

## Article

# Communication Access and Barriers in Hospital Settings: A Cross-Sectional Survey of Hospital Staff Perspectives in Canada

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## Abstract

This study explored communication access and barriers from the perspectives of 96 hospital staff across Canada in February 2025. A cross-sectional observational design was used, with an online survey distributed through social media platforms. Statistical analyses, including binary logistic regression, were conducted using IBM SPSS Statistics version 29. Most respondents identified as female (89.0%) and were between 19 and 49 years old. One in ten hospital staff reported that patients always received communication support from staff, and fewer than 5.0% reported consistent access to communication devices. Support from communication professionals was limited, with 20.2% indicating that this support was never available. Environmental barriers included difficulty accessing devices independently (24.8%), lack of privacy (21.7%), poor Wi-Fi or cellular connectivity (17.2%), and noise (14.7%). When communicating with older adults, staff cited time constraints (53.0%), unclear explanations (13.0%), language barriers (13.0%), and emotional stress (7.0%) as key challenges. Hospital staff appeared committed to supporting patient communication; however, barriers such as limited time, staffing availability, access to communication devices, and environmental challenges may affect the consistency of this support. Communication training was associated with staff perceptions of communication needs and inequities among patients. These findings highlight perceived communication gaps and may support further assessment of communication resources, staff support, and organizational approaches to improving patient-centered communication in hospital settings.

**Keywords:** hospital staff; communication barriers; environmental barriers; communication access; communication training; hospital settings; Canada



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## 1. Introduction

In hospital environments one of the most fundamental elements of care is communication that is frequently overlooked [1,2]. For patients, especially older adults, the ability to express their needs, understand their care, and maintain a human connection is essential to their dignity, safety, and recovery [3–5]. Poor communication can lead to confusion, reduced trust, and emotional stress [1,6,7]. Hospital staff are on the front lines of this challenge, serving not only as medical and care professionals but also as interpreters, advocates,

and sometimes emotional lifelines. Despite their pivotal and multifaceted roles, hospital staff are often expected to navigate the diverse and often complex communication needs of patients without adequate time, tools, or institutional support, contributing to a silent crisis of social isolation within hospital environments [1,8,9].

Frontline healthcare workers often have to handle communication problems with patients without enough support from trained communication staff, helpful technology, or enough time to talk properly with patients [10–13]. Inconsistent availability of communication tools, poor Wi-Fi connectivity, lack of privacy, and time pressures may impede effective communication between staff and patients, potentially contributing to feelings of frustration and disconnect [14,15]. These communication gaps may also contribute to social isolation, a known risk factor for negative physical and psychological outcomes among hospitalized individuals [16–18]. When hospital staff are unable to address communication needs adequately, patients may experience increased feelings of loneliness and helplessness [19].

Existing literature underscores that restricted communication and limited support services often exacerbate emotional strain, hinder recovery, and contribute to greater isolation among patients, particularly older individuals [3,18]. Despite growing recognition of the importance of communication in healthcare, few studies have directly examined how hospital staff perceive their role in supporting patient communication or how communication access, communication barriers, and hospital staff communication training interact within hospital settings. Staff perspectives are critical for identifying institutional gaps, frontline challenges, and opportunities for system-wide improvement [14,20,21]. This study addresses this gap by exploring how hospital staff across Canada may perceive patients' access to communication devices, including personal and hospital-provided devices, communication-related environmental barriers, and their role in supporting patient communication, thereby contributing to ongoing efforts to improve equitable communication and inclusion in hospital care.

## 2. Materials and Methods

### 2.1. Study Design

This study investigated hospital staff perspectives on patient communication access, and barriers within hospital settings using an online survey. Over a two-week period, the survey link was shared through Facebook posts in healthcare-related online groups and forums across Canada, including groups for nurses, physicians, allied health professionals, occupational therapists, speech-language pathologists, hospital social workers, and other healthcare professionals, to reach hospital staff participants nationwide. Recruitment followed a non-probability convenience sampling approach and included both national and regional online communities where available. Eligibility was limited to individuals who self-identified as hospital staff working in Canada. SurveyMonkey served as the platform to gather hospital staff perspectives on patient communication experiences, communication access, and communication barriers in Canadian hospitals [22]. A cross-sectional survey approach was adopted because it provided an efficient way to gather information from hospital staff across multiple provinces in Canada. This design allowed for the collection of perspectives from participants in different locations while preserving anonymity, which likely encouraged candid responses on sensitive issues such as emotional distress and communication barriers. Unlike longitudinal methods, this approach offered a practical means of obtaining a snapshot of hospital staff perspectives within a defined period, without the burden of repeated follow-up in busy hospital care settings [22].

