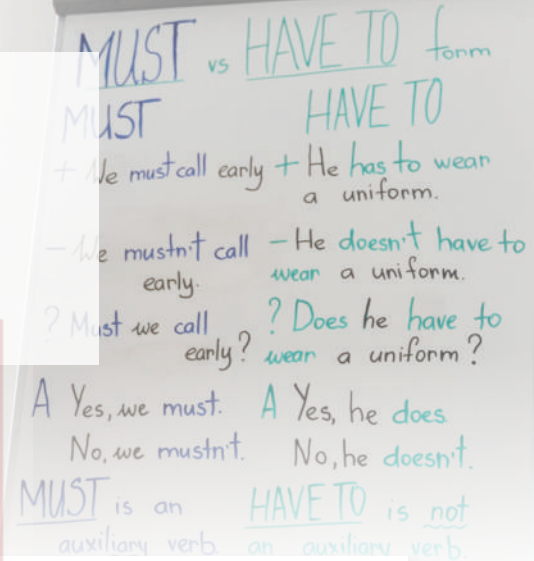


3

Communication Roles of Healthcare Professionals



CHAPTER OUTLINE

- Communication and Healthcare Professionals
- Skills of Communication
- Role of Written Communication: Record Keeping and Prescribing
- Role of Oral Communication
- Critical Thinking
- Nursing Process and Care Plan

KEY POINTS

- **Communication:** A two-way process of exchanging information and much more.
- **Skills of communication:** Listening, Speaking, Reading and Writing are four skills of communication.
- **Client talk:** Clients use a variety of words and expressions to convey how they are feeling.

COMMUNICATION AND HEALTHCARE PROFESSIONALS

Certain standards which are expected in the effective delivery of healthcare are not easy to achieve. Understanding the importance of compassion, the ethical values underpinning positive communication, apparent failures in compassion are crucial parts. There is, at the same time, toughness in the centrality and complexity of communication in therapeutic relationships. Communicating with a patient, which seems to be a simple task, is actually a complex and skilled process so it needs appreciation. It is assumed that communication is a simple two-way exchange of information, whereas it is much more than that. For much of the time, in nursing and midwifery, it is necessary to have communication that demonstrates compassion. People must be receptive to another's communication and put themselves in the other's place while conversing. What might lie ahead can cause anxiety to the patients and service users.

All nurses build partnerships and therapeutic relationships through safe, effective and nondiscriminating communication. They must take account of individual differences, capabilities and needs.

However, professional communication differs from everyday communication and requires more than exposure to the professional setting. Effective communication skills are essential within nursing and are often seen as one of the main skills necessary for nurses to support patients and their families. The provision of

high-quality holistic care requires good communication skills to ensure that the well-being of the patient remains at the forefront of care and that patients and their families receive the information they require to participate in their own care according to their individual preferences. It is, therefore, crucial that nurses use the full range of communication skills at their disposal, while ensuring that the intentions of any nurse–patient interaction are clear.

SKILLS OF COMMUNICATION

There are four skills of communication, i.e., LSRW, which include Listening, Speaking, Reading and Writing (LSRW) (Fig. 3.1).

Listening

It has been explored how listening and questioning can demonstrate that the professional is interested in and focused on the patient. Too often, patients are left with a feeling that they are not being heard. Active listening is a primary source of communication for nurses. What patients say about themselves is very important and in order to be an active listener, nurses need to be engaged in receiving and decoding the messages that patients send. This involves not only listening to the verbal content of the message, but also observing the patient's nonverbal communication and integrating this information into assessing their current emotional state. Nurses listen to a patient with two purposes in mind: (1) To comprehend the message and (2) To evaluate its meaning. As a consequence of active listening, nurses are able to paraphrase the content of a patient's message in different ways throughout the interaction, thus ensuring they have received the message accurately, especially in very intense conversations.



Fig. 3.1: Skills of communication

Speaking

The appropriate use of questions can complement active listening in nurse–patient interactions. There are many forms of questions which can lead the interaction in distinctive directions and provide diverse responses. Closed questions are directive in nature and are driven by the need of the nurse for information. Consequently, they have a specific fact-finding purpose and can be quickly answered with one word or very short responses. An example might be: Do you live at 10, the Avenue? To which the patient can only respond 'yes' or 'no'. Closed questions have their place, but they do not explore the patients' agenda because their answers and involvement in the communication process are restricted.

