CHAPTER II
REVIEW OF LITERATURE

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CHAPTER II

REVIEW OF LITERATURE

2.0 INTRODUCTION

Literature refers to “written works, especially those considered to be of superior or lasting artistic merit: books and writings published on a particular subject”. It covers books, journals, newsletters, etc. A review involves examining or assessing (something) formally with the possibility or intention of instituting change if necessary\(^1\). Therefore a literature review helps the researcher become up to date with current knowledge on a particular topic under study, and also learn about what is known or unknown about the phenomena under study. The literature review describes, summarizes, evaluates and clarifies the scope of study of research. It gives a theoretical background for the research, and helps the author to determine the nature of research. For a person engaged in a research project, literature review can help in formulation or clarification of a research problem, acquaints the researcher with what is going on in the field and helps assess the feasibility of the study\(^2\). A literature review is a synthesis of the literature that describes what is known or has been studied regarding the particular research question or purpose\(^3\). It is important to start any research with a comprehensive literature review of existing, available data pertaining to the area of study.

Communication is a means of establishing a relationship. It is a complex process and involves sending and receiving messages (verbal and non verbal) in which the sender and the receiver encode and decode the received information; this allows for exchange of feelings, information and ideas. Nurses use communication while interacting with patients and their family members, as well as their own colleagues, superiors and other healthcare personnel.

Improper or incomplete communication can have disastrous effects. Care related to patients - if not handed over from one shift to another, omission of an integral part of care, not communicating a critical report to the physician at the right time, etc can have negative outcomes. Even though there is a wide agreement about
the importance of effective communication in nursing, there is also continuing evidence of the need for nurses to improve their communication skills.

In earlier times, it was difficult to review literature since researchers had to personally visit libraries and scan through books, journals and other material. Today technological innovations have made it simpler, and a large amount of information is available at the touch of a button. To review literature on communication skills, the researcher has referred to books and journals, and has also used search engines like Google search, Google scholar, pub med, science direct, CINHALS, etc.

This review of literature highlights the various research studies that are relevant to the study that the researcher plans to undertake as a part of the PhD program in nursing. The topics in this literature review are organized under the following headings:

1. Nurse-patient communication: Verbal
2. Nurse-patient communication: Non verbal
3. Barriers in nurse-patient communication
4. Handoff communication
5. Handoff communication using SBAR
6. Nursing Documentation
7. Communication skill training programs
2.1.1 NURSE-PATIENT COMMUNICATION: VERBAL

Communication is the transfer of information between two or more persons. Good communication between nurses and patients is essential for successful patient care outcomes. For this outcome to be achieved, nurses must understand and help their patients, demonstrating sincerity, courtesy and kindness. Communication with the patient starts at the first interaction and therefore, if communication occurs under appropriate conditions, it will last till the end of this therapeutic relationship. The activity of nurses talking or listening to patients usually exceeds the other activities such as care related procedures. Thus communication can be viewed as a core clinical skill that requires considerable investment in terms of time and resources.

Patients with cancer often experience distress, particularly in the initial period after diagnosis and are likely to develop an affective disorder in the first 2 to 3 months. Communicative behaviors of nurses seem to play an important role in meeting the cognitive and affective needs of a patient with cancer.


The first was “Patient as the centre of communication” - i.e. changes imposed by the disease treatment such as chemotherapy or mastectomy which impact self image, leading to reactions like anger and aggression while communicating with nurses. The characteristics of the patient such as higher education, increased awareness, adherence to self care recommendations,

The second was “Nurse as a human factor” – i.e. self confidence, knowledge, holistic approach, sense of vulnerability about possible effect of cytotoxic drugs on the nurse’s health, as also depression and grief after the death of a patient. Due to these factors, the relationship was deliberately superficial, and non-intimate communication was used – viz. emotional issues were not exchanged between the nurse and the patient.
The third was “Organizational structure” including work load, time balance, lack of supervision, and imposed duties in the context of neglecting nurse and patient needs. Characteristics of the patients, nurses, and care environment seemed to be influential factors in communication. They concluded that “in order to communicate with cancer patients effectively, changes in philosophy and culture of the care environment are essential in order for the patients to feel that their individuality is regarded higher than the nurses’ work. Therefore nurses must receive proper training for care and communication with patients”.

Huang SH et al (2014) investigated oncology nurses’ major responses to handling truth-telling to patients’ terminal illness (TTPTI): what makes oncology nurses act individually and to explore what factors might explain oncology nurses' various actions. A pilot quantitative study was designed to describe full-time nurses' (n = 70) truth-telling experiences at an oncology centre in Taipei. Most nurses expressed that truth-telling was a physician’s responsibility. In all, 54.4% of the nurses stated that they lacked educational training in truth-telling, 75.0% of the nurses expressed that their unit had no principle of truth-telling, and only 10.3% of nurses perceived that they had been fully authorized to perform truth-telling. Nevertheless, 70.6% of nurses responded that they had performed truth-telling, and 20 nurses (29.4%) reported no experience. Within the TTPTI experienced group, nurses responded that the most frequent steps of truth-telling were to understand the patient’s awareness (79.2%), to listen to patients’ voices (47.9%), and to make a decision by respecting the family’s requests (31.3%). The reasons for inaction included "Truth-telling is not my duty", "Families required me to conceal the truth", and "Truth-telling is difficult for me". The responses to their opinion on “Who should reveal the truth to patients?” were: doctors (77.9%); doctors and nurses (13.2%); doctors and the patient’s family (2.9%); doctors, nurses, and the patient’s family together (2.9%); and the patient’s family (2.9%). Consequently, when asked “How do you deal with patients’ or their family members’ truth inquiries?”, the nurses primarily responded with “Tell them to ask the in-charge doctors” (52.9%), “Inquire with the doctors first and then make a decision” (19.1%), “Assess how much truth they already know first” (17.6%), “Tell them a part of the truth” (5.9%), “Tell them the truth” (2.9%), and
“Escape” (1.5%). Nurses also expressed the following reasons against TTPTI: “Truth-telling is not my duty”, “Families required me to conceal the truth from patients”, “Truth-telling to patients is difficult for me”, “No chance to access such patients”, and “Afraid of facing the patients”. Based on a stepwise regression analysis, nurses' truth-telling acts can be predicted based on less perceived difficulty of talking about "Do not resuscitate" with patients, a higher perceived authorization from the unit, and more oncology work experience (adjusted $R^2 = 24.1\%$). They concluded that oncology care experience, perceived comfort in communicating with terminal patients, and unit authorization are important factors for cultivating nurses’ professional accountability in truth-telling. Nursing leaders and educators should consider reducing nursing barriers for truth-telling, improving oncology nurses' professional accountability, and facilitating better quality care environments for terminal patients.

In Italy, Repetto et al (2009) interviewed 622 older patients with various stages of cancer, and the results showed that 412 (66.2%) patients were informed about their illness condition, whereas 210 (33.8%) were not informed. Receiving adequate information facilitated a better patient-health professional relationship for 84.8% of the patients. The authors concluded that illness truth disclosure can enhance patients’ involvement in their cancer care and facilitate disease treatment, prognosis, and more positive expectations. In another study conducted by Jiang et al (2009) in China, attitudes toward truth disclosure varied based on the patient’s cancer stage, and nearly half of patients (49.7%, n = 75) and family members (56%, n = 177) believed that not disclosing the truth about terminal illness was useful for maintaining patients’ quality of life.

Georgaki et al (2002) examined Greek nurses’ attitudes towards truth telling practices when working with cancer patients and their psychological status regarding the difficulties they face in their day to day communication with these patients. A self-administered questionnaire composed of 19 questions, including both multi-item scales and single-item measures, was designed for the study. Two hundred nurses were asked to participate in this study; of these, 148 (74%) completed and returned the questionnaire. A large percentage of the respondents (75.7%) believed that only some patients with cancer should be told the truth of their diagnosis and prognosis,
although a larger percentage (89.1%) believed that the truth should be told to the relatives. Most of the respondents (66.2%) reported that it is difficult to engage in open communication with the patients, because their academic education did not sufficiently train them in communication skills. While 83.78% of the nurse respondents did not reveal that the disease is incurable, 58.1% (86) believed that only the patient's physician should reveal the truth. In their communication with patients, 68.9% (N=102) of nurses avoided using the word ‘concern’. Many nurses (71.6%) believed that truth is an essential element for successful therapeutic intervention. Most of the nurses (51.3%) believed that full information can lead to despair, disappointment and full isolation. Statistical analysis did not reveal significant differences in response rates between males and females, young and old nurses, their level of education or experience. They concluded that caring patients with concern is an essential and major aspect of nursing care. Nursing literature suggests that talking and listening to a patient about issues associated with disease, death and dying is important and difficult, and can be improved with training in which they learn how to communicate effectively in relation to patients’ emotions and feeling, and how to integrate emotional care with practical and medical task.10.

A qualitative descriptive design and thematic analysis was used by McLennon et al (2013) to describe nurses’ experience pertaining to prognosis related communication with patients who have advanced cancer. The study nurses explained the process of how they identified the need for prognosis discussion by recognizing patient cues and knowing when it was time, gathering additional information to gain a better understanding of the full picture and reflecting on risks and benefits with regard to recognized readiness for prognosis information. Nurses recognized subtle signs and described them as intuitive knowing, gaining insight about what is already known by patients, patient characteristics (e.g. educational level, spirituality) and reflecting on the extent of information that should be given and the potential for inflicting pain or removing hope. The barrier to prognosis communication included uncertainly because of lack of knowledge, discomfort due to personal feeling of distress and sadness, disconnect in situations where they were not sure about the amount of information already disclosed and perceived task of providing information if the physician had not already disclosed. Barriers often resulted in moral distress about the perceived
inability to provide advocacy to the patient. The author remarked that the evidence from the study suggested that oncology nurses are in a position to improve the quality of prognosis related communication and end of life care for patients with advanced cancer by facilitating, collaborating or independently participating in prognosis discussion. *Areas where oncology nurses can make a substantial contribution are assessing needs of patients and family, overcoming communication barriers, opening avenues of communication about treatment options and end of life wishes and enabling patient to make informed choices*.

