Good Communication ← ➞ Compassionate Care

CLINICAL COMMUNICATION SKILLS FOR NURSES

- A TRAINING MODULE

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Introduction

“The eyes of men converse as much as their tongues, with the advantage that the ocular dialect needs no dictionary, but is understood the world over.”

Ralph Waldo Emerson

Communication is a vital skill for nurses. We as nurses interact with many people in the course of our profession. Being efficient in communication will help us to maintain an effective relationship with health care personnel and also with patients and their family.

Caring is an important component in nursing. As Morrison & Bernard has rightly quoted “Caring and communicating are inseparably linked. You cannot hope to communicate effectively if you do not care about the person on the receiving end.”

You must have personal experiences where communication is often lacking in our day to day interaction.

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This module will introduce you to communication skills and highlight its importance in your day to day professional (and personal) life. I hope it will enhance the patient – nurse and nurse - nurse interaction.
Aim of the module
This module is designed for nurses. It will enable you to develop personal and professional communication skills, and facilitate you to apply those skills in clinical setting. This will help to create an environment, which will be conducive for your interaction with patients and other nurses, i.e. your colleagues.

Objectives to be achieved
By referring to this module, you will be able to:

1. Define communication
2. Describe the communication process
3. Enumerate the types of communication
4. Describe barriers to communication in the clinical setting
5. Practice skills and techniques that facilitate communication
6. Learn skills for communicating effectively with other nurses using SBAR technique during hands over/off
7. Follow principles of documentation
Cancer is a life-threatening disease. When these patients have to be admitted to hospital for treatment, we are closely involved with patient's concerns, as we provide twenty four hours care. Good communication skills are not only important for relaying information, they are essential for establishing trust and rapport, showing respect for needs and feelings of patient. When encounter with patients are limited by time constraints and workloads, it is even more important to simplify a skill that is never truly perfected.

Therefore communication in nursing is essential making it crucial in achieving good outcome for patients.

What is Communication?
Communication (from the Latin "communis", meaning to share) is the activity of conveying information through the exchange of thoughts, messages, or information, as by speech, visuals, signals, writing, or behavior. It is a continuous, active and complex process.

It is transmitting and sharing of ideas, opinions, facts, and information between persons or groups in such a way that “the meaning received is equivalent to that perceived and understood by the sender”.

Communication process
The communication process consists of five elements:
1. Sender (source)
2. Receiver (audience)
3. Message (content)
4. Channel(s) (medium)
5. Feedback (effect)
1. **Sender** is the person who encodes the message or ideas. Feelings are transmitted through verbal or non-verbal ways. It is the responsibility of the sender to ensure that the message sent is accurate, simple and clear.

2. **Receiver** is the person who receives and decodes the message. The receiver is responsible for attending to the message, interpreting it and responding to the sender's message. The role of sender and receiver changes as two persons interacts, sometimes, sending and receiving concurrently.

3. **Message** is the content of communication. Mode may be verbal, non-verbal or symbolic. Messages are interpreted by those that receive them and respond to them correctly. The response may vary as per individual perception.

4. **Channels** are means of conveying and receiving messages. They include:

<table>
<thead>
<tr>
<th>A). Visual</th>
<th>Facial expressions</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Facial expressions" /></td>
<td>The most expressive part of the body is the face. It reflects emotions / feelings, anger, disgust, fear, happiness, sadness, etc.</td>
</tr>
</tbody>
</table>
The nurses can also convey messages to patients by their facial expression. When patient is awaiting histopathology report, nurses not maintaining eye contact may signal to patient that the diagnosis is confirmed.

### B). Auditory

**Spoken words**

It is important to interpret patient's message based on their cultural background, the settings and tone of voice.

### C). Tactile

**Touch**

It signifies assurance; at times it also provides support when in pain.

**Messages are clearly understood if more channels are used.**

5. **Feedback** is the communication given back by receiver. It reflects whether the meaning of sender’s message is understood.
To be effective, the sender and the receiver must be sensitive and open to each other’s messages, clarify the message and alter their actions accordingly.

"You look funny"

"Yes I look funny"

So, effective communication is:

“When a person interprets a message in the way the sender intended it.”
SECTION II

TYPES OF COMMUNICATION

Communication can be categorized into three different types, depending on the nature of the interaction.

A. Intrapersonal communication: Type of communication whereby a person interacts with himself / herself. This type of communication is intrinsic or reflective.

B. Interpersonal communication: Type of communication where there is one to one interaction or interaction among a small group. This is the most commonly used / practiced form of communication.
For example, while shifting a patient from operation table, there could be an incidence of fall if interpersonal communication is not used effectively.

...and that is why we lift on count of three ...

C. Intergroup communication: Type of communication where interaction between different groups takes place.

When interacting with group, special emphasis is given on clarity of speech as perception of people differ.
FORMS / MODES OF COMMUNICATION

Communication is generally carried out in two different modes: **Verbal and non verbal.** Verbal communication is the use of words in spoken or written form and non verbal is the use of all other forms such as body language, touch etc.

**A) Verbal Communication**

Verbal communication is one way of communicating with people face-to-face. It is important because we consciously use the words we speak. Consider the following while communicating with patient

- **PACE**
- **TONE OF VOICE**
- **CLARITY AND BREVITY**
- **TIMING AND RELEVANCE**
- **CREDIBILITY**
- **HUMOR**

1. **Pace:** A slow pace reflects gentleness and caring

   Remember the LISTENER needs time to hear and digest.
   PAUSE when you want to emphasize an important point.
   WATCH AND LISTEN to cues like nodding or restating of information to ensure that the MESSAGE is understood.