## 2.2. Data Collection

To obtain detailed perspectives on communication access and barriers, the survey included 17 structured multiple-choice questions [18]. Survey items were developed by the research team to address central themes and were written in accessible language to ensure clarity for respondents [18]. The survey was pilot tested and revised to make the questions clear and easy to use for people with different levels of digital experience. A clinician and a speech-language pathologist reviewed the communication questions to ensure they were appropriate for hospital environments. The intended audience was reached through Facebook advertising that featured a high-contrast black-and-yellow poster. Throughout the two-week data collection period (14–28 February 2025), reminder posts were shared to improve engagement. After data collection, responses were screened for completeness and validity before being exported into IBM SPSS v29 for analysis. Participants younger than 19 years were excluded. After data cleaning and removing identifying information, responses from 96 hospital staff were included in the analysis.

## 2.3. Data Analysis

IBM SPSS Statistics version 29 (SPSS v29) was used for all statistical analyses. Descriptive statistics, including frequencies and percentages, were used to summarize demographic characteristics and the main survey findings related to communication access and barriers from hospital staff perspectives (Table 1). Response categories were collapsed during data analysis where appropriate to support meaningful comparisons and address small cell counts. For variables with multiple response categories, selected categories were combined where appropriate (e.g., “Always”, “Often” and “Sometimes”; “Rarely” and “Never”; “No” and “Not sure”).

**Table 1.** Demographic Information Including Gender, Age, and Provinces Across Hospital Staff Respondent Group (N = 96, February 2025).

| Demographics                 | Hospital Staff<br>(N = 96) |
|------------------------------|----------------------------|
| <b>Gender</b>                |                            |
| Women                        | 89% (81)                   |
| Men                          | 6.6% (6)                   |
| Self-Identify                | 4.4% (4)                   |
| <b>Age Group</b>             |                            |
| 19–39                        | 34.4% (33)                 |
| 40–49                        | 30.2% (29)                 |
| 50–59                        | 18.8% (18)                 |
| 60–64                        | 9.4% (9)                   |
| 65+                          | 7.3% (7)                   |
| <b>65–69</b>                 | 6.3%                       |
| <b>70–74</b>                 | 1.0%                       |
| <b>Province of Residence</b> |                            |
| British Columbia             | 28.4% (27)                 |
| Yukon                        | 2.1% (2)                   |
| Alberta                      | 11.6% (11)                 |
| Saskatchewan                 | 2.1% (2)                   |

Table 1. Cont.

| Demographics            | Hospital Staff<br>(N = 96) |
|-------------------------|----------------------------|
| Manitoba                | 3.2% (3)                   |
| Ontario                 | 34.7% (33)                 |
| Quebec                  | 4.2% (4)                   |
| Newfoundland & Labrador | 4.2% (4)                   |
| New Brunswick           | 4.2% (4)                   |
| Nova Scotia             | 5.3% (5)                   |

Note: The study included 96 respondents. Some questions were left unanswered, so totals may vary across questions. Respondents were from all provinces and territories, except for the Northwest Territories and Prince Edward Island. Bold text indicates category headings within the demographic variables. Participants aged 65 years and older were combined into a single age group (65+) for reporting purposes. Italicized rows represent the subgroups (65–69 and 70–74) that comprise the combined 65+ category.

Inferential statistics, including binary logistic regression, were also used to analyze the data. Separate unadjusted binary logistic regression models were conducted to estimate unadjusted odds ratios (ORs) and 95% confidence intervals (CIs). In these analyses, hospital staff communication training (Yes vs. Not Yes) was treated as the independent variable, while communication-related outcomes were treated as dependent variables. Reference categories for each dependent variable are reported in Table 2. Tables and graphs were then used to present the results.