Citak EA et al (2013) explored communication difficulties of pediatric hematology/oncology nurses with patients and their families, as well as their suggestions about communication difficulties. Qualitative data was collected by focus groups, with 21 pediatric hematology/oncology nursing staff from three groups. Content analysis was used for data analysis. Findings were grouped into three main categories. The first category concerned communication difficulties, assessing problems in responding to questions, ineffective communication and conflicts with the patients’ families. Nurses had difficulty responding to questions on negative prognosis and death. The nurses felt that they had inadequate helping skills and failed to establish effective communication with terminally ill patients and those who rejected therapy. The second category was about the effects of communication difficulties on nurses. Nurses felt incompetent, inexperienced, exhausted and tended to avoid communication with family and children. The last yet main category involved suggestions for empowering nurses with communication difficulties. Hinds et al (2005) reported that pediatric nurses looking after children with a life threatening illness such as cancer experience emotions such as a decline in their aims, suffering and a decline in ‘feeling’ competent. The nurses recommended improved nurse patient ratio, so that they could allocate adequate time for patients, rotational change of departments, organizing team meetings and conducting training programs on communication skills. The authors concluded that pediatric nurses needed to be supported, especially during crisis periods. *A feeling of empowerment in communication will improve the quality of care by reducing the feelings of exhaustion and incompetence in nurses*.
A prospective, ethnographic study of post-operative care of patients following major elective gastrointestinal surgery was conducted by Symons NRA et al (2011) to examine communication failures in post-operative care following major elective gastrointestinal surgery. Fifty patients from the point of surgery to discharge representing 659 days of post-operative care were observed by an independent observer who attended ward rounds, examined notes and charts, and conducted interviews with clinical staff. They observed 256 process failures (median 4.5 per patient, range 0-16), of which 74 (29%) were associated with patient harm, 23 (9%) met adverse event criteria, and 85% were preventable. Process failures included problems with lines, tubes and drains, medication, blood transfusion, and blood and radiological investigations. Poor communication was the cause of these failures in 105/256 (41%) cases, of which 104/105 (99%) were preventable. Communication breakdowns were due to poor written communication in 58/105 (55%) and poor verbal communication in 47/105 (45%) cases. Communication failed primarily between surgeons and nurses (46/105) and within the surgical team (19/105). They concluded that communication breakdown is a common cause of process failures following surgery. Improving communication has the potential to decrease such failures and therefore enhance both outcomes and patient safety\textsuperscript{14}.

Emold C et al (2011) examined the association between communication self-efficacy, working environment perceptions, and burnout in an Israeli sample of oncology nurses using a non-randomized convenience sample of nurses. A nine item questionnaire inventory measured communication skill self efficiency was used. Internal consistency between the nine items was found to be good (Cronbach =0.87). Participants consisted of 36 (92.3%) females and three (7.7%) males. The mean age was 40.9 ±11.02. Findings revealed that frequent experiences of emotional exhaustion were reported by >60% of participants, cynicism by 28%, and self-actualization by >80%. With regard to communication self efficiency, 66% of the nurses reported a self confidence rating of 85% or greater about their ability to assess patient’s anxiety and depression, whereas 61.5% reported a self confidence level of 85% about their ability to initiate a discussion with patients about their concerns.
In contrast, challenging a patient who denied his/her illness was reported by 30.8% of nurses as an area they felt least confident about. They also found that nurses who worked in in-house hospitalization unit reported significantly higher (p≤0.01) perceived environmental support (mean= 4.2; SD= 1.56) than those working in an ambulatory setting (mean = 3.3; SD= 0.54). Several statistically significant associations were demonstrated between communication skills, self-efficacy and burnout, as well as between cynicism and reported positive characteristics of the work environment. They concluded that emotional exhaustion and self-actualization were separate and distinct experiences that can occur simultaneously. Communication self-efficacy and a positive perception of the working environment appear to buffer the occurrence of emotional exhaustion and promote self-actualization.

Warnock C et al (2010) aimed to explore the role of the nurse in breaking bad news (BBN) in the inpatient clinical setting. A descriptive survey design was used. Likert type scales and open-ended questions were used to elicit information. 60% (N=142) of the participants were staff nurses, 27% (N=64) were ward sisters/charge nurses. Others included nurse specialists, clinical educators and midwives. The response rate was 71%. Barriers to breaking bad news encountered by the participants were reportedly because of not having time to do it properly (62%), not feeling prepared/it was unexpected (61%), there were barriers to communication e.g. language (57%), lack of privacy (51%), verbal or physical abuse (30%) and nurses were not encouraged to be involved (8%). The responses to being involved in BBN included “I avoid being involved as I find it difficult (6%), I feel able to initiate discussions around BBN (70%), I have good strategies for coping with my emotional reactions (61%), Difficulty dealing with others emotional reactions (25%), I feel confident in my skills in the process of BBN (55%), Good system of support in my area (50%), and I feel able to support those from different cultural backgrounds (41%). The study also analyzed the possible consequences of being involved in BBN. Responses included, it can be rewarding as it helps relatives/patients prepare for the future (82%), it has strengthened my relationship with a patient (77%), it has encouraged me to reflect positively on my own priorities and what is important in life (71%), and it has allowed me to share in important moments with patients (69%). The findings support the view that nurses are involved in breaking bad news as a process.
They also engage in a wide range of supportive activities around the process of breaking bad news.

The authors concluded that being involved in the process of breaking bad news had positive consequences, though it was also associated with difficulties and challenges. Lack of control over events or interactions was a thread which ran through many descriptions. Future guidance and education should encompass the whole process of breaking bad news and acknowledge the challenges nurses face in the inpatient clinical area. This should include how to look after themselves when involved in BBN in a challenging and complex care environment.\textsuperscript{16}

Cossette S et al (2008) conducted a study on the multidimensionality of caring: a confirmatory factor analysis of the Caring Nurse-Patient Interaction Short Scale to evaluate the construct validity of the four-dimensional Caring Nurse-Patient Interaction-Short Scale using confirmatory factor analysis. A methodological study was conducted involving a convenience sample of 531 nursing students in a baccalaureate nursing program (20% were already Registered Nurses). The findings indicated that, as expected with large samples and models, the chi-square -associated P-value was statistically significant ($\chi^2 = 811.43$, d.f. = 224, $p < 0.01$). However, the other indices reached acceptable levels with 0.054 for the standardized root mean-squared residuals, 0.070 for the root mean-square error of approximation, 0.88 for the goodness of fit index, 0.98 for the comparative fit index and 0.97 for the normal fit index. The factor loadings for all items with their hypothesized factor were $\geq 0.48$ and statistically significant at the 0.01 level. They concluded that the Caring Nurse-Patient Interaction Short Scale model was judged to fit the data adequately, and this model emerged as a middle-range theory during the construct validity process and still reflects Watson's theory while offering a structure that is testable in clinical research.\textsuperscript{17}

Wakefield BJ et al (2008) compared differences in nurse patient communication profiles between two telehealth modes: telephone and videophone, and evaluated longitudinal changes in communication, nurse perceptions, and patient satisfaction. Data for this study were drawn from a larger Randomized Control Trial.
Of the 148 subjects in the larger study, 100 patients were approached for this study and most (95%) provided additional consent. Subjects were enrolled in a randomized controlled clinical trial evaluating a 90-day home-based intervention for heart failure. Telephone (n=14) and videophone (n=14) interactions resulting in 84 interactions. These were audio taped and analyzed using the Roter Interaction Analysis System. There were no significant demographic differences between the telephone and videophone groups. Results indicated that nurses were more likely to use open-ended questions, back-channel responses, friendly jokes, and checks for understanding on the telephone compared to videophone. Compliments given and partnership were more common on the videophone. Patients were more likely to give lifestyle information and approval comments on the telephone, and used more closed-ended questions on the videophone. Nurses perceptions of the interactions were not different between the telephone and videophone, nor did their perceptions change significantly over the course of the intervention. There were no significant differences in patient satisfaction between the telephone and videophone. The results of this study did not support use of a videophone over the telephone. They concluded that it is critical to match technologies to patient needs and use the least complex technology possible. When considering use of videophone, health care providers should critically examine the trade-offs between additional complexities with the added value of the visual interaction.

A cross-sectional study by Farrell C et al (2005) aimed at identifying key concerns of cancer patients receiving inpatient chemotherapy, determine the prevalence of anxiety and depression, and assess whether ward nurses could identify patients' concerns. Thirty-three women on a chemotherapy ward in the northwest of England who had breast, ovarian, cervical or uterine cancer were interviewed using a Concerns Checklist and the Hospital Anxiety and Depression Scale. Patients expressed a total of 341 concerns, which ranged from 2 to 27 (mean: 10.33, median: 9.0, S.D.: 6.5). There were no differences in the number of concerns expressed by disease group ($\chi^2=0.12, p=0.94$). Concerns relating to current illness, the future, inability to do things, physical symptoms and treatment were reported by more than 50% of patients. Overall the nurses identified a total of 61 concerns. These represented 20% of those actually disclosed by the patient. The nurses perceived that
patients had a mean of only 1.85 concerns (median: 2.0, S.D.: 1.77, range: 0–8). Mann–Whitney U-test indicated that there was a significant difference between the number of concerns expressed by patients and those perceived by the nurse ($z=4.94$, $p\leq0.01$). There was no evidence of an association between the length of time a nurse had known the patient and the identification of concerns (Spearman’s correlation value $r=0.15$, $p=0.40$). The most accurately identified concerns related to treatment, where a recognition rate of 79% was achieved. The nurses were unable to identify the three main concerns in 70% of patients. Twenty-four percent of patients were found to be probable cases of anxiety and/or depression; there was a moderate correlation between the number of concerns and levels of anxiety and depression. Given the body of evidence showing that the lack of identification of concerns leads to unmet needs, increased psychological distress, dissatisfaction with care and possible complaints, this study has provided clear evidence for the need to address this key area of care, and has highlighted the potential of the Concerns Checklist in busy clinical environments.  

McCabe C (2004) conducted a study on Nurse-patient communication: an exploration of patients’ experiences about how nurses communicate. A qualitative perspective using a hermeneutic phenomenological approach was considered for this study. Eight patients were interviewed using purposeful sampling. Data was collected using unstructured interviews. Following data analysis, four themes emerged. These were, 'lack of communication' as nurses were more concerned with tasks than with talking to them, as they were too ‘busy’. Patients were reassured when the nurses used a personal approach when communicating with them. 'Attending' meant nurses giving attention, showing concern, having open/honest communication and using language that patients could understand. The patients valued verbal and non-verbal communication as an indicator of genuineness because it demonstrated emotional support, understanding and respect for them as individuals. About 'empathy' the patients trusted nurses who empathized with them, and were able to identify specific nursing behaviors that demonstrated empathetic communication.  

Many of the patients expressed an appreciation of 'humor' in nurse–patient interaction. Humor appeared to improve self-esteem when they could make others
laugh and when they could laugh with the nurses. It seemed that the nurses who used humor appeared more approachable to the patients. They concluded that the findings of their study indicated that, nurses can communicate well with patients when they use a patient-centered approach and if health care management wants to ensure that patients receive quality nursing care, they will need to consider patient-centered communication to be essential, to encourage and support nurses to communicate in this manner.

People often use humor in a bid to make themselves more socially acceptable, to identify with other patients, and to distance themselves from their troubles. Chapple A (2004) stated that “Applied” humor is used by some patients in social settings to challenge assumptions others hold about the disease and, in health settings, it is often used to manage feelings, hide embarrassment, reduce tension, share a sense of solidarity with others, or encourage others to examine themselves. Jokes can dispel tension, introduce “awkward” topics, and convey messages about difficult subjects such as death, that might be unacceptable if conveyed seriously$^{21}$. Herth K (1995) in a descriptive study of 14 terminally ill adult cancer patients reported that a sense of humor established rapport, promoted relaxation, provided the distance to examine alternatives, and evoked feelings of joy, lightheartedness, happiness, and hope$^{22}$. In another similar study by the same author described how patients found humor as important for social bonding toward the end of life, with 64% reporting that it helped them to alter their perception of situations that would otherwise be overwhelming. A further 85% described humor as fostering hope, which they felt to be of utmost importance to help them face the realities of their everyday existence$^{23}$. Humor helped patients to talk readily about their cancer, illness, and even death, and the researchers proposed that lighthearted and humorous nature of this “death talk” served an important psychological function in allowing patients to distance themselves from their own deaths while simultaneously permitting an acknowledgment of their terminal condition$^{24}$.