When nurses wish to elicit patients' perceptions, ideas, and feelings, open questions invite them into the conversation at a more participative level, since the patients are provided opportunities to talk freely about their experiences, things that interest them and their concerns.

Communication Strategies

Self Introduction

The nurses meet various people every day in the healthcare field. They are often not introduced by anyone, so they need to introduce themselves. After greeting someone, it is important to introduce yourself and explain the reason for being there.

Nurse: Good morning, Ms Narula. My name is Katty, and I am going to be your nurse today.

Patient: Nice to meet you. You can call me Jenny.

Here are some common responses to introduction.

Formal	Informal
I am very glad to meet you.	Happy to meet you.
I am very happy to meet you.	My pleasure
It is pleasure to meet you.	Nice to meet you.
It is very nice to meet you.	Hi
	Pleased to meet you.

Greetings

Formal	Informal
Good day	Hey!
Greetings!	Hi!
Good morning/afternoon/evening	How is it going?
Hello	What's up?

Refusals

Formal	Informal	Less formal
That is out of question.	No way	No, that is not a good idea
I am afraid that is not possible.	Absolutely not	
You must not do that.	No	
Sorry, that is impossible.	Not a chance	

Making Excuses

- I am sorry, I cannot.
- It is too bad, but
- I regret that
- I would like to help, but
- You will have to pardon me now, but
- I know it is very confusing, but

Offering Help

Formal	Less formal
May I help you?	Let me help you.
Would you like me to help you?	Do you need some help?
May I be of service to you?	Let me give you a hand.
	How about letting me help you?

Accepting Help

- That would be great. Thanks
- That is nice of you. Thanks
- Please

Rejecting Help

- Thanks a lot, but I am fine.
- No, but I appreciate the offer.
- No, but thanks anyway.
- No, it is all right. I can do it myself.

Apologizing

Formal	Less formal	Informal
Please accept my apologies	I am really/so/very sorry.	Sorry
My apologies	I apologize	Oops!
Please forgive me		Sorry about that

Comprehension Checks

Formal	Less formal	Informal
Pardon me. Did you understand me?	Can you hear me?	Right?
Excuse me. Have you been listening to me?	Did you hear what I just said?	Got that?
I am sorry. I was wondering if you heard what I just said.		Did you get that?

Expressing Thank You

Formal	Less formal	Informal
I really appreciate it. Thank you very much.	Thank you. You really should not have.	Thanks
I am very grateful for your help.	Thank you. That was nice of you.	Thanks a million
Thank you so much for your help.		Thanks a lot

Responding to Gratitude

Formal	Informal
Do not mention it	Do not worry about it
It was my pleasure	Sure
Not at all	Forget it
You are more than welcome	It is no problem
	Anytime

Disagreeing

Formal	Less formal	Informal
I am not sure if I agree with you.	That really surprises me because I think	Well I think that
I respect your opinion, but I think	I may be wrong, but	Yes, but
I hate to disagree with you, but I believe	I am sorry, but I do not agree with what you are saying.	I do not think so.
You could be right, but I do not think that		
I understand what you are saying, but in my opinion		

Checking for Understanding

Formal	Informal
Sorry. Are you following me?	Is that clear?
Excuse me. Am I making myself clear?	Are you following me?
I am sorry. Am I making sense?	Am I making sense?
Pardon me. Can you understand what I said?	Can you understand what I am saying?

Writing

Keeping all the reports and records updated is the prime role of nurses as good writers.

To create a coherent piece of writing, nurses need to use appropriate language and tone. They have to express the main ideas while communicating, providing supporting details, examples, or stories. While writing, they should be able to construct complex sentences and use connectors, articles, and phrases correctly. Punctuation marks, correct spellings, and correct capitalization make an impressive report. All their hospital tasks require social and emotional intelligence, along with correct grammar and interpretive knowledge. While preparing a report, if they feel confused or are unable to write, they can create a mind map. The mind map labels can remain as:

REASON → SELF-RESPECT → ACTION → CONSEQUENCE

Reading

Reading all the records and reports to get updated on the health status of a particular patient is a special feature of a good reader (nurses).