**Table 2.** Relationship Between Staff Communication Training and Communication Challenges, Support, and Equity in Patient Care from Hospital Staff Perspectives.

|                                                               | Communication—Hospital Staff Perspectives                                |                       |                      |                       |
|---------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------|----------------------|-----------------------|
|                                                               | Hospital Staff Training for Patient Communication Needs ( <i>n</i> = 83) |                       | <i>p</i> -Value (df) | Unadjusted Odds Ratio |
|                                                               | Yes<br>39.8% (33)                                                        | Not Yes<br>60.2% (50) |                      |                       |
| Adequacy of hospital staff’s communication support            |                                                                          |                       |                      |                       |
| Always, Often, Sometimes                                      | 43.1% (31)                                                               | 56.9% (41)            |                      | Ref                   |
| Rarely, Never                                                 | 18.2% (2)                                                                | 81.8% (9)             | 0.134 (1)            | 0.294 (0.059–1.458)   |
| Addressing communication challenges vs. physical challenges   |                                                                          |                       |                      |                       |
| Yes                                                           | 76.5% (13)                                                               | 23.6% (4)             |                      | Ref                   |
| No, Not Sure                                                  | 29.5% (18)                                                               | 70.5% (43)            | 0.001 (1)            | 0.129 (0.037–0.449)   |
| Equity in Communication support based on language and culture |                                                                          |                       |                      |                       |
| Yes                                                           | 18.9% (7)                                                                | 81.1% (30)            |                      | Ref                   |
| No, Not Sure                                                  | 58.5% (24)                                                               | 41.4% (17)            | 0.001 (1)            | 6.05 (2.16–16.97)     |

Note: The number of participants who answered each question was not equal to the total number of participants. Abbreviations: OR = odds ratio; Ref = reference category. Odds ratios were estimated using separate unadjusted binary logistic regression models, with communication training (Yes vs. Not Yes) entered as the independent variable. Categories were collapsed for binary logistic regression analysis as follows: "Always/Often/Sometimes" vs. "Rarely/Never" and "Yes" vs. "No/Not Sure".

#### 2.4. Ethical Considerations

The Research Ethics Board at the University of Northern British Columbia approved this study (File Number 6009825; Approved on 13 February 2025). Prior to participation, an information letter was distributed through SurveyMonkey outlining the study's purpose, estimated time commitment (10–15 min), and consent information. Online informed

consent was obtained from all participants prior to participation. All procedures were designed to uphold participant rights, including anonymity, voluntary involvement, and freedom to withdraw at any time without consequence. No direct personal identifiers were collected. IP addresses were temporarily collected as part of quality assurance procedures; however, following data screening and quality checks, all IP address information and identifiers were removed from the dataset and were not retained for analysis.

### 2.5. Online Informed Consent Form

Data were collected through an online survey administered using SurveyMonkey. Before accessing the survey questions, participants were presented with a separate online informed consent page describing the study and their rights as participants. Participants who selected “Do Not Agree” or did not respond to the consent page were automatically redirected to the end page and were not permitted to proceed with the survey, ensuring that consent was obtained from all participants prior to participation.