2. **Tone of voice** reflects mood or effect of spoken words. It can be of high pitch (Loud) or low pitch (soft). Heavy tone reflects enthusiasm or anger. Pitch should vary depending on situation.

   “Your bed is wet.”  “I need to change your sheets.”

Close your eyes. Imagine you are communicating the above statements using expressions of disbelief, confusion, or anger.

What would be the patient’s reaction?
Seeta is tired from sleep deprivation and working over time. The patient in her care has been calling for pain relief. Pay attention to Seeta’s communication skills.

Focus on the words and emotions when communicating with patients.

3. Clarity and Brevity
Communication should be clear and concise. Communication is effective or complete when it contains all the necessary information needed for the result you desire.

You are going to be NBM from today night. **X**

You are not to eat or drink anything from 10 pm today. **✓**

Say as little as possible to get your point across.

Small messages are easier to understand.

Speak in a language that patients understand.

Avoid use of medical words like void, colon, sterile, stool.
4. Timing and Relevance

Even though the message is short and clear, it will not be understood if the timing is not appropriate. The message need to be related to interest / concern of the person.

A patient is anxious about the impending surgery for Cancer Colon. The instructions given by the nurse about the Ryle’s tube insertion may not be heard. According to the patient, those instructions are not relevant at that point of time.

*Identify the cues and encourage patients to express their concerns*

**Example:** You have to give instructions to patient on need to swallow when inserting Ryles tube. Patient looks anxious.
Nurse: You seem to be worried. Is something bothering you? Would you like to talk about it?

Once the concerns are expressed and patient is comfortable, then you can provide the necessary instructions.

5. Credibility

Credibility means being trustworthy and reliable. Communication is influenced when a supportive relationship based on trust is established. If the nurse is trustworthy, they will share information. If a nurse is attentive to the patients needs, they may also share information due to a feeling of gratitude.
Credibility is improved by timely response and by providing correct facts for which the nurse should be knowledgeable.

**Example:**
Patient: I was to be taken for surgery at 8 am. What is the reason for delay?
Nurse: I don’t know, but I will find out and let you know.
This response is more credible than an incorrect answer or a guess.
Be sure to find out and explain the cause of delay to the patient.
If you have told a patient that you will be back with the pain medication, but do not do so, till the patient / relative reminds you again an hour later, they may doubt your credibility.

Non-verbal expressions must match with spoken words,

**Example:**
Patient: (with a necrosed flap) Is my wound ugly?
Nurse: (frowning) The wound looks good.
The patient will be watching your expressions. In the above interaction, the patient will realize that you are not being honest.

Your verbal and non verbal expressions must match for credibility.

**6. Humor**
We have heard that laughter is the best medicine. Humor can have a positive influence on healing. Humor is highly subjective and depends on cultural norms.

You may share a joke or funny situation with the patient.

Ensure that the timing for humor is appropriate.

Do not direct humor at the patient, his disease process or the health professional team.
B) NON-VERBAL COMMUNICATION

In our day to day communication with others, only 7% is verbal while the remaining 93% of communication is non-verbal. Non-verbal communication includes voice inflection (38%) and facial expression including body language (55%).

Voice inflection includes alteration in pitch or tone of voice. Body language includes gestures, postures and facial expressions by which a person shows various physical, mental and emotional states and communicates non-verbally with others. Non-word sounds such as “ah” and “hmm” is also a part of non-verbal communication.

Non-verbal behavior enhances communication. While it is often given secondary importance, it is much more important than verbal communication. It includes a series of body languages.

Non-verbal communication either reinforces or contradicts what is said verbally.

Non-verbal behavior enhances communication. While it is often given secondary importance, it is much more important than verbal communication. It includes a series of body languages.

BODY LANGUAGE

- Posture
- Facial expression
- Gestures
- Silence
  - Head motion
  - Eye contact
  - Touch
Features of Body Language

1. Posture

- **Relaxed** - Self assurance, well being
- **Slumped** - Fatigue, low self esteem
- **Rigid** - Tension

2. Head motion

- Head nodding suggests paying attention, acknowledging.
- In some cultures, it suggests ‘Yes’ but in others ‘No’!

3. Facial expressions

- The most expressive part of the body is the face.
- Facial expressions communicate joy, anger, sadness, concern and fear.
- Smiling is a positive expression that is understood universally.
4. **Eye contact**

- Expressions from shock to alarm, joy to surprise are all readable due to expressions of the eye.
- You can convey interest in, but also disagreement, suspicion, anxiety, boredom, shyness, and low self esteem through the eyes.
- Maintaining eye contact gives the impression of honesty and trustworthiness. It is important in initiating, encouraging, and terminating communication.
- In some cultures, minimal eye contact is a sign of respect / politeness.

5. **Gestures**

- Actions communicate particular messages, either in place of speech or together and in parallel with words.
- Gestures include movement of the hands, face or other parts of the body.
- Gestures are a crucial part of everyday conversation such as chatting, describing a route, etc.

6. **Therapeutic touch:**

- Touch as a therapeutic measure, while providing care or during procedures.
- It is important for nurses to practice touch with emotions.
- Rough and careless touch indicates lack of concern.
- Before you touch a patient, ask yourself:
  - What is the purpose?
  - Is it appropriate?
  - How might the individual interpret the touch?
7. **Using Silence**

- Sometimes silence is needed for us and patient to observe one another, sort out feelings, think and consider what has been communicated.
- Silence also allows us to pay attention to non-verbal messages from patients like worried expression or avoiding of eye contact.
- Sounds such as signs, moans, groans or sobs also communicate feeling and thoughts. Sounds can be interpreted in many ways. For e.g. Crying can communicate happiness, sadness or anger.