Kruijver I et al (2000) reviewed the literature on nurse-patient communication in cancer care. They felt that communication behavior of nurses play a crucial role in meeting cognitive and affective needs of patients with cancer. The
aim was to provide an overview of communication between patients with cancer and nurses, and to gain an insight into the state of art research. Thus they wanted to address the question “What communication behaviors of nurses can be distinguished during the care of patients with cancer”. A search was made of three databases: Medline, Nursing and Allied Health Literature, and Library Catalogue of the Netherlands Institute of Primary Health Care. Literature from 1980 to 1097 was selected and restricted to research on nurse patient communication in cancer care. A total of 127 articles were reviewed. Results showed that several communicative behaviors like empathy, touch, comforting strategies, special comfort measures in palliative care, emotionally supportive behaviors, blocking and facilitating behaviors were used by nurses. Patients with cancer perceived behavior that reflected respect and intimacy, and provided companionship, reassurance, encouragement and accompaniment in stressful situation as most supportive, and it was followed by behavior that provided information and clarification about the disease and its treatment.\textsuperscript{25} By using blocking behavior, nurses prevent patients from talking about their problems, whereas through facilitating behavior, nurses are able to achieve more in-depth assessment of the patient’s problems. The facilitators used skills such as picking up cues, clarifying, and summarizing patient’s problems. Maguire et al\textsuperscript{26} found that use of leading questions inhibited patients disclosure of significant information and that nurses, despite communication training were not successful in identifying patients concerns\textsuperscript{5}.

2.1.2 NURSE-PATIENT COMMUNICATION: NON VERBAL

Grimsbø G H et al (2012) investigated emotional cues and concerns (C&C) of cancer patients expressed in e-mail communication with oncology nurses in an online patient–nurse communication service (OPNC), and explored how nurses responded to patients’ C&C. In all, 283 e-messages sent from 38 breast and 22 prostate cancer patients and 286 e-responses from five oncology nurses were coded with the Verona Coding Definitions of Emotional Sequences. They identified 102 cues and 33 concerns expressed in patients’ messages. Cues indicating expression of uncertainty or hope occurred most frequently (38.5% of messages), followed by concerns (24.4%
of messages). There were significant differences between breast and prostate cancer patients in cues and concerns. In the messages from male patients, only 40.9% had expression of cues or concerns. Among the breast cancer patients who were all women, 68.4% of the e-mail messages had cues or concerns. However, when the prostate cancer patients eventually expressed cues and/or concerns, 31.8% expressed two or more C&C in their e-mail communication with the oncology nurses as compared to 28.9% of messages from breast cancer patients (p = 0.03). As a mean, male patients expressed 1.13 cues and 0.21 concerns per message. Female patients expressed 0.98 cues and 0.42 concerns per message. When C&C were expressed in e-mail messages, prostate cancer patients expressed 84.6% as cues and only 15.4% as concerns. Breast cancer patients on the other hand expressed nearly twice as many concerns as the prostate cancer patients (30.1%; p = 0.053). Nurses responded to 85.2% of patients’ C&Cs; more than half of patients’ C&Cs were met with a mixture of information giving and empathic responses. They concluded that patients with breast and prostate cancer express many C&C in e-mail communication with oncology nurses, who demonstrated satisfactory sensitivity to patients’ emotions in their responses to patients.

Uitterhoeve R et al (2009) felt that patients with cancer seldom express their concerns directly but express cues instead. They therefore conducted a study on Cue-responding behavior of oncology nurses in video-simulated interviews. The aim of the paper was to describe nurse-patient interactions, i.e. nurses’ cue-responding behavior in encounters with actors playing the role of patients. In this descriptive observational study conducted from April to June 2004, five oncology nurses interviewed an actor playing the role of a patient with cancer. Each nurse performed seven different interviews (n = 35); these were videotaped and subsequently rated for cue-responding using the Medical Interview Aural Rating Scale. Mixed model analysis was used to investigate the relation between cues and cue-responding. They found that 50% of the patients’ cues were responded to with distancing behavior, while the balance 50% of the patients’ cues were either explored (33%) or acknowledged (17%). In 16% of these responses, nurses used open directive questions. One out of four open directive questions were used as a distancing response, suggesting that open directive questions are not used to explore or acknowledge cues of patients. Cue-responding influenced
subsequent expression of concerns and emotions, i.e. disclosure of a concern was two times higher after exploration or acknowledgement of a preceding cue than after a distancing response. They concluded that Cue-responding is a valuable concept which can contribute to our understanding of optimal ways of communicating. Cue-responding behavior facilitates the disclosure of worries and concerns of patients. They also felt that further research is needed to assess the clinical relevancy of cue-responding.

Schofield NG (2008) reviewed the importance of good communication skills in cancer care, and described research that has identified ways in which health care professionals can improve their communication with patients. The findings of their review showed that a high percentage of concerns of patients are undisclosed or if disclosed are unrecognized. Sixty percent of concerns were undetected by hospice nurses, while Farrell et al showed that 80 percent of patient concerns remained unrecognized in an in-patient setting. The eliciting and identification of concerns, needs and preferences of patients enable the health care professionals to tailor information, which is important as too much or too little information impacts on psychological morbidity and satisfaction with care. This highlights the importance of the communication process at the time of diagnosis and soon after. The focus of patient centered communication is identification of cues.

Butow et al (2002) suggested that cue is a verbal example of vague undefined emotions or non verbal hint example such as crying frowning etc. which suggests an underline unpleasant emotion and would need clarification from the health provider. Therefore nurses’ communication should be able to pick up such cues. Fletcher reported that if an open question was linked to a cue it was 4.5 times more likely to lead to patient disclosure than when it was not linked. Furthermore, if the first cue from patients was not facilitated, the number of cues given by patients dropped by 20 percent regardless of whether or not the second cue was picked up. Several studies show that health care professionals use blocking behaviors like close questions, switching focus, etc to prevent further disclosures of emotions thus changing the path of communication to safer grounds.
Rebouas CBA et al (2007) did an exploratory descriptive study on non-verbal communication among nurses and blind patients during nursing consultations to diabetes patients, based on Hall’s theoretical reference framework. Data were collected by recording the consultations. The recordings were analyzed every fifteen seconds, totaling 1,131 non-verbal communication moments. The analysis revealed intimate distance (91.0%) and seated position (98.3%); no contact occurred (83.3%) of the interactions. Emblematic gestures noted included hand movements (67.4%), looks deviated from the interlocutor (52.8%), and centered on the interlocutor (44.4%). In all the recordings, considerable interference occurred at the moment of nurse-patient interaction. The authors felt that nurses need to know about and deepen non-verbal communication studies and adjust its use to the type of patients in the consultations.

The language of touch includes the tactile symbols of duration, location, action, intensity, frequency, and sensation. Touch is used in different ways: affectional, functional, protective, and non-physical (personal space). The need for touch does not lessen with age. In fact, it may increase due to loss of vision and hearing and increased personal and social isolation. Vortherms RC (1991) suggested that nursing educators need to recognize the importance of nonverbal communication skills (i.e., touch and personal space), and incorporate learning techniques into classroom and clinical experiences.

2.1.3 BARRIERS TO NURSE-PATIENT COMMUNICATION

Tay LH et al (2012) in their study mentioned that language and cultural taboos which increase nurses discomfort when discussing sensitive issues and societies poor perception of and lack of respect for nurses were barriers in communication. Findings of a study conducted by Knox S (1965) showed that excessive workload followed by clerical duties such as charting ranked high as barrier to communication. Nurses also felt that pressure of time hampered nurse-patient relationship, but they also felt that talking to patients kept them away from other duties. Demanding patients and patients attitude was also seen as a barrier.
Chan EA et al (2012) conducted a study on “Nurses' perception of time availability in patient communication in Hong Kong”, to identify their ways of communicating. Focus group interviews were adopted. Three themes were identified regarding nurses' perception of communication with time: (a) Patterns of communication; (b) Routine scheduled communication vs. Meeting individuals' needs; and (c) Saving time through communication. Patterns of communication, based on participants' criteria such as the purpose, who initiated it, the nature of communication, expectation to perform, therapeutic value and relation with time, were explained. By integrating communication into routines as intended actions, nurses demonstrated that communication and relationship building with patients take no extra time. Good communication and good relationships help nurses save time. They concluded that nurses' communication behavior is closely related to their perception of communication. This study suggests the need for a paradigm shift in thinking about communication as requiring time. Additionally, nurses should recognize the value of short, interactive interaction and chit-chat as quality communication for knowing their patients and providing patient-centered care.38

Al-Kandari F. et al (2009) conducted a study on “Factors contributing to nursing task incompletion as perceived by nurses working in Kuwait general hospitals”. This study was conducted to assess the workload of nurses, the nursing activities (tasks) nurses commonly performed on medical and surgical wards, elements of nursing care activities left incomplete by nurses during a shift, factors contributing to task incompletion and the relationship between staffing, demographic variables and task incompletion. The design was an exploratory survey using a self-administered questionnaire. A total of 820 questionnaires were distributed, of which 95% were returned. The findings showed that the five most frequently performed nursing activities were: administration of medication, assessing patient condition, preparing/ updating nursing care plans, close patient monitoring and client health teaching. The most common nursing activities nurses were unable to complete were: comfort talk with patient and family, adequate documentation of nursing care, oral hygiene, routine catheter care, and starting or changing IV fluid on time. Tasks were more complete when the nurse-patient load was less than 5. Nurses' age and
educational background influenced task completion while nurses' gender had no influence on it. They concluded that increased patient load, resulting in increased frequency of nursing and non-nursing tasks, correlated positively with the lack of completion of nursing activities during the shift. Emphasis should be given to maintaining the optimum nurse-patient load and decreasing the non-nursing workload of nurses to enhance the quality of nursing care.39

Park E et al (2005) investigated the communication barriers perceived by older hospitalized patients and nurses in Korea, with the aim to identify disparities between the two parties. The study involved descriptive survey design with convenience sample of 100 patients and 136 nurses. Data collected between January and June 2002 was used for the study. Patients ≥60 yrs, hospitalized for more than 2 days, who were oriented, alert and able to communicate verbally were selected for the study. There was no significant difference (t=1.1, p=0.27) in the total perceived importance of communication barriers between older patients and nurses. In terms of the three types of communication barriers, nurse related barriers were rated higher by patient than by nurse (p=0.01). Nurses rated higher patient related barriers than did the patients (p=0.001). There was no difference between the groups in the rating of environment related barriers. The five most important nurse related barriers as reported by the patients were: using medical terminology, working without a sincere attitude, authoritative attitude, sudden change of subject, and being unfriendly. The five most important nurse-related barriers reported by nurses were: being too busy, presenting several subjects at one time, speaking too fast, using long sentences without a clear message, and not checking if patient had hearing aid on. The five most important patient–related barriers reported by the patients were: not feeling well, being tired, being hard of hearing, pretending to understand, and being hesitant to interrupt the nurse’s work. The five most important patient-related barriers reported by nurses were: being hard of hearing, having poor articulation, not feeling well, forgetting things easily, and being tired. With regards to environment-related barriers, presence of severely ill patients in the unit, noisy environment, patient not having family care-giver around, and poorly lit room were reported as barriers by patients, while nurses reported not having family care-giver, unfamiliar and noisy environment, presence of severely ill patient in the unit, and generation gap. They concluded that nurses and
older patients perceive communication barriers differently. They recommended strategies to remove communication barriers between patient and nurses. They also felt that to reduce nurse–related barriers, nurses need to improve their understanding of communication process, receive proper education and training.\textsuperscript{40}