### 2.6. Validity and Reliability

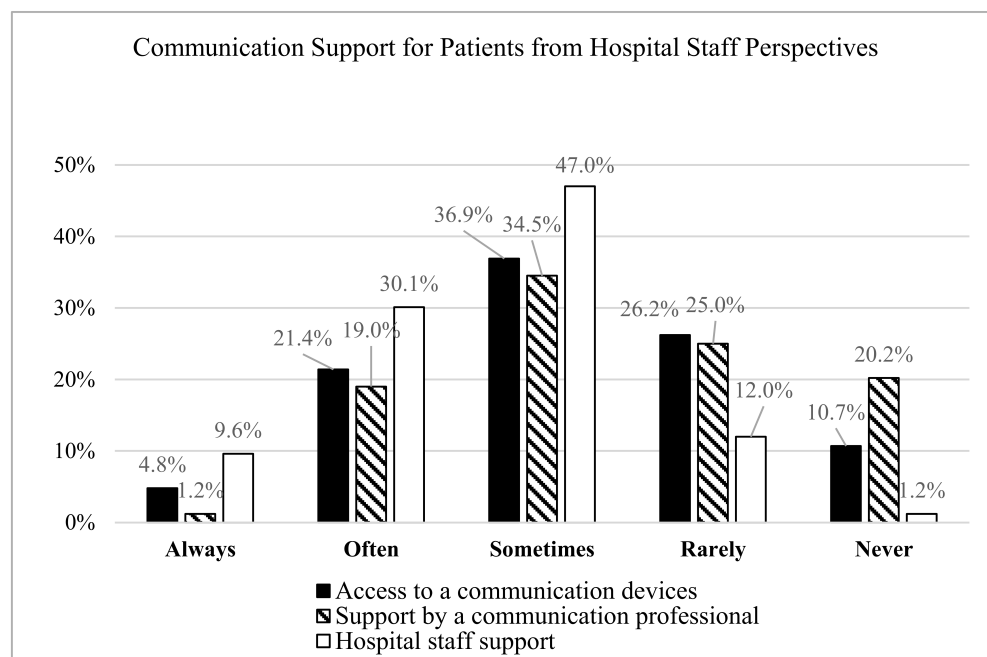
The survey platform (SurveyMonkey), accessed through the UNBC’s institutional license, facilitated consistency across items, applied Skip Logic, and preserved participant anonymity, thereby reducing potential sources of bias associated with the survey platform. Quality assurance procedures included exclusion of implausibly short response times, and temporary collection of IP addresses to identify and eliminate duplicate responses. A total of 104 survey responses were received. Following data cleaning and quality checks, eight responses were excluded, resulting in a final analytic sample of 96 participants. To support face and content validity, the survey instrument underwent pilot testing and expert review prior to distribution. Although internal consistency was not statistically tested (e.g., Cronbach’s alpha), these procedures were intended to improve the clarity and content validity of the survey instrument.

## 3. Results

Table 1 presents the demographic characteristics of the hospital staff respondents (N = 96). Most respondents identified as women (89%,  $n = 81$ ), while a smaller proportion identified as men (6.6%,  $n = 6$ ). In terms of age distribution, most respondents were between 19 and 39 years old (34.4%,  $n = 33$ ), followed by those aged 40 to 49 years (30.2%,  $n = 29$ ). In total, 7.3% of participants were aged 65 years or older, including 6.3% aged 65–69 and 1.0% aged 70–74. No participants were aged 75 or older.

### 3.1. Communication Support for Patients from “Hospital Staff Perspective”

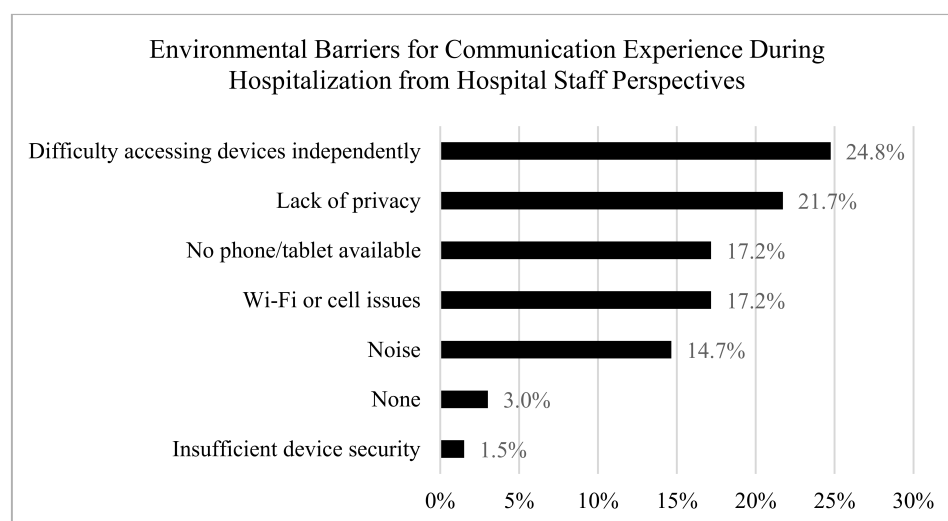
Communication support provided by hospital staff, including assistance with phone calls, videoconferencing, use of smartphones or tablets, provision of visual aids, memory aids, calendars, writing materials, and access to interpreters, was not consistent (Figure 1). From the hospital staff perspective, only 9.6% of respondents reported that patients “always” received communication support, while nearly half (47.0%) received communication support only “sometimes”. Access to communication professionals such as speech-language pathologists or interpreters was even more limited, with only 1.2% of patients always having access and approximately 45.0% reporting that these services were “rarely” or “never” available. According to hospital staff, access to communication devices such as smartphones and tablets was also limited, with only 4.8% of patients always having access to communication devices, while more than one-third of patients had little or no access. These results suggest that respondents perceived that many patients did not receive reliable communication support in hospitals (Figure 1).