*Silence shows acceptance and allows patients to compose their thoughts and feelings.*

8. **Proxemics** is the use and interpretation of space in communication.

- The space between people can establish how close or intimate a conversation is.

**Zones:**
- Intimate = 0-18”, body heat, smell, touch
- Personal = 18-48”, voice change, contact.
- Social = 4-12’, formal interaction
- Public = >12’, gestures exaggerated
9. **Personal space** is an important issue in the hospital and other work area.

- A nurse who walks into a room without permission may be seen as aggressive. In a general ward where space is a constraint, this may not be visibly evident.

- Everyone has a different need for personal space. A person’s personal space may be culturally determined and therefore it is essential for us to respect patient boundaries.

10. **Personal appearance**

- One of the first things noticed during interpersonal communication is the personal appearance. Impression about a person is made within 20 seconds – 4 minutes.

- Nurse’s and patient’s dressing and grooming can be a source of information. Threads or talisman/amulet may be worn for religious purposes. Nurse may enquire about these to establish communication with patient.

- Person who is feeling ill may not pay attention to their personal appearance.

- Requesting for a shave or hair wash maybe a signal that patient is feeling better.

*Our nonverbals govern how other people think and feel about*
Some of the common body movements used and their meanings:

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Body movement/ gestures</th>
<th>Indicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nodding</td>
<td>Agreement</td>
</tr>
<tr>
<td>2</td>
<td>Bowing</td>
<td>Respect / Thanks</td>
</tr>
<tr>
<td>3</td>
<td>Shaking one’s head</td>
<td>Disagreement</td>
</tr>
<tr>
<td>4</td>
<td>Shrugging one’s shoulders</td>
<td>I don’t know</td>
</tr>
<tr>
<td>5</td>
<td>Jumping</td>
<td>Happiness / excitement</td>
</tr>
<tr>
<td>6</td>
<td>Patting on one’s shoulder</td>
<td>Appreciation</td>
</tr>
<tr>
<td>7</td>
<td>Hugging</td>
<td>Showing care / sympathy</td>
</tr>
<tr>
<td>8</td>
<td>Gaping</td>
<td>Astonishment</td>
</tr>
<tr>
<td>9</td>
<td>Frowning</td>
<td>Dislike / displeasure</td>
</tr>
<tr>
<td>10</td>
<td>Wincing</td>
<td>Is in pain</td>
</tr>
<tr>
<td>11</td>
<td>Clenched fist</td>
<td>Anger</td>
</tr>
<tr>
<td>12</td>
<td>Thumbs up</td>
<td>Approval</td>
</tr>
<tr>
<td>13</td>
<td>Thumbs down</td>
<td>Disapproval</td>
</tr>
<tr>
<td>14</td>
<td>“V” sign</td>
<td>Victory / success</td>
</tr>
<tr>
<td>15</td>
<td>Open posture (keeping the trunk of the body open and exposed)</td>
<td>Friendliness / openness / willingness</td>
</tr>
<tr>
<td>16</td>
<td>Closed posture (keeping the trunk hidden, lurching forward and arms and legs crossed)</td>
<td>Hostility / unfriendliness / anxiety</td>
</tr>
</tbody>
</table>

Expressions often encountered when dealing with people:
The patient can communicate using silence, gestures, eye movement, posture and vocal cues. Vocal cues refer to pauses, loudness and tone of speaking voice, which can indicate a range of emotions from anger to nervousness.

You should interpret behavior such as fidgeting, clenching fists, avoidance of eye contact or physical contact and respond to the non-verbal message.

**REMEMBER**

You can “communicate” without saying a word!!
Pay attention to how you communicate non-verbally!

**Be sure the messages that you send are truly what you want to convey!**
Observation is an important non-verbal skill for nurses. "But if you cannot get the habit of observation one way or other, you had better give up the [idea of] being a nurse, for it is not your calling, however kind and anxious you may be." Florence Nightingale

Observation refers to the deliberate use of all five senses to gather and interpret patient and environmental data.

Exercise: Seeing and Looking

Objective: To know the difference between seeing and looking.

Look at the pictures below and note the differences

In nursing, interacting with patients requires that all three channels need to be actively used to identify a situation / problem. We observe when we have an objective to do so. Use DHEPD (Do Help Every Patient Deliberately), when you enter a patient’s room.
D - Distress- observe for signs of pain, pallor, labored breathing
H - Hazards- safety hazards like spills, equipment, cords, sharps.
E - Equipment – IV running, catheter draining, O₂ working
P - People with patient and what they are doing
D - Details: Check the patient’s appearance, condition or other clues that may indicate a need for care.

Now look at the pictures and write the 10 differences:

1. .................................................................
2. .................................................................
3. .................................................................
4. .................................................................
5. .................................................................
6. .................................................................
7. .................................................................
8. .................................................................
9. .................................................................
10. .................................................................

What was the difference between the first spotting of differences and the second?
The difference between seeing and looking is that looking has an objective, while seeing is general. Eyes play an important role in communication. When we wish to communicate effectively, we must remember that visuals should require an objective for them to make sense to the receiver.

Looking at people and making eye contact are the first steps towards striking up relationships and making positive
Importance of non-verbal communication in an oncology setting

- Patients diagnosed with cancer are disturbed or depressed, and may not be able to communicate. It is important for the nurse to interpret the non-verbal communication and intervene appropriately.

- The treatment modalities in some cancers may temporarily affect the patient’s verbal communication ability, and therefore the patient is at a loss about how to communicate verbally. The patient who is intubated and on a ventilator is unable to speak and inform the nurse what his needs are.