In another study, Trovo de Araujo et al (2004) found that the nurses working at the intensive care unit do consider communication with dying patients an effective therapeutic resource, in spite of their own difficulties in communicating with dying patients, viewing themselves as ill prepared to the task, and often distancing themselves from dying patients because of their inability to deal with their own feelings, which were brought forth by the confrontation with imminent death.\textsuperscript{41}

Davis S et al (2003) in their study describes nurses’ perception of communication issues, potential barriers and strategies for nurse-family interaction. An exploratory qualitative methodology was used to elicit descriptions of communication problems using purposive sampling technique. Focus group interviews were used for 60 nurses from oncology and surgical / radiotherapy wards at a major metropolis teaching hospital in Western Australia. Over a three month period, 51 nurses participated in nine focus groups. Nurses identified four factors that affected nurse-family communication, namely: family factors, patient factors, team factors, and work environment factors. Family conflict and cultural language issues were significant contributors to family communication problems. Poor team communication, poorly communicated bad news and treatment plans, staff inexperience, and poor team conflict were some of the team factors contributing to communication problem. Environmental factors included insufficient time, workload, lack of space / facilities and patient mix. Nurses identified a feeling of frustration, stress, inadequacy and guilt in response to what they reported to be poor family communication exchanges. Nurses described five types of strategies to enhance nurse family communication, namely: assessment of family, defining communicating and monitoring plan of care, team approach in Breaking Bad News, on-going team support and family friendly facilities.\textsuperscript{42}
2.1.4 HANDOFF COMMUNICATION

“Handoff of care” communication is a real-time, interactive process of passing patient specific information from one caregiver or team to another for the purpose of ensuring the continuity and safety of patient care. Handoff of care is a National Patient Safety Goal developed by the Joint Commission on Accreditation of Healthcare Organization (JCAHO). The Joint Commission (2006) raised the awareness of the importance of handoffs and handoff communication, when it introduced National Patient Safety Goal (NPSG) 2E that required healthcare organizations to “implement a standardized approach to ‘handoff’ communications, including an opportunity to ask and respond to questions.”

Handoff of care occurs when responsibility for patient care changes due to a change in patient location or change in provider, for e.g., change in level of care, temporary transfer of care, discharge and change in provider or change in service.

Bedside report is an excellent way to build employee teamwork, ownership and accountability. It also meets the goal of patient safety according to the Joint Commission - i.e. improve accuracy of patient identification, improve effectiveness of communication among care givers mainly hands off communication and encourage patients’ active involvement in their own care and decision making. The finding of a study by Baker SJ (2010) revealed that patient information handed over varied according to a nurse’s knowledge level of the individual patient’s condition and also the personal understanding of the patient. Information handed over tends to be incomplete and this may be due to the increasing use of contract nurses.

A cross–sectional study combining quality and quantity was carried out by Darch-Zahavy and Shilman O (2015) with the aim to investigate a patient’s participation in hand over as understood by both patients and nurses. Patients (n=113) who were fully conscious, had literary ability, and who were hospitalized at least one day prior to the survey (response rate 89%) were included. The content analysis of observed hand over revealed that 36% of communication was clarification about the patient’s on-going care. The discussions were initiated mostly by the patients (70.6%)
and less by the nurses (29.4%). Patients viewed handover as an opportunity to get information, wanted to know the intended care plan and schedules, and also to understand professional nursing jargon. The patient-nurse communication during handover included enquiries (86%), co-ordination (29%), information retrieval (29%), friendly dialogues (6%), and complaints (2%). The nurses however found them bothersome, as they thought that the information requested was unimportant or handover were not the proper time for such questioning as the primary purpose of handover was information exchange between nurses and not with the patients. Nurses therefore tended to ignore patients, and talked to each other as if the patients did not exist. Nurses would frequently interrupt the patients (35.3%), and most inquiries were answered tersely with no specification of care options or patient’s right (53.6%). The qualitative findings highlighted the importance of nurses demonstrating communication behaviour which is supportive of a patient’s participation such as calling the patients by name and requesting information about their current state, feelings and former procedures. Interestingly patients too avoided participation during overloaded handover. Possibly the patients could sense the nurses overload and responded to it by limiting their participation. This finding was also consistent with the ‘nice patients syndrome’ identified by Henderson.

These findings present an opportunity for intervention to improve nurse patient communication during handover. The suggestions include: not to ignore requests for information by patients, learn inviting behaviours like calling patients by name, being authentic, avoiding professional jargon, and responding to patients’ needs. To prevent interruption during handover, the outgoing nurse could approach patients towards completion of shift and review their information needs. They should be encouraged to inform the nursing staff about changes in their physical condition.

Lee Henrietta et al (2015) conducted a randomized single blind, control experiment to examine the effect of two factors – namely, an effective statement expressing concern about the information, and verbal reference to a written summary of information on the transmission of clinical information at nursing handover. A total of 157 nurses participated. Four 2-minute videos of a scripted post operative handover were created featuring a nurse handing over a post-op nephrectomy patient.
Handover followed SBAR structure for the four groups - control, affective, written and combined. Overall no significant difference was observed in the success of transmission of a piece of information across the four experimental conditions. Sub group analysis revealed that experimental nurses transmitted more successfully in the condition with an affective qualifier than in the control condition. Their finding also showed that verbally stating a piece information with concern or supplementing it with a written note (or both combined) may not be enough to increase successful transmission. They suggest that intervention aimed at changing nurse’s practices may have a differential effect based on experience.\textsuperscript{47}

The objective of the study done by Ganz F et al (2015) was to describe the quality of ICU nurse hand over related to end of life care, and to compare the practices of different ICU’s in three different countries. A descriptive comparative study of seven ICU’s was undertaken. A convenience sample of 157 hand overs was studied using an ICU end of life hand over tool developed by authors. The tool was a checklist containing 24 items and each item had to be rated as Yes/No. Cronbach’s alpha reliability for the scale was 0.92, while inter rater reliability was 0.68. Content validity was rated by six critical care nursing experts. The highest level of hand over communication was in the areas of goals of care (n=120, 76%) and pain management (n=115, 73%). Significant differences were found between countries in total hand over scores (p ≤ 0.001) The total hand over score was higher if the oncoming registered nurse did not know the patient (p = 0.007), if the patient was expected to die during the shift (p ≤ 0.001) and if the family were present (p ≤ 0.001). The quality of communication related to end of life at hand over in ICU was universally low in legal issues surrounding end of life. The authors recommended the tool to be tested in other ICU’s around the world, and to use a mixed method approach to further explore the influence of local culture on End of Life hand over quality.\textsuperscript{48}

A cross-sectional descriptive survey method was adopted by Kim E et al (2014) to examine nurses’ overall views and perceptions of nursing handover in a 300 bedded hospital located in South Korea. With convenient sampling, 760 nurses responded to the survey, a 63% response rate. The main type of handover was a one-on-one handover between the outgoing and incoming nurse (63.7%). In contrast,
15.1% of respondents reported a head nurse or charge nurse presented all patient information to a gathering of outgoing and incoming nurses. The main method was a verbal handover with a Kardex system used by 54.4%, followed by a verbal handover with electronic medical records (EMRs) used by 39.7%. The majority (96.3%) reported that all patients were covered in the handovers. The most common situation reported by 72.9% of the study’s participants, was that there was no written guideline or checklist for the ward. The average time spent for the handover was 40.4 ± 14.6 minutes. With regard to nurses’ perception about handovers, the majority of nurses were in agreement that “the information received is up to date” (5.45 ± 1.06, 80.9%); “opportunity to ask questions about things I do not understand” (5.34 ± 1.06, 77%); “to debrief with other colleagues when they have a difficult shift” (5.14 ± 1.12, 73.4% agreement); “able to clarify information that has been provided” (5.14 ± 1.01, 71.7% agreement); “provided with sufficient information about patients” (5.12 ± 1.05, 71.8% agreement); and “patient information is provided in a timely fashion” (5.11 ± 0.97, 70.3% agreement).

In contrast, the item with the lowest score was “patients are involved in the handover process”, with a score of 2.31 ± 1.49 (9.7% agreement); followed by “information is received during the handover that is not relevant to patient care” (3.63 ± 1.31, 26.0% agreement); “important information is not always given” (3.76 ± 1.37, 29.0% agreement); and “I find that handover takes too much time” (4.27 ± 1.44, 44.0% agreement). They concluded that nurses’ current perceptions about handovers suggest the need for making some institutional changes in the future for the best practice in South Korean hospitals. They recommend additional studies to identify modifiable factors among the factors affecting nurses’ perceptions and to develop standardized handover protocols.49

Matney S et al (2014) conducted a study on “Nurses as knowledge workers: is there evidence of knowledge in patient handoffs?” The aim was to determine whether knowledge and wisdom were exchanged during medical and surgical patient care handoffs, and to discover how these were expressed. Content analysis of 93 handoffs using the data/information/knowledge/wisdom framework was done. The handoffs included 59% (n = 1010) phrases (utterances) coded as information and 41% (n =
as knowledge. The most frequent information phrases coded were Current Illness & History \((n = 166)\) and Procedures & Treatments \((n = 127)\). The fewest codes were for Risk \((n = 0)\). On the other hand, the most frequent knowledge phrases coded were for Physiologic Signs & Symptoms \((n = 185)\) and the fewest number of knowledge codes assigned was for Allergies \((n = 0)\).