**Figure 1.** Communication Support for Patients from Hospital Staff Perspective. Percentages are based on all respondents (N = 96, February 2025).

### 3.2. Communication Environmental Barriers During Hospitalization from Hospital Staff Perspective

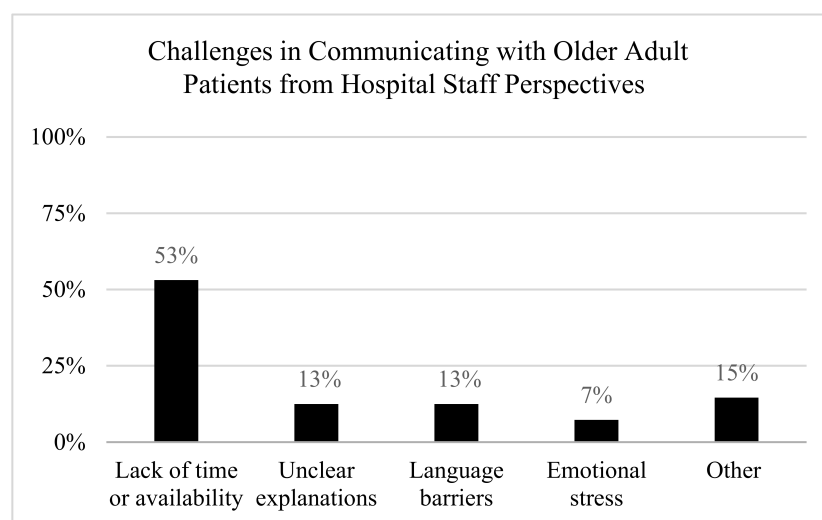
As shown in Figure 2, respondents reported environmental barriers that may have affected hospital staff's ability to communicate with patients during hospitalization. The most frequently reported barrier was difficulty accessing communication devices independently, noted by 24.8% of respondents. This was followed by lack of privacy (21.7%), and issues related to Wi-Fi or cellular connectivity and the unavailability of phones or tablets, each reported by 17.2% of hospital staff. Noise was identified as a barrier by 14.7% of respondents, while only 1.5% mentioned insufficient device security. Notably, only 3.0% of respondents indicated that no environmental barriers were present (Figure 2). These findings suggest that multiple environmental challenges persisted in hospital settings and may have affected patients' ability to communicate effectively during hospitalization.



**Figure 2.** Environmental Barriers to Communication experiences During Hospitalization. Percentages are based on all respondents (N = 96, February 2025).

### 3.3. Challenges in Communicating with Older Adult Patients from Hospital Staff Perspectives

Respondents identified time constraints as the most common challenge faced by healthcare professionals when communicating with older adult patients, accounting for 53.0% of responses (Figure 3). Unclear explanations and language barriers were equally reported, each comprising 13.0% of the responses. These results highlight the challenges of ensuring that medical information is clearly conveyed and understood, particularly when communication needs are complex. Emotional stress accounted for 7.0% of responses, suggesting that hospital staff may recognize it as a factor influencing communication with patients. Lastly, other challenges accounted for 15.0% of responses, which may reflect a combination of previously mentioned issues, such as language barriers, unclear explanations, lack of time, or emotional distress, as participants described in the text box provided for their responses (Figure 3).



**Figure 3.** Biggest challenge in communicating with older adult patients from hospital staff perspectives. Percentages are based on all respondents (N = 96, February 2025).