- The patient may be attached to a monitor. A rise in heart rate and blood pressure along with restlessness and trying to reach for the ET tube may show that the patient has some discomfort. For e.g. pain or obstruction of the airways.

- During such times, the nurse needs to be able to interpret the feelings or signs the patient is trying to express non-verbally.

- The nurse also needs to clarify observations, indicating to the patient that the nurse is caring and thus able to establish a trusting relationship with patient. For example the nurse may say “You look as if you have been crying. Is something bothering you?

- The nurse entering the patient’s unit with an unwelcoming / grim expression and not including the patient in care is also a form of non-verbal communication which can be disturbing to the patient.

**The nurse uses communication skills all day. It is an essential part of nursing.**
SECTION III

BARRIERS TO COMMUNICATION

Communication barriers are interferences or obstacles which limit the receiver’s understanding of messages, and thus can halt or distort communication. They are physical barriers, personal barriers and language barriers. The different communication barriers are detailed below:

1) Physical barriers

- Physical distance
- Distracting noise
- Frequent interference
- Lack of privacy
- Pain
- Hearing Problem
- Tiredness

Communication is prone to misunderstandings because
- the messages are complex,
- the situations are unpredictable
- individual differences can often separate the sender and receiver.

When communicating with hearing impaired persons, you must face them.
2) **Personal barriers**

- Emotions like anger, anxiety, grief, resentment
- Changing subject
- False or inappropriate assurance
- Judgmental attitude
- Unconcerned attitude
- Ego
- Selective listening

**Behavior cues to anxiety are**

- Quick and agitated movement
- Tense muscles
- Trembling extremities
- Rapid speech
- Increased or decreased talking
- Irritability
- Making trivial demands

3) **Language barriers**

- Language, dialect
- Words having different meanings

**Example of words having different meanings:**

Ward in-charge noticed a banana peel lying on the floor.
She instructed the housekeeping boy to remove the peel immediately.

The boy was mopping the floor where a patient had vomited.
He nodded his head to indicate that he would remove the banana peel, but continued mopping.

Just as he finished mopping, a patient slipped on the banana peel.
The ward in-charge was angry as this accident could have been avoided.

*For the ward in-charge* - immediately meant “AT ONCE”
*For the housekeeping staff* - he would remove the peel, after completing the job in hand.

**The speaker and receiver must understand the words - in the same sense.**
Attention must be paid to overcome all these barriers!
Scenario 1.

All three patients have difficulty with communication

1. Introduce self
2. Greet the patient
3. Explain the procedure to the patient, even if he is not able to respond
4. Provide the patient with a pen and paper if he is literate
5. Provide placards with words written on them. For e.g. I have pain / I have difficulty breathing / I am hungry / I am not feeling fine
6. Arrange for a translator if the language is not understood
7. Make sure that assistive devices like glasses or hearing aids are kept within reach
8. Involve the family in the conversation.
9. Provide adequate explanation regarding their diet, treatment, medication and use of devices to patients in a language that they understand.
I am sure you will also be able to recollect such incidences where an effort at communicating with patient would have resolved a lot of problems.
SECTION IV

SKILLS THAT FACILITATE COMMUNICATION

TEN COMMANDMENTS OF COMMUNICATION

- Listening
- Being assertive
- Restating and clarifying messages
- Open ended questions
- Silence
- Imparting information
- Empathy
- Respect
- Warmth
- genuineness

The skills that facilitate communication are

1. Listening

“We have two ears and one mouth so that we can listen twice as much as we speak.”

Epictetus quotes

Verbal communication is speaking + listening.

Listening is often a neglected aspect of effective communication. Instead of listening, we often

- Interrupt, and start talking because we have jumped to a conclusion about what the other person is going to say;
Begin thinking about our response, which blocks our ability to “hear” the message; or

- Ignore the person and their message.

**Listening is not the same as hearing.**

**Types of Listening:**

I. **Attentive listening** occurs when the listener not only listens and is able to answer questions, but also understands the significance of the message.

“So when you are listening to somebody, completely, attentively, then you are listening not only to words, but also to the feelings of what is being conveyed, to the whole of it, not part of it”.

Jiddu Krishnamurthi, IZ quotes

II. **Empathic listening:** When the listener does not necessarily agree with the speaker, but deeply understands that person emotionally and intellectually. This is the highest form of listening and is often referred to as being in “someone’s shoes”.

**The responsibility for ensuring that the listener gets the message lies with the sender.**
III. **Selective listening:** This is when a person hears another, but selects to not hear what is being said by choice or desire to hear some other message.

### Some barriers to active listening

1. We have predetermined attitude and assumptions about person/subject matter to be discussed.
2. We are preoccupied with our own thoughts.
3. We are completing the other person’s thoughts and jumping to conclusions.
4. We feel too tired, anxious, or angry to listen actively.
5. We don't pay enough attention to body language, rate of speech, emphasis, or tone.
6. We are in a hurry.

One formula that has proven to enhance listening skills is portrayed by the acronym LADDER.

- **L** - Look at the person.
- **A** - Ask questions
- **D** - Don’t interrupt
- **D** - Don’t assume
- **E** - Emotions (check yours)
- **R** – Repeat / Restate message

The application of the LADDER formula will lead to both better communication and enhanced relationships.

**EXAMPLE:**

Mrs. Saroj has undergone surgery Brain tumor and was left with loss of motor function. Sarita was the assigned nurse. While expressing her feelings about the illness, Mrs. Saroj said “I used to be the best teachers in the school. I have won many awards”. Sarita quickly replied: “Oh many people go back to their normal lives. You also will be the same ok. Mrs. Saroj stopped talking & did not speak about her feeling again.
Sarita did not acknowledge the need for Mrs. Saroj to tell her story/feeling. She wanted to say the right thing and choose a response that ended the conversation. It made Mrs. Saroj feel that her problem was unimportant.

