ethical approval. Several limitations apply. The cross-sectional design and a single bivariate model do not establish direction or control for profession, age or experience; the regression treats service quality as the predictor, but because R^2 is symmetric the shared variance is the same in either direction. Data are self-reported, drawn from a convenience sample of unnamed hospitals without a reported response rate or sample-size calculation, so selection bias and clustering within hospitals cannot be assessed. All statements were positively worded, which invites acquiescence, and the service-quality items ask whether communication improves outcomes, so the two scales overlap in content and part of their correlation may reflect shared wording and shared method. Mean scores clustered near 2, limiting discrimination. Reliability was assessed only in the pilot; regression diagnostics and main-sample reliability are not reported. The findings should therefore be read as perceptions in a convenience sample, not as measures of actual communication performance or patient outcomes.

5 Conclusion

Healthcare professionals who rated communication between hospital departments favourably also rated service quality favourably, and the association was strong ($r = 0.732$; $R^2 = 0.536$). The result is consistent with international evidence that coordination and communication matter for safe, responsive care, and it adds Saudi multi-professional data on a topic usually studied through nurse-based safety-culture surveys. Confirming that better communication improves care will need designs that track objective outcomes over time, ideally with pre-specified handover interventions and multilevel analysis across hospitals.

Declarations

- **Ethics approval and consent.** Approved by the Standing Committee on Scientific Research Ethics, King Saud University (reference KSU-HE-26-0359, 12 April 2026; Appendix A). Participation was voluntary and anonymous after an information statement; no personal identifiers were collected.
- **Data availability.** All aggregated results supporting the findings are reported in this article. Respondent-level data are held by the research team.
- **Funding, competing interests:** Not Applicable
- **Author contributions: Author contributions**: Literature search and data extraction **A. S.**, E. **M.**, **S. M.**, N. **A.,**
- Writing – original draft: **S.A**, **N.A.**, **A.A**. Writing – review and editing: all authors. All authors approved the final manuscript.
- **AI assistance.** An AI assistant (Claude, Anthropic) was used to structure the manuscript, draft text from the authors' data and verify literature in PubMed. The authors remain responsible for the content.

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A Appendix A. Ethics approval documentation

King Saud University, General Secretariat of Research Ethics Offices — approval letter, reference KSU-HE-26-0359, dated 16 April 2026 (28/10/1447 AH). The letter confirms approval of the research titled "The Role of Effective Communication Between Departments in Improving Health Services" (instrument: questionnaire; status: approved). Arabic original reproduced below; key details are summarised on the title page and in Section 2.6.



المملكة العربية السعودية
جامعة الملك سعود
مكتب الأمانة العامة لأخلاقيات البحوث

بسم الله الرحمن الرحيم

جامعة الملك سعود
King Saud University

الرقم: ٧/٨٢/٢٤٥٩١٨
التاريخ: ١٤٤٧/١٠/٢٨
المرافقات: ٢٠٢٦/٠٤/١٦

Ref No: KSU-HE-26-0359

سعادة الباحثة / د. عبير غازي الحربي
السلام عليكم ورحمة الله وبركاته،،،

حفظها الله

إشارة إلى توصية اللجنة الفرعية الدائمة لأخلاقيات البحوث الإنسانية والاجتماعية في جلستها الثلاثون بتاريخ ١٤٤٧/١٠/١٩هـ، الموافق ٢٠٢٦/٠٤/٠٧ م.

نفيد سعادتكم بموافقة اللجنة الدائمة لأخلاقيات البحث العلمي بجامعة الملك سعود في اجتماعها السابع والعشرون بتاريخ ١٤٤٧/١٠/٢٤ هـ، الموافق ٢٠٢٦/٠٤/١٢ م، على إجراء البحث الموضح بالجدول الاتي:

م	فريق البحث	عنوان البحث	الأداة	الحالة
١	د. عبير غازي الحربي امل سعيد الاحمري اميرة عبدالرحمن المشوح سماح مسفر العتيبي ابتسام محمد الخالدي ساره علي العتيبي نوره خابور العنزي نداء حسن علي أسماء عوده العنزي	دور التواصـــل الفعال بين الإدارات في تحسين الخدمات الصحية	استبانة	الموافقة

وعليه نأمل من الجهات المعنية بالجامعة تسهيل مهمة الباحثة

وتفضلوا بقبول وافر الاحترام،،،،

رئيس اللجنة الدائمة لأخلاقيات البحث العلمي
عنه
أ.د. عبدالله بن محمد المعيوف

- صورة الى ملف الباحثة

المملكة العربية السعودية
ص.ب ٢٤٥٤ الرياض ١١٤٥١
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