Knowledge was present in every handoff although the distribution of information versus knowledge phrases (utterances) differed between the medical and surgical units as noted above. Nurses on medical units communicated Psychosocial, Labs, and Medications (including Pain Medication) categories at a greater frequency than did surgical nurses. This is exemplified by nurses on surgical units communicating most frequently about procedures and IVs, whereas nurses on medical units communicated about assessments, procedures and medications. One nurse made the following statement pertaining to Labs and Medications: This sample of handoffs did not include knowledge utterances about plans of care, nursing diagnoses, multidisciplinary goals, and patient problems. Instead, these were implied. Nurses only explicitly mentioned risk (e.g., risk for falls) three times in over 1700 coded phrases. Nursing-derived patient care goals and patient education content were also missing. Their study concluded that nurses are knowledge workers even though the variability across nurses is high. Increased knowledge in patient handoffs could facilitate critical strategic work of registered nurses and contribute to the patients’ experience and outcomes.\(^{50}\)

Kerr D et al (2014) evaluated whether implementation of a new nursing handover model would lead to improved completion of nursing care activities and documentation. A pre- and post-implementation study using a survey and document audit was conducted in a hospital ED in Melbourne. A convenience sample of nurses completed the survey at baseline \((n = 67)\) and post-intervention \((n = 59)\), and the audit was completed at both time points. Results showed significant improvements in several processes: handover in front of the patient \((p < 0.001)\), patients contributed and/or listened to handover discussions \((p < 0.001)\), and provision of adequate information about all patients in the department \((p < 0.001)\). Nurses also reported a reduction in omission of vital signs \((p = 0.022)\) during handover. The findings
suggested that implementation of a new handover model improved completion of nursing care activities and documentation, and transfer of important information to nurses on oncoming shifts.\textsuperscript{51}

Foster-Hunt et al (2014) carried out a study to uncover the structure of information conveyed during patient hand off and look for principles charactering the organization of information. A qualitative research based on the observational study approach was used. Data was gathered during morning and evening nursing change of shift hand off in a P.I.C.U. Purposive sampling technique was used. The study sample included 40 hands off, each consisting of an outgoing and incoming nurse. Data was collected using observation forms and audio recording to capture shift hand-over reports. Data collection spanned five weeks. The majority of shift handover was rated as moderately organized and organized. Around 71\% of handovers with nurses having \(\leq 3\) year experiences were either moderately disorganized or moderately organized based on shift report (21\% and 50\% respectively). Almost 61\% of reports given by nurses with \(\geq 4\) years experience (n=26) were rated as organized.

The authors suggested that hand over of a nurse having \(\geq 4\) years experience were likely to contain better information progression, higher levels of information integration and more redundancy for high consequence information than those from nurses with \(\leq 3\) years experience. It was also noted that when the incoming nurse was familiar with the patient, outgoing nurses adjusted the level of detailed information. Association was found between the organization of information structure and PICU experience. They concluded that such association may have significant implication for future education and critical care skill acquisition.\textsuperscript{52}

Riesenber LA et al (2010) conduct a systematic review of articles published between January 1, 1987 and August 4, 2008, that focused on nursing handoffs, review of barriers to and strategies for effective handoffs, and identified features of structured handoffs that have been effective. Ninety five articles met the inclusion criteria; Only 20 articles involved research on nursing handoffs. One purpose of the current study was to identify features of nursing handoffs that have been shown to be effective. Ten (50\%) of the research studies included some outcome measure that
might be linked to effectiveness. Thirty three (35%) articles included the use of a handoffs mnemonic. Fourteen different mnemonics were identified with SBAR (Situation, Background, Assessment, Recommendation). In evaluating handoffs, several studies considered the format. Two studies noted that bedside shift reports or walking rounds were viewed positively by patients, and the use of bedside shift reports, walking rounds, or a customized telephone-based system was shown to decrease overtime. But although patient satisfaction and decreased overtime are important outcomes, it was not clear to what degree these were features of more effective handoffs. In a study that compared taped reports with face-to-face shift reports, the taped reports were found to produce more omissions but were less likely to produce incongruence; thus neither format was shown to be completely accurate. While the use of a written, problem-oriented form was found to be more concise and to save nurses time, the accuracy of the content was not measured. In comparison with taped shift reports, having nurses record all the relevant information in a binder located directly outside each patient’s room resulted in increased compliance with the recording of predetermined elements. But such compliance, though valuable, may not be an indicator of an effective handoff.

The use of a standardized written report for transfer of patients from the ED to a unit was shown to yield greater accuracy, increase patients’ and nurses’ satisfaction, and save nurses’ time. Considered together, these results seem to indicate that a standardized format will increase compliance and might result in greater accuracy. Communication barriers were noted most frequently, with general communication problems including such things as lapses in communication or failures to communicate, lengthy or irrelevant content, and inaccurate recall of communicated information. Other communication problems included language barriers, illegible handwriting, and poor communication between nurses and physicians. The author concluded that despite the well-known negative consequences of inadequate nursing handoffs, very little research has been done to identify best practices. There was remarkable consistency in the anecdotally suggested strategies; but there is a paucity of evidence to support them. They called for high-quality studies of handoff outcomes that focus on systems factors, human performance, and the effectiveness of structured protocols and interventions.53
Welsh CA et al (2010) examined two approaches to nursing end of shift reports both taped and written, to identify specific factors limiting and facilitating such handoffs. Twenty nurses were interviewed using a semi structured format. They were asked about the current reporting process, limitations, elements that helped, and ideas for improvement. Analyses revealed six barriers: (1) Inadequate information (80%) - i.e. the incoming nurses did not receive the information necessary to deliver quality patient care, causing them to spend precious time looking for it in the chart or from the outgoing nurse. (2) Inconsistent quality (50%) of nurses resulted in variation in the quality of report based on the nurse giving it. This variability represents inconsistency in report content with some nurses providing complete (all boxes filled in) and relevant reports, whereas others omitted relevant data or provided irrelevant information, such as repeating what is already documented on their end of shift printout (i.e., age, team, vitals, etc.). (3) Limited opportunity to ask questions (35%) i.e. outgoing nurses were frequently not available for questions from the incoming nurses. In some cases, receiving the end of shift report lasted more than 30 minutes so the outgoing staff had already left the unit. (4) Equipment malfunction (35%): All the comments came from nurses who used a tape recorder either currently or had in the past. In fact, recorder malfunction was mentioned as the reason for no longer using a taped process for report. Reasons for equipment malfunction included user error, faulty audiotapes, dead batteries, and substandard equipment. (5) Interruptions (20%) were a barrier. Since night shift has no overlap with evening shift, night shift nurses received report while simultaneously caring for patients and answering phones. (6) Facilitators were ‘Pertinent’ content, notes and space for notes, face-to-face interaction, and structured form/checklist. A structured end-of-shift report has the potential to reduce content omissions and lengthy or disorganized reports. Recommendations for redesign are defining content pertinent to the unit, structuring handoffs so that information is received in a standard way, embedding an opportunity for questions into the process, planning for all 3 handoff sub processes, and conducting peer evaluations and education.

J Bannard-Smith et al (2009) conducted a survey to identify the quality of patient handover in intensive care units in northwest England. The aim was to
establish details surrounding the methodology of handovers which are currently being used. During July 2008, a series of telephone interviews of the sixteen ICUs in this region were conducted. The findings indicated fifteen (93%) units had a designated handover time, and all of them reported that handover had been completed within the allocated time. Thirteen (81%) units used a computer based written handover. The remaining three (19%) used a verbal handover supported by handwritten notes. Eleven (69%) units reported that the handover had commenced on time on the surveyed day but only five (31%) were free from any interruption. The majority of handovers were undertaken at the bedside (62%) rather than in a designated handover room (38%). Of the handovers undertaken at the bedside, only 25% were free from interruptions, compared with 40% of those undertaken in a designated room. Key staff were present at nine (56%) of the handovers. The remaining seven (44%) were attended by trainees only. All the participants felt that the information they had received during the handover that day was adequate to maintain continuity of patient care during their shift. They concluded that all intensive care units surveyed had a handover system in place, although the type, normality and information content varied across the region. Handovers were rarely free from interruptions. Around 20% of ICUs were still operating a verbal handover system with or without handwritten notes. They advocated transition to a computer-based typed sheet in order to improve the quality of patient handover.55

Clark E et al (2009) described and evaluated the PACT (patient assessment, assertive communication, continuum of care, teamwork with trust) project, aimed at improving communication and patient safety within the organization. An action research process was used to implement and monitor the PACT project, with seven nurses being identified as “PACT” champions and they acted as a critical reference group. Two communication tools were developed to standardize and facilitate shift-to-shift (handover prompt card) and nurse-to-doctor (reporting template) communication. Both tools used SBAR (situation, background, assessment, recommendation) principles. All the nurses attended workshops on assertive communication strategies and focused on clinical assessment of the deteriorating patient. Questionnaires with seven Likert scale statements were distributed to nurses and doctors at baseline and post-implementation questionnaires. The PACT
champions also took part in discussions which were recorded digitally and transcribed. Qualitative data was collected from nurses immediately after the project. The findings indicated that at the baseline, 85% of the nurses felt that communication needed to be improved. After implementation, 68% of nurses felt that handover had improved, 82% agreed that there was a need for standardized handover, and 80% felt more confident when communicating with doctors. They concluded that the use of simple structured tools can improve communication and this, in turn, will improve patient outcomes. An audit to look for reduced number of incidents related to communication failures is essential for long-term evaluation of patient outcomes.\(^{56}\)

O’Connell B and Penney W (2001) explored the use of three types of handover techniques (verbal in the office, tape-recorded, and bedside handovers). Data was collected using semi-structured interviews mainly with nurses, clinicians, patients, and relatives (n = 27), field observations of handover (5 sites) and informal interviews conducted during observations (n > 40 nurses). Textual data were managed using NUD*IST. Transcripts were critically reviewed and major themes were identified from the three type of handovers that illustrated their strengths and weaknesses. The findings of this study revealed that handover is more than just a forum for communicating patient care. It is also used as a place where nurses can debrief, clarify information and update knowledge. Overall, each type of handover had particular strengths and limitations; however, no one type of handover was appraised as being more effective. They recommended reviewing of contextual factors that impact on handover, implement streamlined verbal handovers preferably at the bedside, develop ward-specific proforma to structure handovers focusing on patient progress rather than on tasks, use of tape-recorded handovers in adjunct to other verbal communication methods, and to include doctors in the handover process to enhance communication and accuracy of patient care information. They also felt the need to explore more creative ways of conducting the handover of patient care, so that an important aspect of nursing practice does not get classified as just another ritual.\(^{57}\)
2.1.5 HANDOFF COMMUNICATION USING SBAR

Toghian C et al (2014) presented a study to compare the effect of education about the SBAR technique with role play and lecturing on communication skills of nurses in transferring patients to the next shift. In this quasi-experimental study, 78 nurses participated, who were randomly assigned to role play and lecturing groups respectively. SBAR technique was taught to each group separately. At the end of the learning session in each group, the skills of the participants in performing SBAR technique were investigated by the standard SBAR scale. Comparison the total score of skill in performing SBAR technique by independent samples t-test showed that there was a statistical difference between role play and lecturing groups (p = 0.001); i.e. role play as an educational method has better effects on learning of SBAR communication technique. Comparison of the mean score of role play group with lecturing group in the Situation part of the SBAR technique revealed meaningful statistical difference (p = 0.001). Similarly, independent samples t-test showed statistical differences between mean scores of two groups in the Background, Assessment and Recommendation parts of the SBAR technique (P=0.001). They concluded that role play is an effective educational method in teaching SBAR technique for nurses and it can be used as a tool for build effective communication between healthcare professionals.\(^ {58}\)

Renz SM at el (2013) in their study reported that difficulties in communication with medical providers were mainly due to the provider’s style (e.g. rude, hurried, n=31), provider’s treatment decisions (e.g. refusing hospice care for terminally ill, n=3) and provider’s primary language/accent (n=2). Barriers to effective communication included lack of nurse’s skill in assessment and data collection, time constraints and noisy environment. The facilitators of effective communication included nurse’s organization of data, nurse’s confidence in communication and openness to conveyed communication. Sixty nine percent stated no limitation with SBAR tool although 28% found the tool time consuming. With regards to adherence to SBAR, post 3 months review of SBAR recorded that most (78%) had completed documentation, while 22% had missing documentation. It was also noted that SBAR was completed in a timely manner and there was 98% compliance. Implementation of
SBAR tool suggested an improvement in nurse satisfaction with communication. Many of the nurses stated SBAR takes off the guesswork out of the equation, and gives the nurse a delivery template that can be utilized by any nurse regardless of years of experience.59