There was no need for Sarita to respond. She simply needed to listen and paraphrase throughout the conversation, which would demonstrated that she was listening. In addition to listening to the content, we should also observe for nonverbal communication like eye contact, body language.

2. Being assertive
Assertiveness is the ability to express ones beliefs or feelings without violating another’s right.
When an argument erupts, the aggressive person might demand that they are right and others are wrong. Submissive people will be quiet even if they are right. Assertive person ensures that no one loses.

**Examples of different behaviors**

Aggressive
Don't talk to me like that. Do you know how much of work load we have? I have other patients also to look after.

Submissive
I am Sorry. I will be on time now.

Assertive
I am sorry that you are angry. Let me explain to you, the reason for delay.

You are late. This is unacceptable and I am going to complain.
### Examples of Non-Verbal Behavior

<table>
<thead>
<tr>
<th>General Attitude</th>
<th>Non-Assertive / Submissive</th>
<th>Assertive</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not saying much but hoping someone will guess what you want.</td>
<td>Paying close attention to what is being said</td>
<td>Exaggerated show of strength</td>
</tr>
<tr>
<td></td>
<td>Looking like you don’t mean what you say.</td>
<td>Assured manner</td>
<td>Sarcastic style</td>
</tr>
<tr>
<td></td>
<td>Willing to lose.</td>
<td>Showing concern and strength</td>
<td>Air of superiority</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seeking fairness</td>
<td>Need to win</td>
</tr>
</tbody>
</table>

| Voice | Weak, hesitant, soft, rising inflection at end of statements. | Firm, warm, well modulated, relaxed | Tense, loud, cold, shrill, "deadly" |

| Eyes | Downcast, pleading, teary, looking away | Making eye contact but not staring | Narrowed, cold staring |
|      | | | Expressionless, as though looking through you |

| Body Posture | Stoopied, head down | Well balanced, straight on | Stiff and rigid |
|              | Excessive nodding in agreement | Erect and relaxed | Feet apart |
|              | | | May cross arms or have hands on hips |

| Hands | Fidgety | Relaxed gestures | Finger pointing |
|       | Clammy | | Clenched fists |
|       | | | Abrupt movements |

Source: University of Wisconsin Oshkosh Counseling Center (Printed with permission)

Maintaining eye contact, keeping your hands to your sides, relaxed facial muscles, listening to others, showing respect are all forms of assertive behavior.

**Example:**

A fifteen year old boy Ganesh was operated for Glioma and is on the ventilator. The doctor explained to the father that the prognosis of the child is poor. Every family member, friends and relatives (around 25 people) are gathered outside the ICU. They are upset because he is a teenager and it is difficult to accept that he may not be able to see tomorrow.
Relatives: (angrily) He is the only son in our family. All of us want to be near his bed during this critical time in our lives.

In the above situation, an assertive nurse will first introduce himself / herself

Nurse: I know it is a difficult time for all of us. It is not advisable to crowd near his bedside but 2-3 family members can in turn visit him. I will keep you updated about his condition.

**Some reasons for lack of assertiveness**

*Low Self-Esteem and Self-Confidence:* Feelings of low self-esteem or self-worth often lead to individuals dealing with other people in a passive way.

*Roles/Gender:* Certain roles are associated with non-assertive behavior, for example low status work roles or the traditional role of women. Stereotypically, women are seen as passive, while men are expected to be more aggressive.

*Past Experience:* Many people learn to respond in a non-assertive way through experience or through modeling their behavior on that of parents or other role models.

*Stress:* When people are stressed they often feel like they have little or no control over the events their lives.

*Personality Traits:* Some people believe they are either passive or aggressive by nature, in other words that they were born with certain traits and that there is little they can do to change their form of response.

3. **Restating and clarifying messages**

   *Restating* means summarizing the message you have received from the patient in your own words. This demonstrates active listening and concern.

   Patient: “Yesterday night I could not sleep. I stayed awake all night”.
   Nurse: “You had difficulty sleeping”?

   *Clarifying* means ensuring that you have interpreted the message correctly.

   Patient: Cancer is a dreadful disease. I have three small children. I want to be present when they grow up. Patients with cancer always die.
   Nurse: Do you fear that you will not be there to see your children’s future?
4. **Open ended questions**

Open-ended questions are those questions that will seek additional information from the patient. Uses: What, How, Where, Why, When.

Closed ended questions are those questions, which can be answered finitely by either “yes” or “no.”

<table>
<thead>
<tr>
<th>Open ended questions</th>
<th>Closed ended questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How may/can I help you?</td>
<td>May I help you?</td>
</tr>
<tr>
<td>What kind of information are you looking for?</td>
<td>Are you looking for some information?</td>
</tr>
<tr>
<td>What do you want to know?</td>
<td>Is there any more information you need?</td>
</tr>
<tr>
<td>What are you trying to understand?</td>
<td>Does this answer your question?</td>
</tr>
</tbody>
</table>

Ask open ended questions and thus encourage the patient to answer by describing the event, thoughts or feelings.

**Example:**

Nurse: How about your children?
Patient: My sister has been kind to stay with me during this period of illness.
Nurse: You said you were anxious yesterday. How are you feeling today?
Patient: Today I am feeling better. My pain has reduced and I slept well.
Do you like to talk about it?

5. **Using silence**

Many people feel uncomfortable with silence. When used appropriately, it helps patient to organize thoughts and respond to questions. *Silence* shows acceptance, and allows patients to compose their thoughts and feelings. It is especially important when a patient is upset.