Table 2 shows that hospital staff who had received communication training were less likely to report that communication support was provided “Rarely/Never” rather than “Always/Often/Sometimes” (OR = 0.294, 95% CI 0.059–1.458,  $p = 0.134$ ); however, this association was not statistically significant.

Communication training was associated with lower odds of hospital staff reporting that communication challenges were not addressed equally to physical challenges, or that they were not sure, compared with reporting that communication challenges were addressed equally to physical challenges (OR = 0.129, 95% CI: 0.037–0.449,  $p = 0.001$ ), indicating a statistically significant association.

Communication training was associated with higher odds of hospital staff reporting that communication support was not equitable based on language and culture, or that they were not sure, compared with reporting that communication support was equitable (OR = 6.05, 95% CI: 2.16–16.97,  $p = 0.001$ ). This association was statistically significant. These findings should be interpreted as associations rather than evidence of causal relationships.

The analyses presented in Table 2 were exploratory and intended to examine potential associations between communication training and staff perceptions. Therefore, the findings, including the  $p$ -values, should be interpreted with caution.

#### 4. Discussion

The results from hospital staff respondents may offer valuable insights into the practical and systemic barriers to effective communication in clinical settings. While most hospital staff reported providing communication support at least occasionally, some variability in the reported frequency and quality of support was observed [23,24].

Environmental factors reported by hospital staff may further compound communication challenges. Barriers such as lack of privacy, weak Wi-Fi or cellular connectivity, and high noise levels may not be minor inconveniences; they may reflect underlying systemic challenges that contribute to inequities in patients' communication experiences and access to care. These concerns are consistent with previous studies suggesting that environmental factors may contribute to communication inequities, particularly in older adult care [2,25–28].

Hospital staff also reported specific challenges when communicating with older patients, such as limited time, language barriers experienced by patients, and emotional demands. These concerns have been reported in previous studies, which suggest that limited training may reduce staff's preparedness to adapt communication approaches to the cognitive, cultural, and emotional needs of patients, especially older adults [9,26]. Some studies have reported that integrating communication training with age-appropriate and culturally responsive tools could contribute to improved care quality, despite inconsistent uptake in practice [20,28].

The results may reflect broader challenges related to infrastructure, access to resources, or service priorities. Previous studies have also reported that assistive communication devices were not always available or consistently used in hospital settings, particularly for patients with speech, cognitive, or physical impairments [15,23,29].

Moreover, the responses from hospital staff may suggest that communication support sometimes relies on individual staff efforts rather than consistent institutional systems or resources [2,14,20]. In the absence of clear communication protocols, reliable access to devices, and support from trained professionals, the burden of communication falls disproportionately on already overstretched staff [2,14]. These findings may align with previous reviews calling for a system-wide shift in how communication is prioritized in health-care [2,14,21,30]. Addressing these issues may benefit from increased investment in communication resources and workforce support, as well as broader organizational approaches that place greater emphasis on communication within patient care practices [3,14,28,31].

Staff who reported that communication challenges were addressed equally to physical challenges had higher odds of having received communication training compared with those who reported that communication challenges were not addressed equally or were unsure. This finding suggests that from hospital staff perspectives, communication training may be associated with greater recognition of communication as an important part of patient care. This aligns with previous research suggesting that training can support more patient-centered approaches, where communication is viewed as a core component of care rather than an additional task [32,33].

Staff who reported concerns regarding equity in communication support based on language and culture had significantly different odds of having received communication training compared with those who perceived communication support to be equitable. This finding suggests that communication training may be associated with how staff perceive and recognize language- and culture-related communication issues in hospital settings. One possible explanation is that trained staff may be more aware of communication barriers and inequities experienced by patients and therefore more likely to identify these challenges, rather than indicating that communication training leads to poorer communication equity. Similar findings have been reported in previous research suggesting that communication

training can increase staff awareness, confidence, and sensitivity when interacting with patients from diverse backgrounds [30,31]. Greater awareness of communication barriers may also make trained staff more likely to recognize and report inequities that might otherwise go unnoticed. However, because this study used a cross-sectional design and unadjusted analyses, these findings should be interpreted as associations rather than evidence that training directly influences perceptions of communication equity.