Nurses’ use of SBAR and physician’s perception of communication quality after SBAR implementation was assessed at a 13-hospital health care system by Compton J et al (2012). Nurse surveys and physician audits were conducted. Of 156 nurses interviewed, 152 (97.4%) had been educated about SBAR, and 91 (58.3%) used SBAR for critical communication. Of 84 nurses whose proficiency with SBAR was assessed, 72.6% demonstrated good or high proficiency. Of the 155 physicians who responded to the physician survey, 121 (78.1%) said that the last report they received was adequate to make clinical decisions. Of the 27 who indicated that the last report was not adequate to make clinical decisions, 25 (92.6%) had not received the report in the SBAR format. The authors remarked that SBAR was generally well understood, but there were challenges like inconsistent uptake across facilities, lack of physician education about SBAR, and a tendency to view SBAR as a document rather than a verbal technique. They recommended that further research should also examine the effect of SBAR on quality of care and patient outcomes in controlled trials.60

Vardaman JM et al (2012) explored the implementation of the SBAR protocol and investigated the potential impact of SBAR on the day-to-day experiences of nurses. They performed a qualitative case study of two hospitals that were implementing the SBAR protocol, and collected data from 80 semi-structured interviews with nurses, nurse managers, and physicians; observation of nursing and other hospital activities; and documents that pertained to the implementation of the SBAR protocol. Data was analyzed using a thematic approach. Analysis revealed four dimensions of impact that SBAR has beyond its use as a communication tool: schema formation, development of legitimacy, development of social capital, and reinforcement of dominant logics. The results indicated that SBAR may function as more than a tool to standardize communication among nurses and physicians. The findings also indicated that SBAR may aid in schema development that allows rapid
decision making by nurses, provide social capital and legitimacy for less-tenured nurses, and reinforce a move toward standardization in the nursing profession. Their findings further suggest that standardized protocols such as SBAR may be a cost-effective method for hospital managers and administrators to accelerate the socialization of nurses, particularly new hires.61

Miller K et al (2009) describes in situ simulation training session as a method to measure markers of key nursing behaviors in interdisciplinary teams during critical events to assess the extent of high reliability. The nursing behaviors observed were: situational awareness, SBAR-R, closed loop communication and shared mental model. Simulations took place in the labour room and involved multi-disciplinary cadres of hospital staff. The findings indicated that two behavioral markers were consistently observed (nurse introduced self - 93% and prioritized task - 93% of the time) while four behavioral markers were not observed consistently (nurse verbalized changes in maternal and fetal conditions - 65%, requested back up - 62%, and verified gestational age - 53%). Verification of critical information was observed only 19% of the time. The findings in closed loop communication indicated a wide variation in nurses’ performance, where a key behavioral marker occurred <15% of the time. Effective use of SBAR-R was not done 65% of the time in stage one, 46% of the time in stage two and 57% of the time in stage three. Low performance was seen in establishing a shared mental model where the nurses were to communicate their individual situational awareness and arrive at a common understanding of the patient’s condition and plan of care. They concluded that skills necessary for nurses to contribute to highly reliable, interdisciplinary teams are not consistently observed during critical events and constitute breaches in defensive barriers for ensuring patient safety. They also mentioned that nurses play a key role in assuring effective team performance through the transfer of critical information. Nurses need to recognize and identify important clinical and environmental cues, and act in order to ensure that the team progresses along the optimal course for patient safety.62

Woodhall L et al (2008) introduced SBAR communication technique in a tertiary centre in an effort to standardize transfer of information, based on an initial survey which indicated that most healthcare providers saw room for improvement
regarding communication. Flyers explaining the use of SBAR during nurse-to-physician report during critical situations were distributed and displayed on the units. Creative SBAR pocket cards were given as reference guides to all the nursing staff. In addition, laminated nursing shift report templates and report-to-physician telephone checklists were provided to all inpatient nursing station areas. The physician staff initially had some reservations regarding the Recommendation portion of the SBAR tool. They questioned whether a nurse should recommend a medication or procedure prior to the physician’s examination of the patient. This point was clarified to explain that nurses would use the R to communicate “exactly what you need from the physician at that moment.” In January 2007, a survey of the same hospital areas was carried out again to evaluate the perceived efficacy of the SBAR technique. Dramatic improvements were noted in all the areas of communication. The nursing staff were consistently using SBAR during the shift report, and both new and experienced nursing staff were more confident when calling a physician about a critical situation.63

Velji K et al (2008) evaluated the effectiveness of an adapted SBAR tool for both urgent and non-urgent situations within a rehabilitation setting. In phase 1 of this study, clinical staff, patient and family input was gathered in a focus-group format to help guide, validate and refine adaptations to the SBAR tool. In phase 2, the adapted SBAR was implemented in one inter-professional team; clinical and support staff participated in educational workshops with experiential learning to enhance their proficiency in using the SBAR process. Key champions reinforced its use within the team. In phase 3, evaluation of the effectiveness of the adapted SBAR tool focused on three main areas: staff perceptions of team communication and patient safety culture, patient satisfaction, and safety reporting. Findings from this study suggest that staff found the use of the adapted SBAR tool helpful in both individual and team communication, which ultimately affected perceived changes in the safety culture of the study team. There was a positive but not significant impact on patient satisfaction, possibly due to a ceiling effect. Improvements were also seen in safety reporting of incidents and near misses across the organization and within the study team. They also recommended broadening the use of adapted SBAR tool in other centres.64
Wayne JD et al (2008) conducted a study on “Simple standardized patient handoff system that increases accuracy and completeness”. The purpose of this study was to conduct a comprehensive investigation on the determinants of an effective handoff management system. Specifically, they sought to address the following null hypotheses: There is no difference before and after implementation of a new, low-cost, low-tech process for surgery patient handoffs in accuracy of information, completeness, clarity of exact time of patient transfer, and number of tasks appropriately handed off. Baseline description of the handoff process was mapped from three direct observation sessions by an efficiency operations team. A standardized and partially automated handoff form was then developed. After a two-week pilot study, telephone surveys were repeated. Compared with the baseline, residents reported increased accuracy, as measured by the perceived number of inaccuracies found on sign-out sheets \(p = 0.003\). Completeness of the information on sign-out sheets also was improved \(p = 0.015\). Clarity about the time of transfer of care from outgoing (day team) to incoming (night float) improved \(p = 0.0001\). The type of rotation (intensive care unit vs non-intensive care unit) also led to an improvement (confidence interval< 99%). Across both shifts, the perceived number of inappropriate tasks transferred decreased significantly. Experience (months of training) and type of rotation did not affect these measures. They concluded that by simplifying and standardizing the handoff instrument, we demonstrated improvements in resident perceptions of accuracy, completeness, and number of tasks transferred. This low-cost, low-tech paradigm may be useful to others.

2.1.6 NURSING DOCUMENTATION

Documentation is any written or electronically generated information about a patient that describes the care or service provided to that patient. Health records may be paper documents or electronic documents such as electronic medical records, faxes, e-mails, audio or video tapes and images. Through documentation, nurses communicate their observations, decisions, actions and outcomes of these actions for patients. Documentation is an accurate account of what occurred and when it occurred. Nurses may document information pertaining to individual patients or groups of patients. Progress notes (nurses’ notes) are used to communicate nursing
assessments, interventions carried out, and the impact of these interventions on patient outcomes.

Coffey C et al (2015) compared the completeness of paper documentation with that of electronic documentation for trauma resuscitations in a level I pediatric trauma center where 100% electronic documentation was achieved in August 2012. A random sample of trauma resuscitations documented on paper (n = 200) was compared with a random sample of trauma resuscitations documented electronically (n = 200) to identify the presence or absence of the documentation of 11 key data elements for each trauma resuscitation. Results revealed that the electronic documentation more frequently captured five data elements: time of team activation (100% vs 85%, P < 0.00), primary assessment (94% vs 88%, P < 0.036), arrival time of attending physician (98% vs 93.5%, P < 0.026), intravenous fluid volume in the emergency department (94% vs 88%, P < 0.036), and disposition (100% vs 89.5%, P < 0.00). The paper documentation more often recorded one data element: volume of intravenous fluids administered prior to arrival (92.5% vs 100%, P < 0.00). No statistical difference in documentation rates was found for five data elements: vital signs, treatment by emergency medical personnel, arrival time in the emergency department, and level of trauma alert activation. They concluded that electronic documentation produced superior records of pediatric trauma resuscitations compared with paper documentation. Since the electronic medical record improves patient safety, it should be adopted as the standard documentation method for all trauma resuscitations.66

Wang N et al (2013) investigated nursing assessment document practice in aged care homes to compare the quality of nursing assessment documents in paper based and electronic nursing system. The findings revealed that 14/159 paper based records (9%) did not contain any resident assessment form. In contrast, all 249 electronic resident records contained document assessment forms, either admission or on-going. The mean number of document assessment forms in each record was 14.46 (SD 8.45) in the paper based system and 28.10 (SD 17.52) in the electronic system indicating a significant increase in quality of assessment documentation in the electronic system (p ≤ 0.001). But the overall scores for completeness of on-going

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assessment forms and timeliness of documents of admission assessment form were lower in electronic than in paper based system (p = 0.001). Comprehensiveness of assessment documents was higher (66%) in electronic than paper based one (58%). The authors felt a need to investigate the factors causing flaws in nursing assessment document such as incompleteness and delayed documentation.67

A small scale documentation analysis was conducted by Kim H et al (2011) to explore the medical and surgical nursing content of the patient records at a large teaching hospital affiliated to Partners Healthcare System (PHS), in preparation for a computerized documentation system. The analysis consisted of two parts: (1) analyzing 25 existing structured forms to investigate the nature of nursing documentation; and (2) reviewing 20 sets of nursing care plans, admission assessment forms, flow sheets, and nursing progress notes randomly selected from ICUs, to investigate the completeness of nursing documentation in the context of nursing process. A total of 1293 documentation items were collected from the 25 forms. The most common mode of data entry was free text (59%) and Boolean (30%). Only 11% of the items were documented using pre-defined pick-lists. The 1048 unique documentation items were mapped to the care component categories of the Clinical Care Classification (CCC) system. The results showed that nurses’ responsibility for documentation was stretched to non-clinical (“housekeeping”) data. This implied that the “assessment”, “diagnosis”, and “intervention” categories, which reflect the problem solving oriented aspect of nursing care conducted through the nursing process, were not sufficient to capture the health coordination and management aspect of nursing care provided outside the nursing process. The chart review analysis showed that the current documentation failed to deliver sufficient and accurate data to represent nursing care. Two major problems leading to the failure were identified: incomplete documentation of nursing care process (e.g., missing assessment data, missing goal statement, etc) and improper writing style that caused confusion in interpreting the documented data. Through this study, they identified a number of problems associated with the paper record that require resolution in the new computerized system, including elimination of documentation redundancy, areas where more structure is needed to properly capture data on nursing practice, and
various design considerations to support more complete and accurate documentation of nursing care. 68