Tips for Nurses

Test Your Command Over Oral Communication

First of all, it is very important to know where you actually stand and thereafter try to brush up on the areas where improvement is needed to judge your command over oral communication. Try to answer the following questions:

1. Am I able to initiate conversation?
2. Do I need any encouragement to speak?
3. Am I a good listener too?
4. Am I able to use variation in my tone?
5. Do I attract the attention of my patient when I speak?
6. Is there any coordination in my speech and gestures?
7. Can I make eye contact with my patient?
8. Am I confident in my speech?
9. Do I have a good vocabulary?
10. Can my speech overpower others?

ROLE OF WRITTEN COMMUNICATION: RECORD KEEPING AND PRESCRIBING

Nurses are required to use written communication when accurately documenting the care given to a patient. Nursing notes, which are increasingly being recorded electronically, are legal documents and can be produced in court as evidence. An incomplete or insufficient record can lead the court to determine that the care given to a patient was not of a reasonable standard, particularly since many months or years may have elapsed before a case comes to court.



Tips for Nurses

Documentation must be completed contemporaneously and should be specific, factual, accurate, measurable, and written using standardized medical or English terminology, avoiding jargon or abbreviations.

As a member of the wider healthcare team, the healthcare assistant (HCA) or assistant practitioner (AP) or nursing student takes personal accountability for good record keeping. They must keep clear, accurate, and timely records of the care they provide to their patients to support communication, continuity, and decision making.

ROLE OF ORAL COMMUNICATION

The language used in healthcare settings is different from general, conversational English.

Client talk: Clients use a variety of words and expressions to describe how they are feeling, many of which are idiomatic. Nurses may not find them in a standard English dictionary and they cannot be understood word for word. To communicate effectively with clients and colleagues, the staff members need to understand spoken, idiomatic English.

Nursing Knowledge Tree
An Initiative by CBS Nursing Division



Tips for Nurses

Nurses must use medical/nursing terminology as well as specialized ways of communicating with clients. In addition, nurses must understand the language that clients use in the healthcare setting.



Interactive Session

Dialogue between a Nurse and Mrs Jindal

- Nurse : Good morning, Mrs Jindal. (smile)
 Mrs Jindal : Hello... (looks away)
 Nurse : I see that you seem upset. Could you please tell me what is going on in your mind?
 Mrs Jindal : Well, my problems are getting worse.
 Nurse : Are you concerned about your health?
 Mrs Jindal : Yes, I've had this toe fracture for a long time. I accidentally bumped my toe and now the sore won't go away. To make matters worse, this abdominal pain is not getting better.
 Nurse : When did you bump your toe?
 Mrs Jindal : I bumped it 6 weeks ago.
 Nurse : Did you do anything to make it feel better?
 Mrs Jindal : I put some ointment and a bandage on it, but the pain hasn't gone away. It's getting worse.
 Nurse : Is your toe still in pain? I will take a closer look shortly. The abdominal pain is due to pain killers. How is your pain now?

Contd...

Mrs Jindal : It seems like the Brufen helped; it's not hurting as much.
 Nurse : How would you rate your pain on a scale of 0 to 10?
 Mrs Jindal : About a 5, but, now that the indigestion has turned up, I don't know if I will be able to care for my toe.
 Nurse : (Places her hand on Mrs Jindal's shoulder and uses a quiet tone of voice) I understand that it has been quite challenging for you with all that you have been going through and indeed health concerns can be very draining. I just want to let you know that you are in the right place because my team and I will take the best care of you.
 Mrs Jindal : I appreciate it. Just go nice and easy with me.
 Nurse : Yes, Mrs Jindal. Please let me know if you have any questions or concerns. Now you can get ready for your family's visit. They are coming soon.

The nurses must encourage the client to express any concerns and ask questions about treatment and procedures, and should welcome participation of family members in such discussions by the end of the shift. In many cultures, the family is involved in key decisions on the healthcare of a family member.



Tips for Nurses

Tips for Effective Oral Communication

In oral communication, we can adopt many styles such as formal, informal, direct, indirect, persuasive, strong, blunt, polite, normal, etc. The style of speech depends on our relationships with others, our mood, the situations in which we are communicating and the context, etc.