6. **Imparting information:** giving facts when the patient asks or seeks information through health education, or individual interaction. This will help to relieve fear and anxiety and promote adherence to treatment.
Example:
Nurse: I will be showing you how to change your colostomy bag.
Patient: I am worried about the soft watery stools.
Nurse: This will occur for two days and will change to soft stool once you take your full diet.
Patient: What about the odour. Will it affect my surrounding.
Nurse: The colostomy bag is fitted with a charcoal filter which will absorb the odor and thus will not be noticeable.
Patient: I am so glad. I was worried about the odor.

7. **Empathy**: is to understand and be sensitive to feelings, beliefs and situation of others.

**Example**
*Patient*: I am really worried about the MRI. Is it painful?
*Nurse*: It is upsetting to have a test you are unaware of. I wonder if the outcome of the investigation is worrying you.

8. **Respect**: communicates belief in a patient.

**Example**
*Patient*: The nurses treat me like a child. Everyone just tells me what to do without asking my opinion.
*Nurse*: You are angry because you are not included in decisions regarding your care. I will certainly discuss this with all the staff members, so that they become aware and include you in the planning of care. (Communicates that patient is worthy and nurse is willing to make extra effort.)

9. **Warmth**: conveys genuine caring. Warmth is communicated mainly through the use of non-verbal behavior. Also, words such as, “You’re really in pain; let me do what I can to help”.

**Example**
*Patient*: I just want to go home just now. (Urgent voice tone, tense facial muscles.)
*Nurse*: Sits down next to the patient. Do you want to talk about it? (Voice shows concern)
10. **Genuineness**: is the ability to respond honestly.

**Example:**

*Patient:* Does it ever bother you to see all the blood and wound? (Patient asks as nurse changes a dressing).

*Nurse:* Yes, sometimes it really bothers me, but this is a temporary process and a part of getting well. It is satisfying to be a part of it.

A nurse must be able to communicate genuineness, caring and warmth to the patient in ways that are non-judgmental.

**Facilitating communication in day to day nursing work.**

**Example: Admission Process.**

1. Introduce yourself to the patient and relatives.
2. Greet patient and address patient by name or Mr/Ji.
3. Maintain pleasant expression while interacting with patients & relatives.
4. Maintain eye contact with patient.
5. Initiate conversation by using open ended questions.
7. Restate the main message.
10. Orient patient and family to surrounding.
11. Answer patient / relatives queries if any.

**Points to remember**

- **Verbal communication is effective when pacing, tone clarity, brevity, timing and relevance and credibility is met.**
- **Verbal communication and non verbal communication happens simultaneously and therefore attention should be paid to the spoken words and emotions/feelings.**
- **Words of encouragement along with non-verbal gestures are more likely to give a positive feedback to patients and may**
  - Encourage patients to participate in discussion
  - Allay fears and give reassurance
  - Show openness and warmth
  - Reduce nervousness in patients.
- **Use of active listening, assertiveness, restating/clarifying messages, open ended questions, silence, imparting information, empathy, respect, warmth and genuineness facilitates communication.**
REAL LIFE SCENARIO - Nurse – Patient Communication

What does the following communicate? What measures will you follow?
1. A patient has undergone neurosurgery. While talking, you notice that he has slurred speech on 2nd post-op day:
   a. Understand that this is a normal phenomena
   b. Check for muscle weakness. Use a GCS.
   c. Understand this as a sign of confusion. This is normal after surgery.
   d. Ignore the slurred speech. Patient will regain normal speech in a week’s time.

2. Patient on anti coagulant therapy is bleeding from the dressing site and gums: on inquiry with the patient, you are informed that this has started from the time the new medication has been started. You will
   a. Report to the supervisor.
   b. Familiarize self with effects of anti-coagulant therapy, observe for signs of bleeding and notify physician.
   c. Ignore the bleeding - it will stop once the drip is over.
   d. Assess and stop the infusion drip.

3. Patient on prolonged bed rest complained to you about tenderness and warmth in calf: you will
   a. Encourage patient to wear TED stocking or place patient on sequential compression device (SCD).
   b. Educate patient on use of TED.
   c. Document patient teaching on use of TED.
   d. All of the above.

4. You have hung an IV infusion with KCL. Patient says “since you hung that medication, my arm really hurts”. You will
   a. Inform the patient that this is as per Doctor’s orders and needs to be followed.
   b. Stop the IV infusion, flush with normal saline, document and notify physician.
   c. Inform that it is normal to feel burning sensation when KCL is added.
   d. Notify the in-charge.

5. A patient is in the ICU and is disturbed by the constant beeping of the alarms. The relative requests you to switch off the alarm.
   a. Turn off the alarm so that patient sleeps comfortably.
   b. Explain to the patient when oriented that the alarm is switched on for their own safety.
   c. Keep the relative away from the unit.
   d. Report to the in-charge.

Answer key: 1.( b ), 2.( b ), 3.( d ) 4.( b ), 5.( b ).
SECTION V

COMMUNICATION BETWEEN NURSES
HANDOVER USING SBAR

“Fundamentally who we are and how we work together is what our patients receive.” Nancy Moore, 2000

A Nurse's Role

A Nurse has a very important role to play in the Clinical setting. There are many Challenges to face in the Shift.

Communication skills are a major part of a nurse’s day

You are responsible and accountable for the patients assigned to you. Once your shift is complete, you need to transfer this responsibility to the next shift personnel. This is called as handoff or hand over.

Handoff should be carried out without interruptions.
Hands off is the passing of the care of one or more patients to nurses working on the next shift, by informing them of

1. tests ordered,
2. response to treatment
3. recent changes in condition and circumstances,
4. plan of care including potential problems
5. management issues and
6. Evolving or resolving problems.