Tornvall E et al (2009) conducted a study to implement and evaluate a standardized nursing record, using patients with leg ulcer as an example, regarding the content of the nursing record and district nurses’ experiences of documentation. A prospective, stratified and randomized intervention study with one intervention group and one control group was used. A standardized nursing wound care record was designed and implemented in the electronic patient record in the intervention group for a period of three months. Pre- and post-intervention audits of nursing records ($n = 102$ and $n = 92$, respectively) were carried out, and 126 district nurses answered questionnaires pre-intervention and 83 post-intervention. Analysis showed that in the nursing status, the search words ‘skin/tissue’ was used by 95% of the DNs in both groups and ‘pain’ by 92% and 98%, respectively. ‘Sexuality’ and ‘spiritual/cultural’ were ranked as almost never used. Within the intervention group, the DNs’ knowledge in nursing documentation ($p = 0.016$), the nursing process ($p = 0.014$) and how to handle a computer ($p = 0.003$) improved in relation to the intervention. No statistically significant differences were found in the control group. The average of the self-reported time for documentation in the intervention group increased from 68 min/day before to 81 min/day after intervention ($p \leq 0.05$). The pattern was similar in the control group but without statistical significance. They concluded that using the standardized nursing wound care record improved nursing documentation, meeting legal demands, which should increase the safety of patient. There was however a discrepancy between the nurses stated knowledge and how they carried out the documentation. They expressed that regular in-service training together with the use of evidence based standardized nursing records, as a link to clinical reasoning about nursing care, could be ways to effect change. 69

Adamsen L et al (2000) attempted to characterize basic nursing care in a Danish hospital by collecting data on patient perceptions of their main somatic problems in seven pre-set categories. These data include documentation of patient problems in corresponding problem categories, and the staff’s additional knowledge about patient problems. Triangulation of methods was used. Data were collected on
120 patients and from 22 nurses. The patients had 2.3 problems on an average: pain (58%) and sleep (43%) were the problems cited most frequently. Nursing records documented that only 31% of patients' experienced problems. The nursing staff had more knowledge than was registered in the nursing records. However, one-third of the patients' problems were totally unknown to the nursing staff. From the patients' point of view, essential aspects of basic nursing care are overlooked in daily clinical practice.70

Brooks TJ (1998) investigated nurses' perceptions of the function and value of documentation and barriers to this process. Using a multiple cases method, seven staff nurses from a 248-bed regional health care facility in Massachusetts were interviewed and their nurses' notes examined to determine whether nursing documentation is used as a vehicle for communicating clinical issues and knowledge. The subjects were asked to discuss factors that influence charting behavior, what was considered important to document as compared with what was actually documented, and barriers to this process. They were asked to consider the difference between actual "nurse work" and documented data. The study’s findings suggested that nurses do not clearly document their knowledge and practice issues. The content of the nurses' notes was not valued by the subjects in spite of having a supposedly user-friendly charting format and sophisticated documentation aids such as flow sheets, graphic records, and computer-generated care plans. Though they developed a compassionate understanding of patient issues and realistic care strategies, these issues and strategies were not documented. Behavioral issues that were considered of utmost importance to nurses, such as patient confusion, anxiety related to surgery, and the frustration of not being able to talk, were not noted but rather communicated verbally to other care providers. Management decisions relating to patient care such as patient-nurse collaboration was also absent from the documentation. Practice was generally charted in terms of scientific, technical, or organizational strategies, with little reference to the connection and concern so often associated with nursing care. This could imply that nurses' notes were not capturing nurses' holistic concerns.71
2.1.7 COMMUNICATION SKILL TRAINING FOR NURSES

Nurses need to be taught how to respond to different questions (for e.g. am I dying?) and about treatment options and their relation to care interventions which incorporate patient needs, fears, and preferences.\(^{44}\)

Grant MS et al (2014) reviewed the literature on communication education to pre-licensure registered nursing students. The goal of this review was to identify recent educational methods, frameworks and evaluation tools, and to assess the quality of this recent evidence. Various data sources like PubMed, CINAHL and PsychINFO were reviewed from 2002 to 2013, addressing nurse-patient communication and educational interventions. Studies were evaluated using the Johns Hopkins Nursing Evidence based Practice (JHNEBP) Rating Scale. This scale categorizes the levels of evidence and methodological quality. Twenty studies met both inclusion and exclusion criteria. The conclusions of the reviewed studies recommend the use of experiential educational methods such as SPs and simulation as was the case in a review by Chant et al (2002) which included use of SPs, videodisks, flashcards, group-work and drama workshops\(^{72}\). There is a move towards using more simulation in nursing education as it allows students to experience a more realistic clinical situation. They concluded that despite the importance of communication in nursing education, the quality of evidence to support specific communication interventions continues to be low. They recommended that future communication education research should: a) explore the highest quality designs available and use randomization where possible; b) more consistently use theoretical frameworks and their accompanying outcome measures; and c) that tools should be tested for evidence of reliability and validity.\(^{73}\)

Moore PM et al (2013) conducted a review to determine whether Communication Skill Training is effective in improving the communication skills of healthcare personnel (HCPs) involved in cancer care, and in improving patient health status and satisfaction. Selection criteria included Randomized Control Trials evaluating 'Communication Skill Training (CST)' compared with 'no CST' or other CST in HCPs working in cancer care. Primary outcomes were changes in HCP
communication skills measured in interactions with real and/or simulated patients with cancer, using objective scales. They included 15 RCTs (42 records) conducted mainly in outpatient settings. In all, 1147 HCPs participated (536 doctors, 522 nurses and 80 mixed HCPs). HCPs in the CST group were statistically significantly more likely to use open questions in the post-intervention interviews than the control group (five studies, 679 participant interviews; $p = 0.04$, $I^2 = 65\%$) and more likely to show empathy towards patients (six studies, 727 participant interviews; $p = 0.004$, $I^2 = 0\%$); this evidence was considered to be of moderate and high quality, respectively. Doctors and nurses did not perform statistically significantly differently for any HCP outcomes. There were no statistically significant differences in the other healthcare personnel communication skills except for the subgroup of participant interviews with simulated patients, where the intervention group was significantly less likely to present 'facts only' compared to the control group (four studies, 344 participant interviews; $p = 0.01$, $I^2 = 70\%$). There were no significant differences between the groups with regard to outcomes assessing HCP burnout, patient satisfaction or patient perception of the HCP’s communication skills. Patients in the control group experienced a greater reduction in mean anxiety scores in a meta-analyses of two studies (169 participant interviews; $p = 0.02$; $I^2 = 8\%$). They concluded that various CST courses appear to be effective in improving some types of HCP communication skills related to information gathering and supportive skills, though they were unable to determine whether the effects of CST are sustained over time, whether consolidation sessions are necessary, and which types of CST programs are most likely to work. They found no evidence to support a beneficial effect of CST on HCP burnout, patients' mental or physical health, and patient satisfaction. 

Lau Ying et al (2013) developed and evaluated a learner centered Communication Skill Training (CST) course using quantitative and qualitative design. Sixty two student nurses attended this two day course. There was a significant difference between mean pre and post test scores. For communication ability, scores were 53±5.85 and 54.77 ± 5.31 respectively ($p = 0.15$). The Wilcoxon signed rank test found post test improvement in the scores for content of communication (12.39 ± 2.32 to 10.02 ± 2.11) and handling communication barriers (10.02±2.12 to 15.08±2.03) ($p \leq 0.001$). Although the scale of communication ability clinical interaction,
interpersonal dysfunction and social problem solving were improved, the increase was not statistically significant ($p \geq 0.05$). The findings revealed that the course was effective in improving communication skills, especially in terms of the content and the handling of communication barriers and filled an important gap in the training needs of nursing students in Macao.  

Goldsmith J et al (2013) presented the pilot work exploring a novel communication training curriculum named COMFORT, an acronym that identifies the seven basic principles of nurse communication – namely, communication, orientation and opportunity, mindful presence, family, openings, relating, and team (COMFORT). The study examines the potential efficacy of the COMFORT curriculum for everyday communication challenges experienced by members of the Georgia Organization of Nurse Leaders. Participants were prompted to describe communication barriers and then apply an aspect of the COMFORT curriculum to this barrier. Responses revealed primary communication barriers with co-workers and patients/ families. Nurses described resistance in getting physicians “involved more closely with all ancillary departments for more complete assessment” and having to work with physicians who were “uncomfortable discussing death/ dying/ comfort care with patients and families.” Having to “relay or explain to a family” about a patient’s care, status, or disease “when something goes wrong” was considered difficult. Nurses described the daunting task of having to explain medical prognoses and procedures in “terms that are understandable.” To investigate how exposure to the COMFORT model can promote solutions to nurse-identified communication challenges, nurses were asked to apply COMFORT to their communication challenge and to rank order the COMFORT principles. Nurses ranked C-communication (n = 14, 66%) as a primary resolution tool. The C in COMFORT espouses nurses to consider the relational function of their communication in addition to the tasks that must be completed to achieve excellent patient care. Next, family communication (n = 7, 33%) was considered second most important among COMFORT components. These findings suggest that COMFORT content creates awareness of the participant’s own communication practices and has the potential to change communication behaviors.
Radtke JV et al (2012) described the experience and perceptions of nurse study participants regarding communication intervention (training and communication tools) for use with non-speaking, critically ill patients. Small focus groups and an individual interview were conducted with six critical care nurses. Transcripts were analysed using qualitative content analysis and constant comparison. Critical care nurses’ evaluations of: (i) a basic communication skills training program (BCST) and (ii) augmentative and alternative communication strategies (AAC) introduced during their study participation. Six main categories were identified in the data: (a) communication value/ perceived competence; (b) communication intention; (c) benefits of training; (d) barriers to implementation; (e) preferences/ utilization of strategies; and (f) leading-following. Perceived value of and individual competence in communication with non-speaking patients varied. Nurses prioritized communication about physical needs, but recognized complexity of other intended patient messages. Primary barriers to practice integration included patients’ mental status, time constraints, and the small proportion of nurses trained or knowledgeable about best patient communication practices in the ICU. The results suggested that the communication skills training program could be valuable in reinforcing basic/intuitive communication strategies, assisting in the acquisition of new skills and ensuring communication supply availability. Practice integration will most likely require unit-wide interdisciplinary dissemination, expert modeling and reinforcement.77