To be effective in our communication, we should follow the following points:

- | | |
|--------------------------------|---|
| 1. Correct pronunciation | 8. Proper body movements |
| 2. Variation in tone | 9. Eye contact |
| 3. To the point | 10. Proper use of intonation |
| 4. Choice of the proper words | 11. Use active rather than passive voice |
| 5. Avoid irrelevant material | 12. Mind our speed of speaking |
| 6. Natural style | 13. Learn the proper use of pauses, punctuation, etc. |
| 7. Use simple and common words | 14. Enrich vocabulary |



Interactive Session

Dialogue between Nurse and Ms Batra

Nurse : Good evening, Ms Batra.
 Ms Batra : Hello, nurse.
 Nurse : How are you feeling?
 Ms Batra : You know, sometimes I can't seem to catch my breath. It's really scary.
 Nurse : Well, no wonder. All those years of smoking have affected your health.
 Ms Batra : I know. I wish I had kicked the habit.
 Nurse : It's going to be fine, don't worry. But it's not good to smoke. You should quit smoking. It causes a lot of health problems.
 Ms Batra : You are making me feel guilty.
 Nurse : I didn't mean to make you feel that way. It's just the reality of things. However, we will do the best we can to help you out of this.
 Ms Batra : Well, it just seems to be getting worse since I came to the hospital. Maybe if you allowed me to take my energy pills, I would be better by now.
 Nurse : You will be better soon. Herbal supplements are not allowed in the hospital; you've been told that. Sometimes they can cause problems.
 Ms Batra : I just feel useless. I wonder how I will be able to continue working.
 Nurse : You'll be fine, you're a strong woman. Things will work out soon, you'll see.

Addressing personal health-related issues is part of providing holistic care to clients. The words that clients use to describe bodily functions and body parts are different from those that healthcare professionals use.



Tips for Nurses

To communicate effectively with clients, nurses need to understand the words clients use. To give culturally holistic care to clients, nurses need to listen to patients to find out what they believe about health and illness and to understand culturally influenced health behavior.

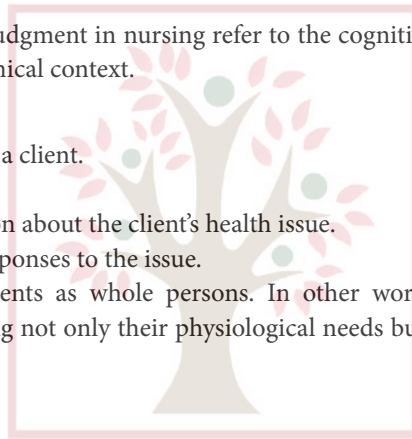
CRITICAL THINKING

Critical thinking and critical judgment in nursing refer to the cognitive skills necessary for problem solving and decision making in the clinical context.

The nurses do the following:

- Gather information about a client.
- Assess the information.
- Draw a tentative conclusion about the client's health issue.
- Then evaluate possible responses to the issue.

Holistic nursing considers clients as whole persons. In other words, holistic nursing considers all the dimensions of clients, including not only their physiological needs but also their psychosocial, spiritual and cultural needs.



Tips for Nurses

The nurses should use gathered information about the patients' needs to provide holistic care that addresses all dimensions of the individual. The goal should be to heal the whole person. Therefore, to think holistically about an individual is part of thinking critically about the patients' care.

For nurses' to establish a positive relationship with clients, it is helpful to be able to make small talk. Small talk, usually starts with some neutral topics. But, depending on the client and the situation, small talk could lead to more personal talk. Small talk helps to establish common ground between the nurse and client. It also helps to relax the client and foster a connection and level of comfort with the nurse. Clients are more likely to be responsive to a nurse with whom they feel comfortable. Based on the information provided in the client's record and the nurse's assessment of the client, the nurse writes a nursing diagnosis and a goal for treating the client. The nurse also identifies nursing interventions and desired outcomes to accomplish the goal.

NURSING PROCESS AND CARE PLAN

The nursing process is a systematic procedure used to provide nursing care (Fig. 3.2). It consists of the following five components:

1. Assessment
2. Diagnosing
3. Planning
4. Implementation
5. Evaluation



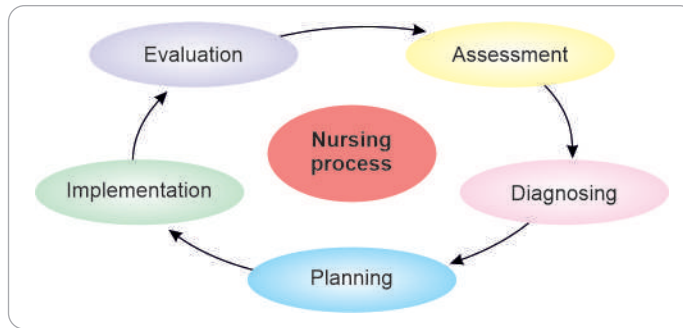


Fig. 3.2: Nursing process

In assessment, the nurses collect data about the client in diagnosing, analyze the data and determine a nursing diagnosis, in planning, create a nursing care plan, which includes nursing interventions and desired outcomes for the clients; in implementation, the nurses put into action the interventions that have been identified in the care plan; in evaluation, the nurses evaluate the clients' progress toward achieving the desired outcomes and thereby evaluate the effectiveness of the nursing care plans. More than one component can be involved at any given time in the nursing process.