## 5. Strengths and Limitations

Regarding the strengths of this study, data were collected from hospital staff across multiple provinces in Canada. Because the survey was shared online through the Survey Monkey platform, staff from different regions and hospital settings had the opportunity to participate. This approach allowed the study to include perspectives on communication access and barriers from multiple locations rather than from a single hospital setting. Another strength is that the survey included both multiple-choice questions and Likert Scale questions, allowing staff to report clear, measurable patterns. The study also protected participant privacy. Responses were anonymous, and no identifying information was collected. This may have made hospital staff more willing to respond honestly about sensitive issues such as emotional stress, communication barriers, and gaps in support.

Regarding the limitations of the study, this study used a cross-sectional design, meaning that the data were collected at a single point in time. As a result, the study cannot assess changes over time or establish causal relationships, including whether communication training is associated with improved communication outcomes. Instead, the findings identify only associations between variables. The study was also based on self-reported data, meaning that hospital staff described their own experiences and perceptions, which may have been influenced by recall bias, personal opinions, or social desirability bias. In addition, although pilot testing and expert review were conducted, internal consistency was not assessed. The findings may have been affected by self-selection bias, as staff with a stronger interest in communication access and barriers may have been more likely to participate in the survey. The findings may not be representative of all hospital staff in Canada and should therefore be interpreted with caution.

Detailed participant characteristics and workplace information, including professional roles and care settings, were not collected. Therefore, it was not possible to examine whether perceptions differed across professional groups, hospital contexts, or clinical environments. In addition, this study focused only on hospital staff perspectives and did not include patient-reported outcomes; therefore, patient experiences and perceptions of communication access and barriers were not captured.

Some age groups and regions were under-represented in the sample. For example, some provinces had small numbers of respondents. Therefore, the findings should be interpreted cautiously. Future studies with larger sample sizes, additional participant and workplace characteristics, and longer data collection periods may help confirm and strengthen the findings of this research.

## 6. Conclusions

This research study explored hospital staff perspectives on communication access and barriers in hospital settings in Canada. The findings suggested that communication support for patients was not consistently available during hospitalization and that access to communication professionals and communication devices remained limited. Hospital staff also identified environmental and organizational factors that may have affected effective communication and described challenges in supporting communication with older adult patients.

These findings suggest that although hospital staff may attempt to support patient communication, limited time, staffing availability, restricted access to communication devices, and environmental barriers may reduce the consistency and effectiveness of this support.

The results also suggest that hospital staff communication training may play an important role in how communication with older adult patients is understood and supported. While trained and untrained staff reported similar challenges, such as lack of time and unclear explanations, training may also have been linked to greater awareness of language and cultural inequities in communication support.

To improve patient experience and reduce communication-related stress among hospital staff, healthcare systems may consider investing in both physical resources, such as communication devices, and connectivity infrastructure, and human resources, such as training and interpreter services. The findings of this study identify perceived communication gaps that may warrant further assessment and future evaluation of potential interventions, implementation feasibility, and their impact on patient and staff outcomes. Addressing communication challenges may benefit from becoming a shared organizational priority embedded within workflows, supported by policy, and championed by leadership to help ensure that all patients, regardless of age or ability, can express themselves, understand their care, and maintain meaningful human connections during hospitalization.

**Author Contributions:** S.F. and S.A.-A. conceived this paper. S.F., S.A.-A. and E.R. developed the study design and protocol. S.A.-A. conducted the literature review and was responsible for implementing the methodology, contributing to the study design, data collection, and analysis as part of her master's thesis. E.R. was responsible for project administration, and S.F. and E.R. developed challenges and recommendations. T.K.-R., A.A., D.B., S.W. and T.F. critically revised drafts of the manuscript and provided valuable feedback. All authors have read and agreed to the published version of the manuscript.

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**Informed Consent Statement:** Prior to participation, an information letter was distributed that outlined the study's purpose and consent form. Online informed consent was obtained from all participants prior to participation. All procedures were designed to uphold participant rights, including anonymity, voluntary involvement, and freedom to withdraw at any time without consequence.

**Data Availability Statement:** The de-identified data and survey materials that support the findings of this study are available from the corresponding author, upon reasonable request.

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**Conflicts of Interest:** The authors declare no conflicts of interest.

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