Turner M et al (2011) explored the attitudes of cancer and palliative care staff undergoing mandatory Communication Skill Training (CST). Respondents were mainly doctors (486%), nurses (45.9%) and allied healthcare professionals. When asked to self rate their communication skills, 51.4% rated their skills as excellent, 45.9% as good and 28% did not respond. There was a significant difference between nurses and doctors (p < 0.05) with nurses rating their skills higher than those of the doctors. The finding of the study demonstrated that doctors were more opposed to mandatory CST than their nursing colleagues. They recommended randomized control trials to assess the impact of different levels and duration of training.78
Brown R et al (2010) developed a training module and evaluated its effectiveness in discussing prognosis in an oncology setting. The participants completed a two year training module. They also completed a pre and post survey to evaluate their own confidence as well as the helpfulness of the module. The module involved five strategies mainly ascertaining patient’s needs for prognostic information, negotiating with patients the type of information they would like, describe ways to provide information in a sensitive manner, need to respond empathetically to patient’s emotions, and respond appropriately to information cues. The participants’ confidence in discussing prognosis increase significantly when compared before (X=3.46, SD=0.927) and after (X=4.13, SD=0.774) they attended the module (p < 0.001). Around 72% expressed satisfaction about the contents of the module. They concluded that this short training program demonstrated success in improving confidence to discuss prognosis and self efficacy.79

Gough J et al (2009) conducted a study to describe the educational program developed for graduate nurses and to describe the results of the evaluation of the program. They adapted a communication skill simulation program with 57 graduate nurses. This included communication strategies and techniques for nurses to employ when dealing with difficult clinical communication situations. In the 1st stage, a workshop was organized for the whole group. The facilitator led the discussion with a videotape, on good communication. The nurses met in pairs with an actor for 20 minutes and worked through a scenario where one nurse is a parent, the other an observer and the three of them critiqued the communication and gave structural feedback. The post program results showed that the percentage of respondents who felt adequately or very adequately prepared rose from 7% to 51% following participation. A paired ‘t’ test revealed a change of mean score from 3.3 to 4.5. They concluded that the value of communication skill education is indicated by these evaluation results and the measured improvement in participant’s sense of preparedness for practice.80

Rask MT et al (2009) conducted a study on “Effects of an intervention aimed at improving nurse-patient communication in an oncology outpatient clinic”. The study aimed to evaluate a standardized two-day (33 hours) communication skills
training program in a nursing cancer care. In all, 24 nurses in an oncology outpatient clinic participated, and were randomly assigned to the intervention program or a control group. A total of 413 patients treated in the clinic during two recruitment periods (before and after the communication skills training) completed a questionnaire package assessing the nurse-patient relationship, psychological well-being, and cancer-related self-efficacy. Nurse group differences in change scores between time points (baseline, one week, and three months after the communication skills training) on measures related to communication and work-related stress were all non significant. Time-by-group analyses of patient data showed that training did not affect patient perception of nurse empathy and attentiveness, patients’ anxious/ depressed/ angry/ positive mood, as well as cancer-related self-efficacy. The results were unable to support the hypotheses that nurse communication skills training would be associated with improved nurse and patient outcomes.81

Bylund CL et al (2008) developed a workshop for training faculty to facilitate small group role play sessions for a communication skills training program and assess the impact of that workshop on the trainees' self-efficacy about facilitation skills. The findings suggested that the workshop had a significant effect on participants' self-efficacy in facilitating communication skills training. At least 75% of the participants reported feeling comfortable facilitating communication skills training to small groups. They concluded that the facilitation workshop was successful in providing participants with the confidence to successfully facilitate small group role play sessions in communication skills training. Sufficient time for skill practice was needed. Improvement in communication skill training is expected to be reflected in more effective clinical communicators who in turn provide a higher quality care.82

Complexities in nursing documentation were explored by Cheevakasemsook A et al (2006). Analysis revealed that the complexities in nursing documentation include three aspects: disruption, incompleteness and inappropriate charting. Factors that influenced documentation included: nurses’ limited competence, motivation and confidence; ineffective nursing procedures; and inadequate nursing audit, supervision and staff development.83
Edwards N et al (2006) evaluated the communication skill training improvement in nurses’ communication skills after a multiple component intervention that included the RNAO (Registered Nurses Association of Ontario) therapeutic relationship best practice guidelines. The aim of the study was to compare the frequency and quality of selected verbal communication (e.g. active listening, initiating assertiveness) used by nurses before and five months after the BPG recommendation. Before and after design was used. The intervention was implemented in two hospitals and one community care agency. Nurses’ responses were audio taped, transcribed and scored using set criteria. Eight scenarios reflecting an array of post partum case studies were developed by the principal investigator. Each brief scenario was followed by a set of client comments. Twenty two nurses were involved in the study. It was seen that active listening skills were more frequently used than initiating skills. There was a significant decrease in the number of active listening skills used by nurses from pre to post test ($p \leq 0.0001$). There was a significant increase in the use of initiating skills from pre to post ($p \leq 0.0001$). The authors concluded that there were statistically significant improvement in the quality of nurses’ active listening and initiating skills post intervention. These findings provide preliminary support for effectiveness of a mix of several strategies in improving communication skills among nurses.

Fellowes D et al (2003) assessed whether communication skills training is effective in changing behavior of health professionals in cancer care with regard to communication/ interaction with patients. Randomized controlled trials or controlled before and after studies of communication skills training in cancer health professionals, measuring changes in behavior/skills using objective and validated scales were searched through various search engines. Two reviewers independently assessed trial quality and extracted data. Although 2822 references were considered, only two trials involving 232 health professionals were included. One provided an intensive three-day course, and then assessed oncology doctors interacting with a total of 640 patients; the other provided a modular course, and then used role play with oncology nurses for skill assessment. In one trial, course attendees used more focused questions (34% increase, $p < 0.005$), focused and open questions (27% increase, $p = 0.005$), expressions of empathy (69% increase, $p < 0.005$) and appropriate responses.
to cues (38% increase, \( p < 0.05 \)) at follow up than non-attendees. No significant differences were found between attendees and non-attendees in use of leading questions. From baseline to follow up in the same study, attendees had significantly different changes in rates of leading questions (relative risk 0.72, \( p < 0.05 \)), focused questions (RR 1.25, \( p < 0.005 \)), open questions (RR 1.17, \( p < 0.05 \)) and empathy (RR 1.50, \( p = 0.005 \)). The only significant difference in observed communication skills in the second trial was that the trained groups were more in control of the follow-up interview than the untrained group (\( p < 0.05 \)). Both studies investigated differences in summarizing, interrupting and checking, but found none.\(^85\)

Audiotape nursing assessment with patients was undertaken before and after communication skill training course by Wilkinson SM et al (2002) to find the impact of training on nurses’ ability to communicate effectively, and was evaluated according to coverage of nine previously identified key areas of communication. Mean post course scores rose by 5.9 points (\( p < 0.001 \)) to 16.3 (out of a possible 27). All nine individual areas of the assessment showed statistically significant improvement post intervention (\( p < 0.001 \)). The areas showing most improvement were those with a high emotional content. The study demonstrated that an integrated approach to communication skills training has the potential to improve nurses' skills, particularly in emotionally laden areas across the spectrum of roles in cancer care.\(^86\)

de los Rios CJL et al (2002) examined the effects of a nurse-patient interaction training program on the perceived well-being and medical recovery of patients in the critical care unit of a second level care hospital. The program sought to establish specific nurse behaviour such as visual contact, greeting the patient, offering help, physical proximity, praising, smiling, verbal requests, comforting touch, avoiding criticism/yelling/scolding, and ignoring the patient. The effects of the program were measured in terms of patients' perceived well-being, pain, level of satisfaction with nurse care, length of stay in the hospital, as well as instruction following, and approving or thanking nurse behaviour. Behavioural recording involved videotaping nurse-patient interaction through a video camera and recorder controlled by an automatic motion detection device which could get activated at any time within the corresponding area. Medical recovery measures included the scales of the Acute
Physiology Age Chronic Health Evaluation II (APACHE-II) assessment system, the Glasgow Coma Scale, caregiver estimates of apparent emotional state, independence from life-support equipment, reflexes, wound healing and general clinical stability. To assess inter-observer reliability, independent raters examined a random sample of at least one-hour of videotaped nurse-patient interaction in each eight hour hospital shift. Reliability levels exceeded 80% for any given behavioural category or scale estimate. Results consistently indicated both clinical and statistically significant higher scores for the appropriate interaction and recovery measures of experimental participants as compared to those in the waiting list condition. In view of several measures adopted to mitigate alternative explanations of the results, and the practicality, low cost and effectiveness of the nurse-patient program, its use was recommended in the context of health care facilities and conditions in developing nations.  

Fallowfield et al (2001) reported data from a training initiative endorsed by Royal College of Nursing (UK) aimed at helping senior nurses to identify their personal strengths and weakness when communicating, learning new teaching methods and encouraging new teaching initiatives. Nurses with minimum two years experience post registration, working in oncology and having a supervisory/teaching role were included. In all, 129 nurses participated in the course over a two year period. The two day course had teaching materials designed by the authors. The two day course had a maximum of 12 participants led by one facilitator. Prior to initiation of the course, the nurses completed a 32 item questionnaire covering demographic details, previous experience of communication skill training, and a 22 visual analogue scale on which they rated their own confidence in dealing with communication difficulties in oncology and in teaching. The nurses worked on personal communication problem via group discussions, video demonstrations, small group teaching exercises, and role plays with a professional actor. The findings revealed that with regard to general communication problems, the commonest problem was dealing with colleagues (39%), giving complex information and eliciting informed consent (27%). Evaluation of the course revealed that participants found the course interesting (M=9.63, SD=0.75), useful and enjoyable (M=9.48, SD=0.92), informative and highly relevant to their nursing practice (M=9.59, SD=0.75). More importantly, 99% of the nurses said that they would recommend the course to other
colleagues. The authors concluded by reporting that time, experience and previous training had not helped nurses to deal with communication issues. However an educational approach appeared to increase self-confidence in dealing with difficult communication issues. They remarked that communication and management skill are vital components of nursing, and there is an increasing need to provide more resources for effective training in these areas, to ensure the professional and personal well being of nurses.88
2.2 SUMMARY

A review of literature revealed that the life threatening potential of cancer for the patient and the perception of potential or actual suffering impact on nurses, their learning and clinical practice. Language barriers and cultural taboos increase nurses’ discomfort while discussing sensitive topics. Nurses need to recognize the value of short, interactive interaction and chitchat as quality communication for getting to know their patients. Privacy needs to be ensured whenever required. Compassionate attention will improve interpersonal relations. Open communication and accuracy are seen as nurses gain experience. Communication training may help in role clarity, and focus attention on effective teamwork. It will also improve confidence of nurses. Communication efficacy and positive perception of working environment will help to evade emotional exhaustion and promote self actualization.

Communication within oncology can pose a challenging situation but is essential for enhancing care and patient outcome, and this can be achieved by paying attention to the training needs of healthcare professionals. Evidence suggests that experiential methods are more effective than didactic methods of training in communication skills but the studies do not indicate that any one method is superior to others.

Goals attained in each of the studies cited in the review of literature helped the me gain an insight into different research methodologies used, the tools developed and different techniques undertaken - which gave me clarity about the topic under study. It has also helped me to understand different views from varied authors who have undertaken the study on different aspects of clinical communication skills.

The review also helped me understand that clinical communication is an important area especially for nurses, and there is a need to undertake such studies in the future. The review also provided information about various authors seeking solutions for different aspects of clinical communication. The review has given me concept clarity and also helped me choose various techniques I may find useful while planning the actual study.
Research in improving the care of hospitalized patients is of interest to both doctors and nurses. A study of this research and the conclusions it has arrived at, will be the starting point of further improvements in patient care.
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