Telephone Report

Nurses sometimes contact the clinician about clients by telephone—for example, when there is a medical emergency or when there is a significant or noteworthy change in the clients' condition.

After completing the telephone report, the nurse documents the data, the time, the person called, the person who received the information, what information was given, and what information was received. At the end of the shift, the nurses document the care that was given to the client in the form of a program note.

Culture in Nursing

In some cultures, it is expected that nurses give advice. Clients may expect nurses to give them advice, and nurses may assume it as part of their responsibility to give advice. Instead of giving advice, the nurses need to give patients the required information or present options and allow patients to make their own decisions and take responsibility for their own choices.

In some cultures, it is considered appropriate to comfort clients with false reassurance. Clients become more anxious, rather than less, especially if the nurses' message differs greatly from the clients' perceptions of the problems. The language used in healthcare settings is different from general, conversational English. Nurses must use medical/nursing terminology as well as specialized ways of communicating with clients. In addition, nurses must understand the language that clients use in the healthcare setting.

Nurses should use only abbreviations, acronyms, and symbols that are accepted by the healthcare facility where they work. Be concise in documenting nursing care. Concise writing is brief and to the point. It is often grammatically incomplete. Change full sentences into thought units.

Nursing Care Plans

Nursing care plans reflect the nursing process. They organize information about client care and specify the actions nurses take in providing care for the client. They also allow for continuity of care from one nurse to another. Care plans typically consist of the following four categories of information:

1. Nursing diagnoses
2. Goal/desired outcomes
3. Nursing interventions
4. Evaluation

Nursing care plans require a specialized kind of writing.

Student care plans tend to be longer and more detailed than care plans used by practicing nurses. Students care plans may include assessment data, rationales for nursing interventions, and supporting literature for each rationale.

Subjective versus Objective Data

Gathering assessment data is the first step in preparing a nursing care plan. Assessment data are divided into two types:

1. **Subjective data** refers to how the client experiences an illness or health problem. It includes feelings, values, beliefs, attitudes, and perceptions, as well as sensations that are apparent only to the person affected and can be described or verified only by that person. Subjective data are also referred to as symptoms. Some examples are feelings of inadequacy, concern about the illness, itching and pain.
2. **Objective data** can be seen, heard, felt, or smelled by someone other than the person affected. They can be measured using some kind of standard—for example, blood pressure reading or observation of a skin lesion. Objective data are gathered during the health assessment to validate subjective data. They are also referred to as signs.

Information provided by other people, such as family members or other healthcare providers, can be either subjective or objective, depending on whether it is based on fact. For example, “Dad is very confused today” is subjective. However, “Dad couldn’t remember his address or phone number today” is objective.

Note the subjective and objective ways of describing the same problem:

Subjective data	Objective data
“When I push myself to move, I feel weak all over.”	• Blood pressure 85/57 mm Hg • Pulse 91 beats/min • Cool, clammy skin
“I feel like my stomach is being twisted and it’s so painful.”	• Blood-tinged diarrhea • Hyperactive bowel sounds in all 4 quadrants • Vomited 70 mL yellow-tinged fluid
“It’s hard for me to breathe.”	• Crackles heard over lung fields bilaterally • Diminished lung sounds in middle and lower lobes bilaterally
Nephew stated: “He seems to be in some pain this evening.”	Client grimaced and raised eyebrows during assessment.
“I would like to have Holy Communion with the priest.”	• Has a rosary around neck • Holding hymn book

Documentation

The patient record is a legal document that can be used in court as evidence.



Tips for Nurses

Nurses must meet certain legal standards when they record information about client care.

Document as often as required by the healthcare agency where you work and as soon as possible after completing an assessment or intervention. Never document before providing nursing care.