*In addition, both responsibility and authority are transferred.*

The purpose of ‘Hands off’ is to provide information about the patient that is correct, complete and clear to the receiver, thereby reducing time wastage, minimizing errors and thus improving patient well being.

The transfer of information can take place in any setting where patient care is transferred from one healthcare professional to another, even if it is for a short duration.

- Nursing shift changes
- Temporary coverage by another nurse
- Transfer from one ward to another
  - One department to another.
Result of Ineffective Hands off

During Handoff:
1. The highlights of patients are discussed during a common gathering. Sensitive issues like test reports, DNR, social and family issues to be discussed here.
2. The outgoing nurse and incoming nurse visit their patients at bedside.
3. The outgoing nurse introduces the incoming nurse to patient.
4. The incoming nurse greets the patient.
5. Handover is carried out using the SBAR format.
6. The outgoing nurse discusses the patient conditions/complaints
7. The plan of care is discussed with incoming nurse
8. Discuss any referrals or reports that are awaited.
9. The incoming nurse checks for drainage tubing, IV infusions, IV site, suture site, flap etc.
10. The medication sheet, TPR sheet, I/O chart and nurses progress sheet is reviewed
11. Involve patient in discussion. ask patient if they have any questions
12. The incoming nurse should inform patients what to expect in next shift.
13. Ensure that the handover is complete without interruption/distractions, only relevant information’s are discussed and only patient’s relative is present during handover.
Example
The handover can be carried out using the SBAR technique.

S: Situation. Mr. Kishore Nadar diagnosed as Cancer of Buccal Mucosa, is admitted today morning.

B: He is a known diabetic and is on treatment for the last 5 years. He has brought his medications with him.; he has no known allergies. His blood sugar is 272mg/dl.

A: Vital parameters are normal. His pain score is 2.

R: He has a physician reference. Dr. Dev will see him at 4pm. Do collect the biochen reports before his arrival.

**SBAR**, an acronym that stands for

*Situation,*

*Background,*

*Assessment,*

*Recommendation,*

is a technique used for prompt and appropriate communication in the healthcare organization.

*This SBAR tool was developed by Kaiser Permanente.*

SBAR it is a structured communication tool that promotes critical thinking and provides an opportunity to clarify doubts.

It is an easy to remember technique that plays a situation in a predefined framework.

It allows easy and focused communication among team members.

The person starting the communication must plan ahead on what information need to be conveyed, so that information is transmitted in a clear organized manner. Make sure you have all information in SBAR format.
Communication using SBAR: Nurse - Nurse

For example, a patient is prepared for Hickmans insertion in the ward and then transferred to the OR for surgery. The ward nurse would give the essential data to the circulating nurse in the SBAR format:

- **S**: 10-year-old male scheduled for Hickmans insertion at 11:00 a.m. today.
- **B**: Has no known drug allergies, no underlying health problems or past surgical history. He had an older sibling who died recently in a car accident, and patient's mother is emotionally distraught with her child undergoing general anesthesia for surgery, no matter how routine.
- **A**: Temperature 98.4° F (36.9°C), Pulse 100, Respirations 24, Blood Pressure 110/60. Child has voiced no concerns about surgery or “going to sleep” for surgery.
- **R**: Should do fine with the OR, however will need to keep in communication with the mother to allay her concerns.

READ BACK

If an order is given telephonically by doctor, (not encouraged except in emergency situations), then use read back strategy.

A read-back is a communication strategy used to verify information exchanged. The strategy involves the sender initiating a message, the receiver accepting the
message and confirming what was communicated, and the sender verifying that the message was received.

Typically, information is called out anticipating a response on any order that must be checked back.

A nurse is accepting a telephone order from a physician: "Give amoxicillin 875 mg every 12 hrs for 7 days." The nurse verifies and validates the order by recording it directly into the chart and reading it back to the physician, "Okay, Doctor, that was amoxicillin 875 mg every 12 hrs for 7 days?" The physician acknowledges the information with a check-back, "Yes, that is correct."
### EXAMPLE OF HANDOVER FORMAT USING SBAR