Tips for Nurses

Documentation should be factual, accurate, complete, current and organized. Documentation must identify that the client received individualized, goal-directed nursing care based on nursing assessment. Record only information that is relevant to the client's current health problems and care. Do not record personal information that has no effect on the client's current condition, as that could be considered an invasion of the client's privacy and cause for a lawsuit.

Electronic Documentation

Hospitals and other healthcare facilities now use electronic medical records (EMRs) as shown in Figure 3.3, which are characterized by computerized charting with pull-down menus and boxes to be checked or filled out in order to record assessment data and document standard care. Normal responses for various assessments and options for standard care are included in the computer program. Despite the widespread use of computerized charting, some aspects of client care, such as progress notes, are still typed into the electronic record. Progress notes are used to document abnormal findings, also referred to as *charting by exception* (CBE). In addition, some facilities have not transitioned from paper records, especially home healthcare agencies.

The screenshot displays an EMR interface for a patient with admission number 2004500000. The patient's details include: Title: Senior, Family name: Kumar, Given name: Manoj, Date of birth: 05/03/1992, Sex: Male, Blood group: AB. The immunization record shows a Tetagam injection on 08/07/2004, with a dosage of 2 mg/dL, titer of 345, and application type of Subcutaneous. A search window is open, showing a list of immunizations with 'Tetagam' highlighted. The interface includes a 'Nursing Knowledge Tree' watermark and a 'Top 10 Quicklist' at the bottom.

Admission (2004500000)	
New patient Search Archive New person	
:: Immunization	
Admission Nr.	2004500000
Title:	Senior
Family name:	Kumar
Given name:	Manoj
Date of birth:	05/03/1992
Sex:	Male
Blood group:	AB
Date	08/07/2004
Type	Tetagam
Medicine	Anti-tetanus immunization
Dosage	2 mg/dL
Titer	345
Refresh date	08/06/2006
Application type	Subcutaneous
Application by	admin
Notes	
Save	
Admission data Barcode labels Make	

Options for this patient:

- Confirmation of inability to work
- Charts folder
- Diagnostic Results
- Medocs
- DRG (composite)
- Prescriptions
- Notes & Reports
- Immunization

Search :: Immunization (Immunization) - Mozilla

Please enter search keyword:

Search

Top 10 Quicklist

- Immunization
- Tetagam

Yes, this one!

Fig. 3.3: Electronic medical record

Documentation by Hand

In facilities where documentation is done by hand, make sure that your entries are easy to read. Handwriting that is not legible can be misread by other healthcare professionals, which can result in misinterpretation of essential information. Use black ink in case photocopies need to be made, so that changes are easy to identify. If you make a mistake in your recording, do not erase or use correction fluid. Draw 1 line through the mistake and write the words *mistaken entry* next to it, followed by your initials or name. Do not write the word *error*, when indicating a recording mistake because the word *error* could imply that a clinical error was made. Write on every line, but do not write between lines. If there is any blank space left over on a line, draw a line through it so that no one can add or change any information at another time.



Tips for Nurses

Sign each recording with your name and title. For nursing students, the abbreviation NS is used; for registered nurses, the abbreviation RN is used. (In computerized charting, the computer adds your name, your title, the date and the time.)

Finally, correct spelling is essential for accuracy. For example, *librium* and *lithium* and *celexa* and *celebrex* are similar in spelling, but refer to different medications. In addition, incorrect spellings can give a negative impression to colleagues and decrease the nurses' credibility. Look up any words you are unsure about in a dictionary. (Although computerized charting has a spell check function, it will not catch incorrect words that are spelled correctly.)

Date and Time

The date and time of each recording should be documented. Use the 24-hour clock, also known as military time, to avoid any confusion about whether a time was am or pm. For example, in the conventional way of writing time in the United States, 9:00 could refer to 9:00 am or 9:00 pm. In the 24-hour system, there is no potential for confusion between morning and afternoon hours.



Tips for Nurses

In the 24-hour system, morning times do not change, but 0 is written before the first number, up through the number 9. Colons are not used to separate minutes from the hour. For example, 9:00 am = 0900 (pronounced oh-nine-hundred) and 11:30 am = 1130. Afternoon and evening times are calculated differently. Except for the noon and midnight hours, simply add 12 to the hour. For example, 1:30 pm = 1330 and 10:30 pm = 2230. Midnight is written as 2400. Noon is written as 1200.

ASSESS YOURSELF

1. What are the skills of communication?
2. Describe the communication roles of healthcare professionals.