**DATE:** _____________  
**WARD:** ____________________

<table>
<thead>
<tr>
<th>S</th>
<th>B</th>
<th>A</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients name:</td>
<td>Unit:</td>
<td>Relevant Past History:</td>
<td><strong>Documentation of above parameters should be recorded in the nurses progress sheet</strong></td>
</tr>
<tr>
<td>Age:</td>
<td>Reg no:</td>
<td>Medications, Blood products: (Refer to medication sheet)</td>
<td></td>
</tr>
<tr>
<td>DOA:</td>
<td>DOS:</td>
<td>Urine: continent/Incontinent/Foleys/urostomy</td>
<td></td>
</tr>
<tr>
<td>Diagnosis:</td>
<td>Surgery:</td>
<td>Bowel: opened/ incontinent /Ostomy</td>
<td></td>
</tr>
<tr>
<td>Allergies:</td>
<td>Sensory impairment:</td>
<td>Mobility: Restricted/Unrestricted</td>
<td></td>
</tr>
<tr>
<td>Co-morbidity: diabetes/hypertension/other(specific)___________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet: FD/DD/RT/SRD/special orders</td>
<td></td>
<td>Co-morbidity: diabetes/hypertension/other(specific)___________</td>
<td></td>
</tr>
<tr>
<td>Lines: Arterial/Central/Hickman/PICC</td>
<td>IV fluid due: _____ drops/min_____</td>
<td>Lines: Arterial/Central/Hickman/PICC</td>
<td></td>
</tr>
<tr>
<td>Breathing: Normal/Rapid/slow/labored/audible wheeze</td>
<td></td>
<td>Breathing: Normal/Rapid/slow/labored/audible wheeze</td>
<td></td>
</tr>
<tr>
<td>Skin: Rash/cold/moist/hot/warm/edematous. Bedsore: Absent/Present: Grade I/II/III/IV</td>
<td></td>
<td>Skin: Rash/cold/moist/hot/warm/edematous. Bedsore: Absent/Present: Grade I/II/III/IV</td>
<td></td>
</tr>
<tr>
<td>Surgical incision: Intact/redness/discoloration/oozing/gaping/other___________</td>
<td></td>
<td>Surgical incision: Intact/redness/discoloration/oozing/gaping/other___________</td>
<td></td>
</tr>
<tr>
<td>Flap: Warm/cold/discolored</td>
<td></td>
<td>Flap: Warm/cold/discolored</td>
<td></td>
</tr>
<tr>
<td>Communication difficulty: yes/no</td>
<td></td>
<td>Communication difficulty: yes/no</td>
<td></td>
</tr>
<tr>
<td>Drains: yes/no color of drain: normal/ abnormal</td>
<td></td>
<td>Drains: yes/no color of drain: normal/ abnormal</td>
<td></td>
</tr>
<tr>
<td>Pain score:_____ GCS score: ____Fall risk: yes/no</td>
<td></td>
<td>Pain score:_____ GCS score: ____Fall risk: yes/no</td>
<td></td>
</tr>
<tr>
<td>Any recent change in patients condition/complaints</td>
<td></td>
<td>Any recent change in patients condition/complaints</td>
<td></td>
</tr>
<tr>
<td>Investigation / Reports pending</td>
<td></td>
<td>Investigation / Reports pending</td>
<td></td>
</tr>
<tr>
<td>Critical results intimated to concerned doctors</td>
<td></td>
<td>Critical results intimated to concerned doctors</td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td></td>
<td>Referrals</td>
<td></td>
</tr>
<tr>
<td>Any special restriction: isolation/DNR/NBM/Donot charge drain</td>
<td></td>
<td>Any special restriction: isolation/DNR/NBM/Donot charge drain</td>
<td></td>
</tr>
<tr>
<td>Plan of care: (what needs to happen in next shift)</td>
<td></td>
<td>Plan of care: (what needs to happen in next shift)</td>
<td></td>
</tr>
</tbody>
</table>

**HANDED OVER BY**

**MORNING:** ___________ CC NO:_________ TO _________ CC. NO_________

**EVENING:** ___________ CC NO:_________ TO _________ CC. NO_________

**NIGHT:** ___________ CC NO:_________ TO _________ CC. NO_________
Documentation is the act of recording patient’s status and care in a written form. In the health care setting, this documentation is in patient's records. Documentation is essentially communication, that reveals the patient's current health status, the treatment provided, response to treatment and nursing care given.

For nurses, the documentation may be in progress sheet, nurse’s record, TPR sheet, GCS sheet, checklists, medication sheet etc. All relevant information relevant to the patient including nursing care should be documented in a timely manner.

For eg:

Mr. Mulla diagnosed with cancer lung, is admitted in the medical ward with dyspnea, wheezing, cough and hemoptysis.

10 am: Oxygen inhalation started with 4L/min using nasal cannula (signature)

10.15 am: Seen and examined by Dr. Yadav. Inj Lasix 40mg IV stat given. (signature)

Proper documentation is an important part of Good Communication Skill.

You are responsible for documenting the care you provide. Never chart the action of others, as though you have done it.
Many Hospitals are adopting computerized patient record.

The following points should be followed when charting on a computer.

1. Do not leave patients data displayed on computer screen. This is a breach of confidentiality.
2. Entries are a permanent part of the record and cannot be deleted.
3. Log out after every entry, if you are going to be away from the terminal. This will prevent others logging with your name.
4. Your password is confidential. Don’t share it with others. You are responsible for the data entered under your password.
Medication documentation

- Check the prescription for correct entry before sending to pharmacy.
- Follow 8Rs while administering medication.
- Document the reason if drug was not administered.
- Report any error in any of the process of drug preparation or administration.
- Ommision in documentation may lead to double dosing and adverse events.

8 Rs (Rights)
- Right patient
- Right drug
- Right route
- Right time
- Right dose
- Right documentation
- Right response
- Right to refuse treatment

Avoid double dosing by proper documentation.
POINTS TO REMEMBER WHILE DOCUMENTING

1. Document in chronological order.
2. Document date and time of each entry
3. Avoid recording in advance
4. Entries must be legible, clear and brief.
5. Use only commonly accepted abbreviations
6. Document what you see, hear, feel and smell.
7. Emphasize observations by using minimum words
8. Use terms which are observable and measurable while documenting.
9. Begin your charting, once the hands off is completed. Document in nurses progress sheets, all assessments like daily observations, vital signs, condition of wound/suture line, drainage, condition of flap, GCS, complaints if any.,
10. Document implementation of treatment or nursing care and the outcomes.
11. In case of an error while documenting, draw a line through it and initial it.
12. Each entry should be signed by you along with CC no.
13. Patient’s record is a legal document. Maintain its confidentiality
14. Outsiders are not permitted to check/view patient’s record
REFERENCES

“If there were one aspect of health care delivery an organization could work on, that would have the greatest impact on patient safety, it would be improving the effectiveness of communication at all levels – written, oral, electronic”

Richard K. Croteau, MD, executive director for strategic initiatives for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
Credits ...

- Dr. V. Murthy (my Guide) for his supportive interaction and encouragement.
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